ADVANCING PARTNERS & COMMUNITIES

MULTISECTORAL ENGAGEMENT:

FHI 360's Dynamic Approach to Locally-Owned Family Planning Programs in Uganda

July 2019

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JSI Research & Training Institute, Inc.

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National Population Council

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ACRONYMS

ADHO	Assistant District Health Officer
APC	Advancing Partners and Communities
CAO	Chief Administrative Officer
CBFP	Community-Based Family Planning
CDO	Community Development Officer
DCDO	District Community Development Officer
DHIS2	District Health Information System2
DHO	District Health Officer
FP	Family planning
FP-CIP	Family Planning Costed Implementation Plan
FP WG	Family Planning Working Group
GoU	Government of Uganda
HMIS	Health Management Information System
HPP	Health Policy Project
IP	Implementing partner
JSI	JSI Research & Training Institute, Inc.
MoH	Ministry of Health
NGO	Nongovernmental Organization
NPC	National Population Council
PMA 2020	Performance Monitoring and Accountability 2020
QIC	Quality Improvement Collaborative
RAPID	Resources for Awareness of Population Impact on Development
RHITES	Regional Health Integrated to Enhance Systems
SCALE+	System-wide Collaborative Action for Livelihoods and Environment Plus
SNE	Social Norms Exploration
TFR	Total Fertility Rate
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHT	Village Health Team
WHO	World Health Organization

BACKGROUND

Population and People—More than a "Sector"

The size of a country's population—and the rate of its overall growth as well as that of specific segments—affects the nature of challenges faced by every development sector. Similarly, the size of an individual family, and the spacing of children within it, define the realities embraced every day by that household.

Despite the fundamental importance of population at both the macro and micro levels, involvement in "planning" for this issue is generally relegated at the government level to a single sector, and at the family level to a single contact point (i.e., a clinic or community distributor) aimed largely at adult women.

Efforts to expand ownership, resources, and services to other sectors and throughout communities can be challenging. The World Health Organization (WHO) notes that barriers to multisectoral and intersectoral action include lack of political will or commitment, lack of resources and coordination, and entrenched siloed thinking. However, WHO also asserts that a systematic multisectoral APPROACH to family planning (FP) can help address conflicting interests among sectors, power imbalances, and competition for resources.[1] At the community level, providing political, religious, and cultural leaders with information about the importance of FP and building the capacity of technical leaders about how to coordinate and structure multisectoral approaches to FP will help increase uptake of available services.

Uganda and the Challenge of a Multisectoral FP Approach

The Government of Uganda (GoU) has for many years addressed FP as a high priority and committed itself to meeting the ambitious national goal of 50 percent modern contraceptive use by 2020. In 2016, the total fertility rate (TFR) in Uganda was 5.4 children—among the highest in the world. This rate is driven by various factors, including high percentages of unintended and teenage pregnancies (over 25 percent).[2] Between 2001 and 2016, use of modern contraceptives nearly doubled in the country, from 14 percent to 35 percent.[3] However, much work remains to be done to reach the GoU's goal of reducing unmet need for FP to 10 percent and increasing the modern contraceptive prevalence rate to 50 percent by 2020.[4]

The GoU has recognized that promoting uptake of FP services requires addressing an array of underlying determinants, many of which lie beyond the health sector. Further, effectively engaging other sectors requires approaches that focus on all stakeholders who may influence both the quality of and the demand for services. The GoU has therefore launched a multisectoral effort that addresses FP challenges through pathways that transcend traditional sectoral boundaries and promotes ownership

[1] World Health Organization Regional Office for Europe. 2018. Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region Governance for a sustainable future: improving health and well-being for all. Copenhagen, Denmark.
[2] Uganda Bureau of Statistics (UBOS) and ICF International, Inc. 2018. *Uganda Demographic and Health Survey 2016.* Kampala, Uganda, and Rockville, Maryland, USA: UBOS and ICF.
[3] Uganda Bureau of Statistics (UBOS) and ICF International, Inc. 2012. *Uganda Demographic and Health Survey 2011*. Kampala, Uganda, and Calverton, Maryland, USA: UBOS and ICF.
[4] Ministry of Health, Uganda. 2014. *Uganda Family Planning Costed Implementation Plan, 2015–2020*. Kampala: Ministry of Health, Uganda.

and good governance for FP by building accountability across sectors and strengthening collaborations and partnerships.

A key step forward in these new efforts was the launch by the President of Uganda in 2014 of a Family Planning Costed Implementation Plan (FP-CIP) for 2015–2020 to lay out strategies and resources to reach the ambitious national goal for modern contraceptive prevalence. Development of the FP-CIP was supported by the United Nations Population Fund (UNFPA), the United States Agency for International Development's (USAID) Health Policy Project (HPP) and Advancing Partners & Communities Project (APC), the Gates Institute on Population and Reproductive Health at Johns Hopkins Bloomberg School of Public Health, the African Medical and Research Foundation, and others. The FP-CIP Task Force and Technical Support Team, in consultation with expert groups, developed the technical strategy through an inclusive, country-driven process that encompassed goal setting, situation analysis, results formulation, and activity planning. The multisectoral nature of the FP-CIP and the roles of different institutions are clearly laid out, with Office of the Prime Minister coordinating implementation and assisted by the National Population Council (NCP).

FP-CIP ADVOCACY SUCCESS IN BUTALEJA DISTRICT

Before 2017, the Butaleja District Health Office did not have an FP work plan or budget. With support from the APC, the district held a stakeholder meeting, chaired by the district's Chief Administrative Officer, to create a plan and budget for FP activities in FY 2017/18 that reflected the key priorities of the national FP-CIP. The plan was presented to the District Technical Planning Committee and District Council for approval. A budget of 10,000,000 Uganda shillings was approved, and the district chairperson personally lobbied for additional funding from implementing non-governmental organizations (NGOs). The proposal and work plan were approved. Further, to address the staffing gap, 20 additional midwives were recruited and 35 Village Health Team (VHT) members trained to offer FP services in three sub-counties.

At a national level, APC participated in the FP-CIP development process through the Technical Support Team, which identified strategic priorities and activities and estimated costs through an inclusive decision-making approach that included the Ministry of Health (MoH), development and implementing partners (IPs), civil society organizations, advocates, and beneficiaries. This country-driven process included a comprehensive situational analysis structured around six essential thematic areas: **1.** Demand creation; **2.** Service delivery and access; **3.** Contraceptive security; **4.** Policy and enabling environment; **5.** Financing; **6.** Stewardship, management, and accountability.

At district level, APC facilitated district workshops that enabled stakeholders to identify district-specific challenges to FP and come up with interventions to address the identified challenges. The leaders assessed the FP data in their districts, including maternal and infant mortality, teenage pregnancy, and fertility rates; unmet need for contraception; and modern contraceptive rates. These District FP-CIP Action Plans were embraced by political and faith leaders and implementing partners. Key outcomes from the action planning workshops were district-level budgetary commitments to FP activities and joint work plans, which districts have committed to beyond the life of the APC project.

The Contribution of Advancing Partners & Communities (APC)

The Advancing Partners & Communities Project (APC) was led by JSI Research & Training Institute, Inc. (JSI) and implemented by FHI 360 in Uganda. This document outlines activities and approaches undertaken between 2014 and 2019 by APC to support this important effort (see box). APC introduced a multisectoral approach to FP programming in close collaboration with the MoH and the National Population Council (NPC)—a semi-autonomous government institution mandated to develop and oversee implementation of the National Population Policy, coordinate the population program, and prepare the country to harness the Demographic Dividend. APC was mandated by USAID to work in five districts in different geographic regions of Uganda: Agago, Butaleja, Buyende, Kyegegwa, and Rubirizi. In collaboration with experts from the Makerere School of Public Health, APC conducted a hotspot mapping of all districts in Uganda, focusing largely on TFRs and contraceptive prevalence rates. The selected districts represented the lowest performing districts by region using the latest Uganda Demographic and Health Survey data (**Table 1**).

TABLE 1: TOTAL FERTILITY RATES OF SELECTED DISTRICTS

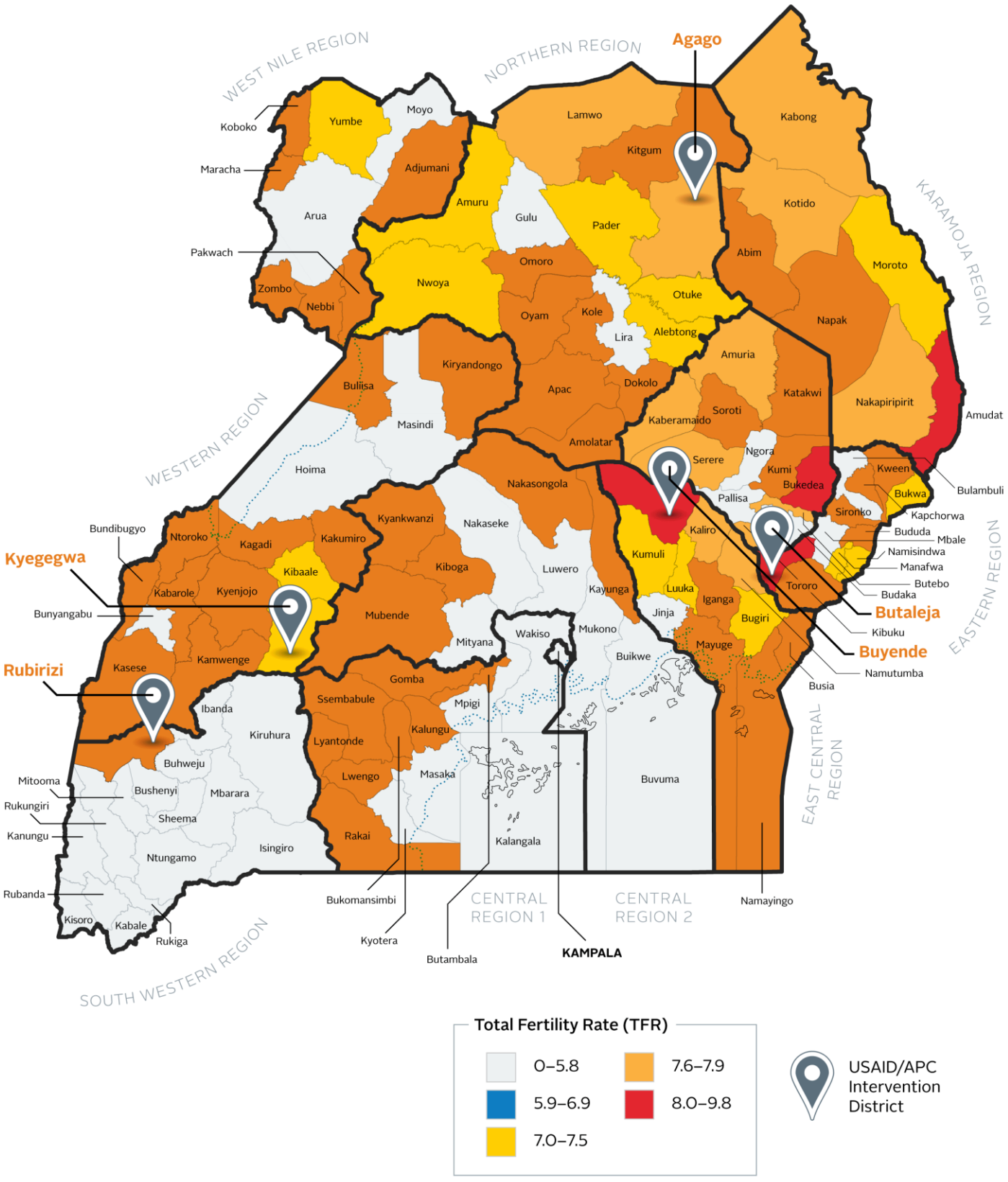
DISTRICT	TFR
East-Central BUYENDE	8.3
East BUTALEJA	8
North AGAGO	7.7
Western KYEGWEGWA	7.0
S-Western RUBIRIZI	6.2

The Advancing Partners & Communities (APC) Uganda Project was a five-year effort funded by USAID/Uganda and implemented by FHI 360 to advance and support community programs that seek to improve the overall health of communities—including use of modern FP. APC Uganda's strategic approach focused on two key objectives aligned with USAID's Country Development Cooperation Strategy:

- Strengthen effective country leadership and coordination for FP programs
- Create the enabling framework to transform social norms that impact demand for and use of modern contraception

The project produced a compendium of tested interventions and resources to address negative social norms and barriers towards FP uptake and a model for creating a favorable environment and local ownership of FP programming. The tools and resources used to implement this approach are hyperlinked in the blue textboxes throughout the document.

FIGURE 1: MAP OF UGANDA'S FERTILITY HOT SPOTS



THREE PRINCIPLES OF A SYSTEMATIC APPROACH TO MULTISECTORAL COLLABORATION

APC employed three principles consistently throughout its work:

- Basing strategies and decisions on evidence and disseminating this evidence broadly
- Basing decisions and actions on collaborative processes and feedback loops
- Engaging champions at the local level

1. **Utilize evidence:** At the beginning of the project, APC collected existing data and conducted qualitative research regarding behaviors and perceived benefits and barriers to provision and uptake of FP services in the priority districts through fertility hotspot mapping[5] and social norms exploration.[6] This data was used to select districts and design tailored packages of interventions for five hot spot districts.

In addition, APC introduced and customized the Resources for the Awareness of Population Impacts on Development (RAPID) model to district FP working groups. RAPID is a computer-based advocacy tool that uses local data to project the social and economic consequences of population growth on various sectors (labor, education, health, urbanization, and agriculture).[7] Prior to APC, this tool had only been used at the national level in Uganda.

2. **Rely on collaboration:** APC employed SCALE+ to engage stakeholders from multiple sectors and multiple levels. SCALE+ is a methodology used by FHI 360 to bring about broad and

OVERALL GOALS OF APC IN UGANDA

The major intended effects of APC's introduction of multisector approaches to FP in Uganda were to:

1. **Reduce** unintended and mistimed pregnancies in target communities
2. **Improve** MoH capacity to lead, coordinate, and operationalize the FP-CIP and other components of national plans and policies
3. **Enhance** ability of the MoH and district teams to collect, report, analyze, and use FP/reproductive health data for strategic decision making in multisectoral domains
4. **Increase** government support for non-health sector stakeholders to integrate and address FP and population issues in their programs
5. **Transform** social norms that negatively impact demand for and use of modern contraception
6. **Advocate** for policy change to allow the inclusion of drug shops to provide injectable contraceptives

[5] Identifying Fertility Hotspots in Uganda. Available from: https://www.ngoconnect.net/resource/identifying-fertility-hotspots-uganda

[6] Exploring the Deep-rooted Social Norms that Affect Demand for and Use of Modern Contraceptive Methods in Ugandan Communities. Available from: https://www.ngoconnect.net/resource/exploring-deep-rooted-social-norms-affect-demand-and-use-modern-contraceptive-methods

[7] Resources for the Awareness of Population Impacts on Development (RAPID). Available from: https://www.avenirhealth.org/software-mobile-rapid.php

sustained collective impact.[8] It embraces the need to understand how diverse forces and structures influence a complex development issue so that committed groups can work effectively towards a commonly agreed-on objective.

SCALE+ begins with a mapping of the whole system and aims to engage local energy, local resources, local intelligence, and mutual accountability to analyze a problem and take action. It offers a process for approaching development challenges from multidisciplinary perspectives and with stakeholders from multiple sectors in a bid to have them take responsibility for the development need.

SCALE+ also specifies indicators to help evaluate progress toward improved stakeholder relationships and increased social capital. Social capital is the strength of bonds within each group as well as the bridges to other groups within a defined network. Through the SCALE+ methodology, APC engaged partners in jointly identifying problems and solutions and also committing to specific actions—according to their specific roles in the community—to bring about change. As the initial catalyst and facilitator of this process, APC played a strong role in ensuring continuous communication among the various stakeholders.

3. **Engage local champions:** When individuals must make personal decisions about their own actions or the lives of those they care about, they are most likely to be influenced by the opinions of those they know, respect, and with whom they share common values and experiences. Decisions about FP are likely to be affected by positive role models and champions who are nearest to one socially, culturally, and in myriad other ways. APC ensured that champions were engaged across "sectors" within communities and neighborhoods and were linked through referral systems to FP services.

ESTABLISHING AN EVIDENCE BASE—UNDERSTANDING FP DETERMINANTS

At the beginning of the project, APC identified sub-counties within the five priority districts with higher-than-average fertility and teenage pregnancy rates. The project conducted qualitative research in these "hot spot" areas with both community members and health providers (Village Health Teams, or VHTs, and facility-based health workers). Reproductive-aged sub-groups interviewed included teenage boys and girls 15–19 years, male and female youths aged 20–24, low parity women 25–34, and men 35–49.

APC used several ***Social Norms Exploration (SNE)*** tools developed by USAID's Passages Project to facilitate a series of participatory learning activities with the different sub-groups. The tools included

Tools and Resources

Identifying Fertility Hotspots in Uganda

Identifying Fertility Hotspots in Uganda – The How to Guide

Social Norms Exploration Tool

Social Norms Exploration Report

Experience based co-design toolkit

[8] System-wide Collaborative Action for Livelihoods and Environment (SCALE+). Available from: http://scaleplus.fhi360.org/index.html

the “5 whys approach” (which attempts to uncover highly entrenched benefits and barriers to behaviors), vignettes, a pocket chart, and a problem tree.

APC used these tools in facilitating discussions to elicit attitudes towards modern contraceptives, child marriage, teenage pregnancy, and high fertility. Discussions also aimed to identify key influencers regarding these issues in the community across the different district hotspots. APC facilitated 50 group discussions using the “5 whys approach,” 19 group discussions using the vignettes, 21 discussions using pocket charts, and 14 discussions using the problem tree. Key influencers were also identified in the participatory activities included religious leaders, parents, local council chairpersons, teachers, and cultural leaders. APC then mapped out these influencers location and the systems of accountability at subcounty and district levels and actively engaged them through their respective sectors to support the FP program.

STEPS TO EXPERIENCE-BASED CO-DESIGN:

1. Interview the FP clients to gain a better understanding of the care experience
2. Film/record the interviews to reference them later if possible
3. Identify, through dialogue, negative and positive experiences, or touch points, along patients’ care journeys and record them
4. Map the touch points (with clients’ verification) along a negative-to-positive spectrum, which is called an “emotional map”
5. Discuss the map and design improvements to services and key messages to address barriers to service identified with providers and clients

APC also applied user-centered design principles through the use of experience-based co-design (EBCD). This methodology is a participatory, user-centered approach that engages clients in improving or redesigning FP services. It enables clients to tell the stories of their experiences with health services, often revealing unexpected areas for improvement, important key messages, and better service delivery strategies. APC used EBCD to engage specific groups of current and potential FP clients (e.g., in- and out-of-school youth and women of low parity). We used the information to work with influencers and health care providers to design interventions with the community beneficiaries in mind. For example, in-school youths noted that they preferred talking to health workers about pregnancy prevention; thus senior women teachers invited midwives to schools to talk about this topic.

Interventions for each district were tailored based on findings and key influencers identified in the SNE (**Figure 2**).

FIGURE 2: INTERVENTION MATRIX BY DISTRICT

ACTIVITY	DISTRICT				
	Buyende	Butaleja	Rubirizi	Kyegegwa	Agago
Multisectoral engagement and data for decision making: disseminating hot spot, SNE, and DHS data to inform RAPID model, district FP-CIP action plans, etc.	■	■	■	■	■
Community dialogues: led by influencers and focused on transforming negative social norms around FP myths and misconceptions	■	■	■	■	■
Positive girls' development (Anyaka Malwiri): mentoring program on sexual and reproductive health (SRH), financial literacy, and soft-skills curriculum; adapted from USAID Youth Power Action project in Uganda.					■
Faith-based programming (Christian Family Life Education Curriculum): designed to build religious leaders capacity to be able talk to young people about adolescent SRH topics	■			■	
Expanded Quality Improvement Collaborative (QIC): community-based family planning (CBFP)* quality improvement collaborative was expanded beyond health care providers to include community influencers	■	■	■	■	■
Male engagement (Emanzi): male engagement mentoring activity focused on transforming gender norms while improving health seeking behavior, including HIV testing and FP uptake		■	■	■	■
Cultural institutions: the leaders from these traditional kingdoms were engaged specifically to conduct parenting dialogues	■			■	
Drug shops Implementation science study[+]: 12–month study exploring feasibility and acceptability of drug shops provision and administration of injectable contraception		■			■
Mobile for Reproductive Health (M4RH): opt-in mobile health intervention designed for young people seeking SRH information on Viamo's 161 Service	■	■	■	■	■
Innovation grants: small grants to local organizations to design and test local solutions	■	■	■	■	■

* *Community-based family planning (CBFP) brings FP information and methods to women and men where they live, rather than requiring them to visit health facilities. Under APC, this involved training VHTs to provide short-term FP services, including injectable contraceptives, and to refer for long-acting and permanent methods.*

[+] *The drug shops implementation science study was conducted by FHI 360 in 20 districts representing each region of Uganda. Two of these districts were included in the five APC intervention districts.*

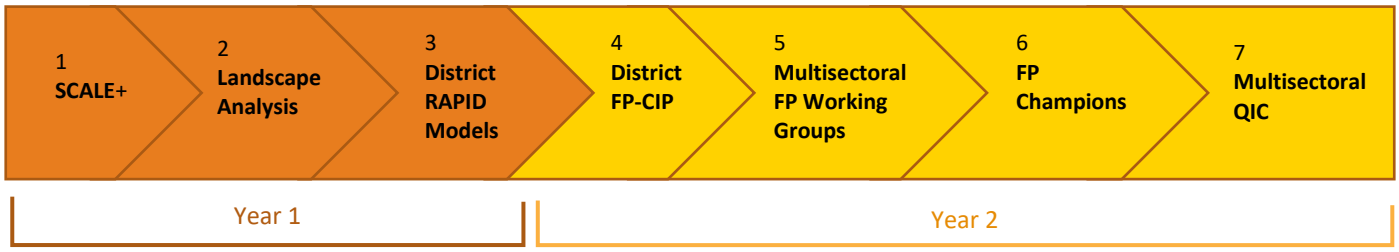
SEVEN FOUNDATIONAL ELEMENTS

Following the formative research, APC facilitated a seven-step implementation process to establish multisectoral FP programming in its five priority districts (see **Figure 3**, below). Together, the seven steps forged sustainable commitments that would continue beyond the project's end in Uganda. Although implementation is depicted in the figure in a linear way, the multisectoral collaboratives themselves are involved in iterative processes—committing to their own targets, monitoring achievements, and redefining goals.

APC also developed this detailed guide to the seven steps, designed for national and district leadership as well as IPs to be able to apply this approach. The guide includes hyperlinks to the tools for each of the steps.

The steps—as they were carried out in Uganda—and the tools associated with each, are described in the sections that follow.

FIGURE 3: FOUNDATIONAL ELEMENTS AND TIMELINE TO IMPLEMENTING MULTISECTORAL APPROACH FOR FAMILY PLANNING



1. Introduce SCALE + to bring key stakeholders together to address a common cause
2. Conduct a landscape analysis to know which stakeholder is doing what and where in FP
3. Support district technical leaders to develop and disseminate district-specific RAPID models
4. Develop District FP Costed Implementation Plans
5. Constitute district multisectoral FP WG and develop FP action plans
6. Select and train FP champions (key influencers at community level) to mobilize and sensitize community members about FP
7. Establish community-based multisectoral quality improvement collaboratives that include facilities

ELEMENT 1: SCALE+ and the Whole System in the Room (WSR) Approach

Tools and Resources

SCALE+

In July 2018, APC began to create awareness about FP and seek buy-in from local leaders, including local councils (LCs) and religious, cultural, and clan heads. Leaders discussed with their own cohorts what they could do in their respective constituencies to address teenage pregnancy and early marriages and promote FP. This resulted in the formation of the FP working groups, who developed action plans with commitments by each sector.

ELEMENT 2: Landscape Analysis

Tools and Resources

Stakeholder mapping tool

FHI 360 conducted a landscape analysis in each district to map activities of stakeholders involved in FP. Analyses focused on FP providers as well as supporters, their areas of coverage, challenges faced, and recommendations for improvements in each district. Multiple sectors were included in the mapping, including those concerned with agriculture, community development, health, education, and administration. The results were used to inform the composition of Multisectoral Family Planning Working Groups (FP WGs) (see Step 5). The mapping processes helped APC to identify who the key FP stakeholders were, what their areas of focus were, and their coverage. This process provided information for potential synergies and establishment of a referral and linkage system.

As a result of landscape analysis in Butaleja district, an organized rice farmers' group (Doho rice scheme that includes large- and small-scale farmers) was mapped as a group to target because of its big membership size (all rice farmers around the Doho catchment). The members work for long hours, which limits their time to access health services. The farmer group is well structured with influential leaders who were identified as members of the multisectoral FP WG and as FP champions.

ELEMENT 3: RAPID Model Development and Dissemination

Tools and Resources

RAPID Model

To increase use of data for planning, key officials (including the District Planner, Biostatistician, District Health Officer, and Education Officer) in each district were trained by NPC in the use of the RAPID model as an advocacy tool to support FP.

Multisectoral FP working group working on RAPID modeling. Credit: Dennis Kibwola, FHI 360

RAPID is a computer model developed by SPECTRUM that incorporates selected data (for a country, region, district, etc.) to project the future consequences of population growth on various development sectors. RAPID projects specific human resource costs—such as pay for teachers, schools, health care workers, hospital beds—that will be required based on specified population growth rates. For each district, the participants used the model to project costs associated with two fertility scenarios:

- Business as usual (high fertility)
- Vision 2040 (low fertility level by 2040)

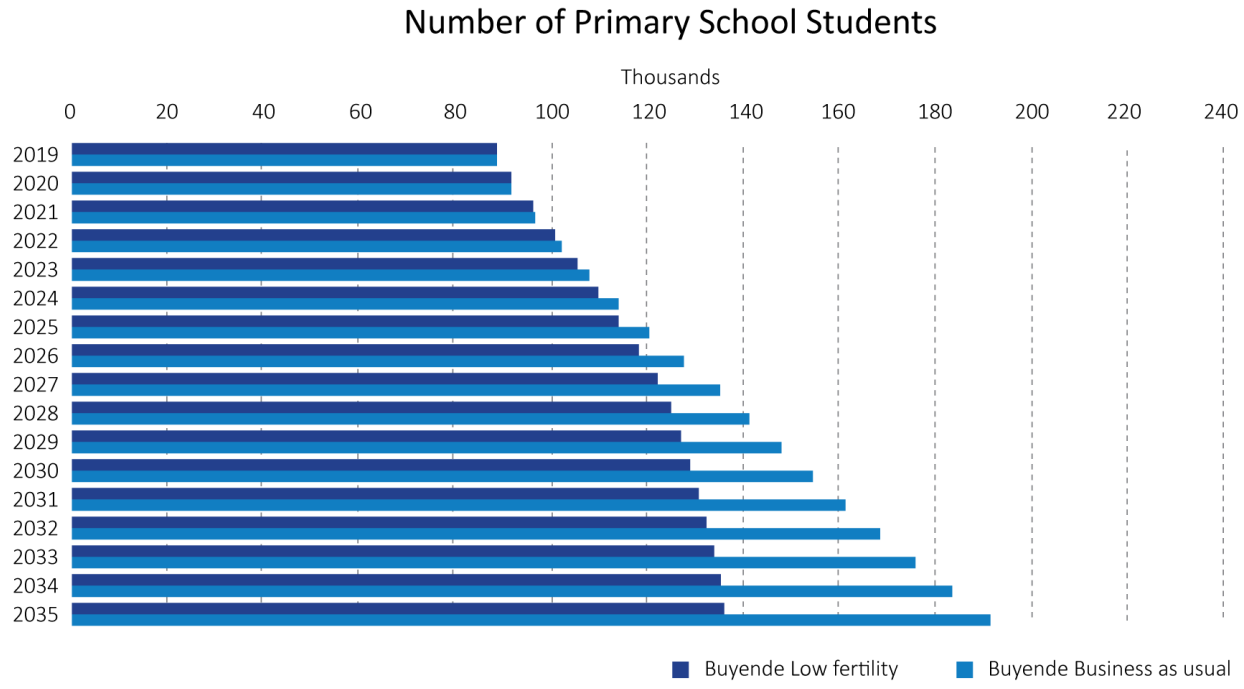
The results of the modeling demonstrated very clearly the overall costs to multiple sectors of population growth and helped policymakers and other stakeholders understand the resources and lives that can be saved by investing in FP.

The NPC supported all five APC districts to identify data sources that for variables that are affected by FP challenges across health and non-health sectors. In this exercise, relevant data was identified from PMA 2020 reports, DHIS2, the National Population and Housing Census 2014 Report, and from the different district reports.

From February to March 2019, the models were disseminated to the political and technical leaders, religious and cultural leaders, and IPs in each of the districts by NPC and FHI 360. Upon seeing the evidence displayed graphically by the district RAPID model, each district leadership team agreed to commit to a budget for FP per sector. This activity created buy-in necessary to mobilize officials as well as stakeholders across different sectors to convene FP multisectoral meetings as well as a workshop to develop each district's FP-CIP action plan.

In Buyende district, RAPID model results illustrated the long-term scenarios related to health and education (**Figure 4**). District officials discussed how a lower fertility rate would result in higher-quality education services with less burden on the infrastructure. With no change in FP measures in this district, there will be continued high enrollment with less classroom space and poor teacher-pupil, pupil-latrine, and desk-pupil ratios.

FIGURE 4: EXPECTED INCREASE IN PRIMARY STUDENT POPULATION IN THE CONTEXT OF CONTINUED HIGH FERTILITY, BUYENDE, 2014–2040 (USING RAPID MODEL)



ELEMENT 4: Family Planning Costed Implementation Plan

Tools and Resources

Uganda FP-CIP

Report on review of the FP-CIP 2015–2020

FHI 360 was able to successfully engage the districts in FP-CIP development and operationalization. Building on the RAPID model, in March 2019 select district leadership, including district health officers, district planners, and district community development officers, met to develop tailored district CIP Action Plans across the CIP's six essential thematic areas. District CIP Action Plans were embraced by political and faith leaders and IPs. After each district FP-CIP plan was launched, a district Multisectoral FP Working Group was created to follow and monitor implementation progress.

ELEMENT 5: District-based Multisectoral FP Working Groups

Tools and Resources

Terms of reference

Action planning template

FHI 360, in collaboration with the NPC, formed the Multisectoral FP Working Groups (FP WGs) and convened monthly meetings. Members included a variety of actors, ensuring representation from each level of government from national down to the sub-county and community-level (see **Table 2**).

The purpose of the FP WG was to bring together all sectors routinely to discuss FP and population issues both the current and what is projected by the RAPID model. Terms of reference were drafted by FHI 360 and NPC spelling out member roles were. They were presented, discussed, and adopted and signed by the working groups in each district.

To enhance learning and expedite the launch of this activity, APC organized learning visits to Dokolo district, which was successful in allocating resources for FP. In addition, the working groups were able to identify small grant opportunities through the office of the community development officer. Several of the districts were able to identify funding through these grants to support youth groups. The working groups were motived to meet and develop district-specific action plans based on local resources, because they felt accountable and part of something bigger than just their sector and district.

Each FP WG is chaired by the Chief Administrative Officer (CAO) of the district; the District Planner acts as the Secretary. The membership of the group includes the technical team (District Health Officer, District Education Officer, district community development officer, FP focal person, District Information Officer, and Chief Finance Officer), the political leadership (District Chairperson, District Speaker, Secretary for Health and Community Based Services, District Youth Councilor, District Chairperson for Persons with Disabilities), religious and cultural leaders, representatives of farmer groups, and a representative of FP champions and IPs.

TABLE 2: ROLES AND RESPONSIBILITIES OF KEY ORGANIZATIONS/INDIVIDUALS INVOLVED IN FP WGS

LEVEL	ORGANIZATION	ROLE AND RESPONSIBILITY
National	National Population Council	Represents the GoU and offers technical guidance and participates in project implementation. NPC ensures the alignment of the district plan to national plans and guidelines. Also leads RAPID model adaptation for districts.
	Ministry of Health, Reproductive Health Division, FP Focal Person	Ensures implementation is according to the policy guidelines. As the supervisor of the District Health Services, MoH addresses the concerns raised at the district level.
District	Chief Administrative Officer	Chairs the Multisectoral FP WG. As the technical supervisor in the district, the CAO is responsible for ensuring that the Multisectoral FP WG is functional. He/she ensures members report as required. The CAO can delegate this role to the Deputy CAO or the Principal Assistant Secretary.
	District Planner	Nominated by the CAO to serve as the secretariat to the WG and ensures FP is included in the different sector work plans. The District Planner also works with the CAO to ensure the Multisectoral FP WG is functional.
	District Health Officer	Act as the WG's technical coordinator and ensures that members receive the necessary information and tools. The DHO addresses all technical questions related to FP. He/she also ensures that FP is prioritized and the WG members play their roles. The DHO works with the FP focal person, who is usually the Assistant DHO (ADHO).
	District Council Representative	Ensures that FP issues integrated in the overall district work plan and budget are funded. Holds the technical team to account regarding implementation of FP interventions. As a political leader, also mobilizes community members for uptake of FP.
	District Sector Heads	Plan and budget for FP in their work plans and budgets. They ensure integration of FP in their routine activities and sensitize community members on the importance of FP in addressing the different challenges affecting them.
Sub-county and community level	FP champions, religious leaders, Local Council/ politicians, school senior women teachers, youth champions, and community development officers	Mobilize and sensitize members of the community about FP. They also refer potential users of FP for FP services.

ELEMENT 6: Selection and Training of FP Champions

Tools and Resources

Selection criteria for FP champions

In each district, 15 FP champions—both men and women—were selected based upon the following criteria:

- ✓ Individuals based/rooted in the community
- ✓ Influential with potential to make a difference in FP in the district
- ✓ Committed to reproductive health (RH) and FP with a track record of work
- ✓ Willingness to promote FP

In the five districts, FP champions included farmers, business people, teachers, VHTs, religious leaders, sub-county political leaders, technical officers, and cultural leaders. Many of these champions were also engaged in activities, such as Emanzi, described in the intervention matrix (**Figure 2**). They were trained in how to communicate to people about FP and tasked to sensitize communities and mobilize community support by speaking positively about the importance of FP for quality of life and dispelling myths and misperceptions about FP services. They also act as role models and share their positive experiences as FP users. One of their primary roles is to refer those interested to trained FP service providers. APC developed a specific referral form to track referrals made by FP champions and members of the collaborative (see Element 7).

ELEMENT 7: Community-Based Multisectoral Quality Improvement Collaboratives

Tools and Resources

Collaborative group activity form

Indicator tracking table

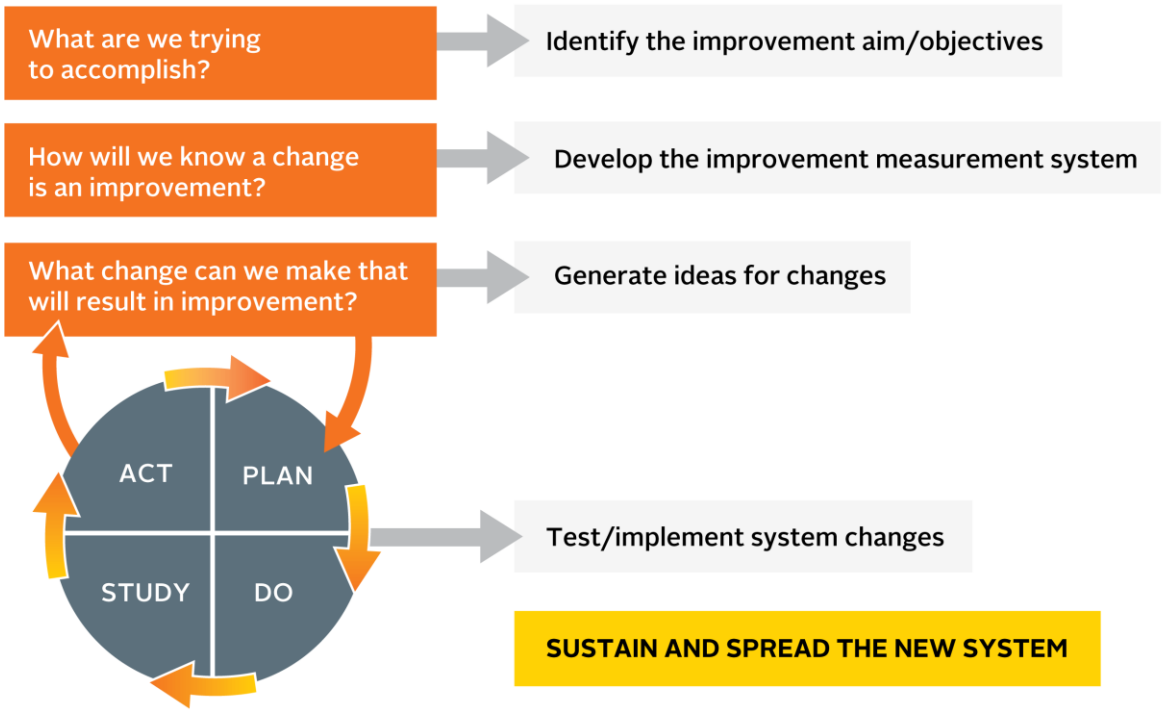
Collaborative referral form

The community-based multisectoral QICs were established and operationalized in each district by FP stakeholders identified through the SCALE+ and landscape analyses. The model follows FHI 360's Quality Improvement Model (**Figure 5**) and was previously used by VHT members and midwives when establishing the CBFP Learning Site in Busia District.[9] For this multisectoral approach, APC expanded the model to include community members, such as the FP Champions, FP WG members, and other influencers participating in APC-led activities. The multisectoral QIC teams visited the CBFP Learning Site to promote peer-to-peer transfer of experience to accelerate the adoption of QIC in the five intervention districts.

APC was able to track the number of completed referrals and contribute to increases in FP use. APC established a monitoring system for the collaborative with tracking system at facility level. All monitoring tools were designed to feed into the facility health management information system (HMIS) 105 reporting format. Between January and May 2019, a total of 1,169 completed referrals were made by the multisectoral collaborative members. This result demonstrates that engaging community-based stakeholders (including those in non-health sectors) to make referrals for FP can yield results.

[9] Applying a Quality Improvement Model to Strengthen Community-based Family Planning Services in Busia District, Uganda. Available at: https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/uganda_qi_brief_final_508.pdf

FIGURE 5: FHI 360 QUALITY IMPROVEMENT MODEL



Source: GL Langley, KM Nolan, TW Nolan, CL Norman, and LP Provost, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (San Francisco: Jossey-Bass, 1996).

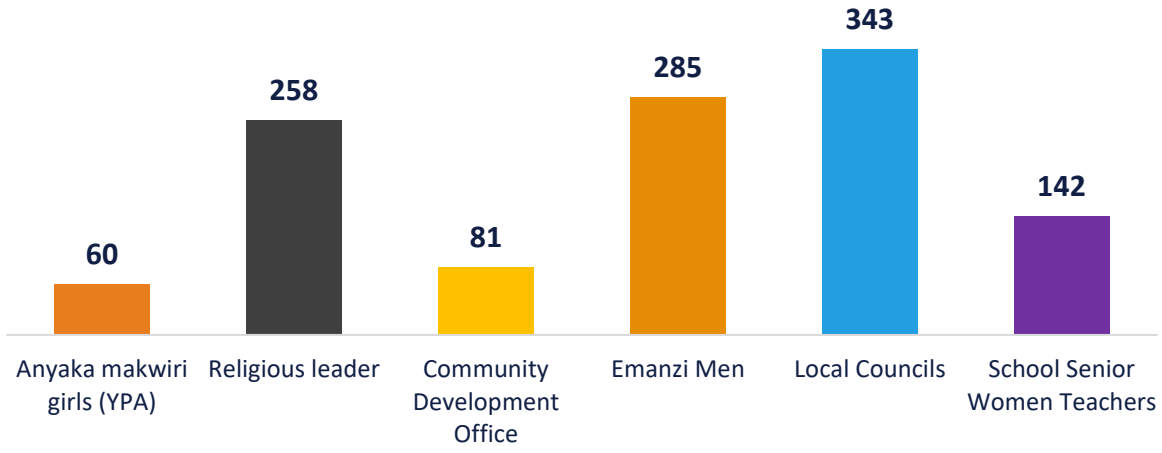
RESULTS

During APC's two years of implementing this approach (2017–2019), the project has achieved important measurable results across the five districts. These include:

1. Trained and mentored 173 VHTs to provide community-based FP services
2. Trained 50 health workers to mentor and supervise VHTs
3. Referred over 1,500 clients for long-acting and permanent methods via VHTs and multisectoral QIC
4. Offered short-term FP services to over 19,049
5. Rolled out community-based FP, including providing and administering injectables to 115 drug shops across 20 districts

The project was able to link its advocacy efforts to FP use by tracking the number of completed referrals (**Figure 6**).

FIGURE 6: COMPLETE FP REFERRALS, BY CATEGORY (JANUARY–MAY 2019)



All five districts where APC implemented this approach are now using district-specific RAPID data models to provide statistics on population effects on the development of different sectors, and district leaders are using these data as a starting point to promote FP. The district chairpersons of Butaleja and Rubirizi have tasked their DHOs to routinely provide them with data from health facilities for use in sensitizing communities. UNFPA has tasked NPC to lead the development of district-level FP-CIP action plans in all remaining districts over the next two years; there are 127 districts in Uganda. NPC has found the RAPID model and multisectoral engagement to be very effective for this task, and their senior leadership has approved national scale-up of multisectoral engagement with the RAPID model. To date, NPC has introduced RAPID modeling to an additional 20 districts.

> *"I have communicated to the District Executive Committee. No sector budget will be approved if it does not include funds specifically for FP."*
>
> -District Planner, Buyende District

A Multisectoral FP WG is in place in each of the APC priority districts, with participation by grass root implementers—including religious and cultural leaders, FP champions, school senior women and head teachers, Emanzi Male models, parenting models, community development officers (CDOs), and Local Councils/political leaders. All five districts have committed to integrate FP into their work plans and budgets. Three districts have already committed funds for FP in the financial year 2019/2020.

The Multisectoral FP WGs all developed their own action plans that were signed by the five respective districts' community, cultural, and religious leaders (from both health and non-health sectors), promising to support and promote FP use and pregnancy-prevention messaging and measure their own progress quarterly. Collaborative structures and processes for health and non-health sectors to conduct district- and community-level FP interventions were established to carry out the FP action plans and a range of innovative activities—including improved referral networks, joint and/or integrated FP dialogues and myth bursting outreach, and integrated FP district-level planning meetings by representatives from each sector.

In addition, all of the districts identified means to support quarterly WG meetings beyond the life of the project. In one district, funding for the meetings is through a community-based organization that was a member of the group. In another district, the district health office has included the meetings in its budget. The remaining three districts plan to meet either before or after Local Council meetings and/or district planning meetings that convene members. The five districts can potentially be used as learning sites for other IPs interested in scaling up this approach.

CONCLUSIONS

Multisector efforts are still new in Uganda; these initial positive outcomes are important for convincing districts—and communities—of their value. FHI 360's multisectoral approach has provided a forum for and empowered community representatives to push district sector heads in the FP WGs to help solve community issues. This approach has brought about a mindset of change among many cultural and religious leaders regarding FP. In Butaleja district, for example, when the Pentecostal Bishop attended the first FP WG meeting, he clearly told members that he could not be part of a team that goes against God's commands. In the following meeting, he returned with strategies about how FP can be promoted among religious leaders—saying he had been convinced FP is beneficial.

Engaging the sub-counties more in the FP WG would have enhanced APC's results. With approximately one year to implement, the project was not able to link the FP WG with sub-counties and communities as much as desired. Convening some of the FP WG meetings in different sub-counties would have provided more opportunities for communities to engage directly with FP WG members. This would also have provided an opportunity for the FP WG to give feedback to the communities on the work that they are doing and enhance accountability and ownership of the FP WG action plans. APC recommends that other IPs and donors operating in Uganda continue to engage the districts as learning sites for a multisectoral approach to enhance peer-to-peer learning and accelerate the scale-up of this successful approach to new districts.

Significantly, a multi-stakeholder engagement methodology like SCALE+ allowed diverse stakeholders to co-create solutions to a common development challenge and then to address these together through collective action. This resulted in the creation and/or enhancement of social capital, which, as noted earlier, was one of the keys to the success of the FP multisectoral work. Additionally, APC's engagement of civil society organizations has translated to sustainability of the platforms that were established, such as the FP WG. Civil society organizations are local, and they remain active and involved in the communities beyond the life of one project. It is critical to engage them in meaningful ways early and often, to achieve and sustain results.