ADVANCING PARTNERS & COMMUNITIES

APC UGANDA ACTIVITY FINAL REPORT

OCTOBER 1, 2017 – JUNE 30, 2019

USAID FROM THE AMERICAN PEOPLE

JSI Research & Training Institute, Inc.

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

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OCTOBER 1, 2017 – JUNE 30, 2019

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Cooperative Agreement: No. AID-OAA-A-12-00047
APC Uganda Activity Start and End Date: July 14, 2014–June 30, 2019
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ACTIVITY INFORMATION

Activity Name:	Advancing Partners & Communities (APC)
Project:	APC Uganda
Activity Start Date and End Date:	October 1, 2012–September 30, 2019 (Uganda Activity July 14, 2014–June 30, 2019)
Name of Prime Implementing Partners:	JSI Research & Training Institute
Contract/Agreement Number:	Cooperative Agreement No. AID-OAA-A-12-00047
Name of Subcontractors/Subawardees and Dollar Amounts:	2014-2016: Straight Talk Foundation ($71,515), Concerned Parents Association ($63,840), Text to Change ($67,500) 2017-2019: Health Development Initiatives, Western Uganda Faith-Based Network, EXP Momentum, Straight Talk Foundation, Action for Community Development ($20,000/each), Viamo ($33,600)
Major Counterpart Organizations:	FHI 360
Geographic Coverage (Districts):	National-level technical support to Uganda Ministry of Health family planning/reproductive health programming. Five districts — Agago, Butaleja, Buyende, Kyegegwa, and Rubirizi — and 20 drug shop implementation science pilot districts
Reporting Period:	October 1, 2017–June 30, 2019
AOR Name:	Marguerite Farrell

ACRONYMS AND ABBREVIATIONS

APC	Advancing Partners & Communities
CBFP	Community-Based Family Planning
CDCS	Country Development Cooperation Strategy
CDO	Community Development Officer
CFLE	Christian Family Life Education
CIP	Costed Implementation Plan
DALY	Disability-Adjusted Life Year
DHIS	District Health Information System
DMPA-IM	Intramuscular Depot-Medroxyprogesterone Acetate
DMPA-SC	Subcutaneous Depot-Medroxyprogesterone Acetate
DO	Development Objective
DSO	Drug Shop Operator
FP	Family Planning
ICT	Information Communication and Technology
IR	Intermediate Result
JMS	Joint Medical Stores
LARC	Long-Acting Reversible Contraception
LC	Local Council
m4RH	Mobile for Reproductive Health
MOH	Ministry of Health
MSI	Marie Stopes International
NDA	National Drug Authority
NPC	National Population Council
PMA2020	Performance Monitoring and Accountability (towards the year) 2020
QI	Quality Improvement
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security

RHITES	Regional Health Integration to Enhance Services
SITES	Strategic Information Technical Services
SMS	Short Message Service
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
TOR	Terms of Reference
TWG	Technical Working Group
UDHS	Uganda Demographic and Health Survey
UHMG	Uganda Health Marketing Group
UNFPA	United Nations Population Fund
UPMB	Uganda Protestant Medical Bureau
USAID	U.S. Agency for International Development
VHT	Village Health Team
YPA	Youth Power Action

ADVANCING PARTNERS & COMMUNITIES

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1. INTRODUCTION

1.1 Activity description

Uganda has made substantial progress in increasing access to and use of modern contraception. However, the total fertility rate (TFR) has reduced only moderately from 7.0 in 2000 to 5.4 in 2016 (UDHS 2016). Uganda also continues to experience one of the fastest rates of population growth globally. Although the age-specific fertility rate for youth ages 15–19 has dropped over the past five years (from 145 in 2011 to 132 in 2016), it has remained much higher among youth living in rural areas than among youth in urban areas.

The demographic drivers behind the high TFR are deeply entrenched in cultural, social, and political contextual factors. Uganda continues to have a very young population, with more than 50 percent of Ugandans currently younger than 18. More than half (54 percent) of women in Uganda begin childbearing by age 19, with 46 percent having at least one live birth. Women living in rural Uganda on average initiate sex at age 16.9, marry at age 19.3, initiate contraception at age 23.3, and have had three children by the time they initiate contraceptive use.

In Uganda, data suggest that women's use of family planning (FP) services is affected by a variety of outside influences — social and cultural norms, gender roles, and religion. Even when FP services are available, these norms prevent FP uptake. Community group engagement or community dialogue is recognized as a FP high-impact practice that can be applied to enhance FP acceptability and use but is not being widely implemented by FP programs. Advancing Partners & Communities (APC) has tested and applied several interventions that address the socio-cultural norms that affect FP, guided by results from fertility hot spot mapping and social norms exploration. These exercises were conducted through dialogues with different community groups including parents, women of low parity, men, adolescent girls, and young women to make them appreciate the importance of FP and prevention of teenage pregnancies.

Therefore, U.S. Agency for International Development (USAID)/APC Uganda focused on implementing and testing interventions that addresses the socio-cultural factors driving Uganda's high TFR, targeting youth ages 15–19 and low-parity women in hot spot districts. "Social norms change" approaches were adapted to change the social determinants of FP use and address barriers starting at the household level in the hot spot areas, through engagement of key identified gatekeepers, influencers at community (village), subcounty, and district levels to achieve normative shifts regarding FP. The activities were differentiated for each of the districts.

APC has been a USAID-funded project led by JSI Research and Training Institute and implemented by FHI 360 in Uganda between 2014 and 2019. This report focuses on the period from October 2017 through June 2019. The goal of APC was to reduce mistimed and unwanted pregnancies among teenagers

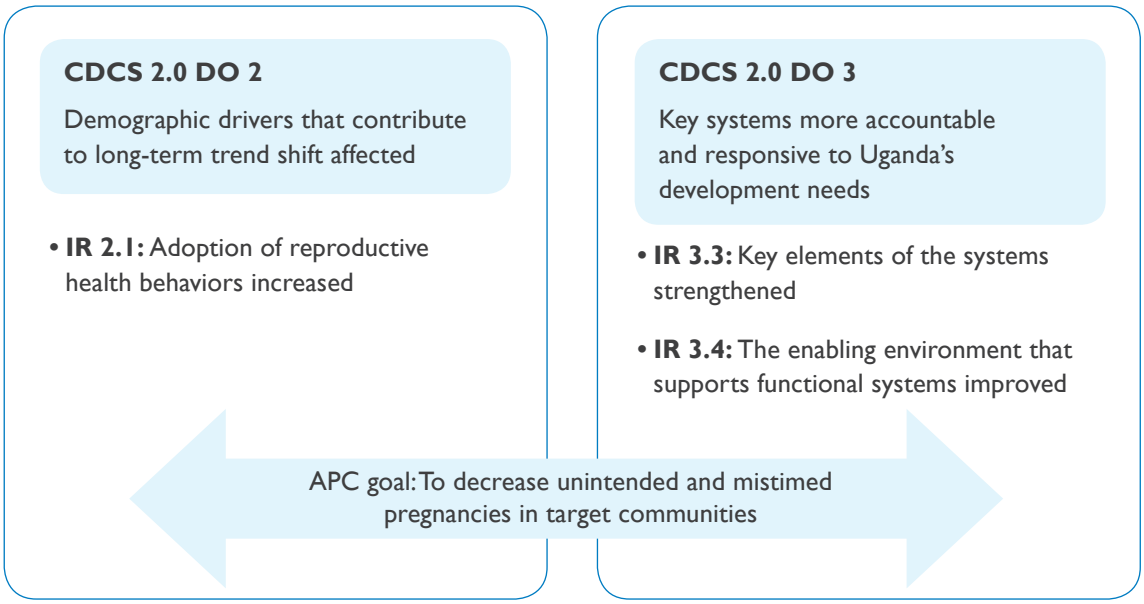
and women of low parity and contribute to a reduction in TFR. To respond to the above challenges, APC Uganda focused on 1) strengthening effective country leadership and coordination for FP programs and 2) creating the enabling framework to transform social norms that affect demand for and use of modern contraception.

A key element of this activity has been identifying, testing, and supporting the spread of community-led innovations and high-impact practices in FP service delivery, and supporting the Uganda Ministry of Health (MOH) and National Drug Authority (NDA) to introduce injectable contraceptives in drug shops through a pilot in all 20 targets districts.

1.2 Alignment to the country development cooperation strategy 2016–2021

The activity was aligned with the 2016–2021 USAID Uganda Country Development Cooperation Strategy (CDCS) 2.0 development objectives (DOs) 2 and 3, as illustrated in Figure 1.

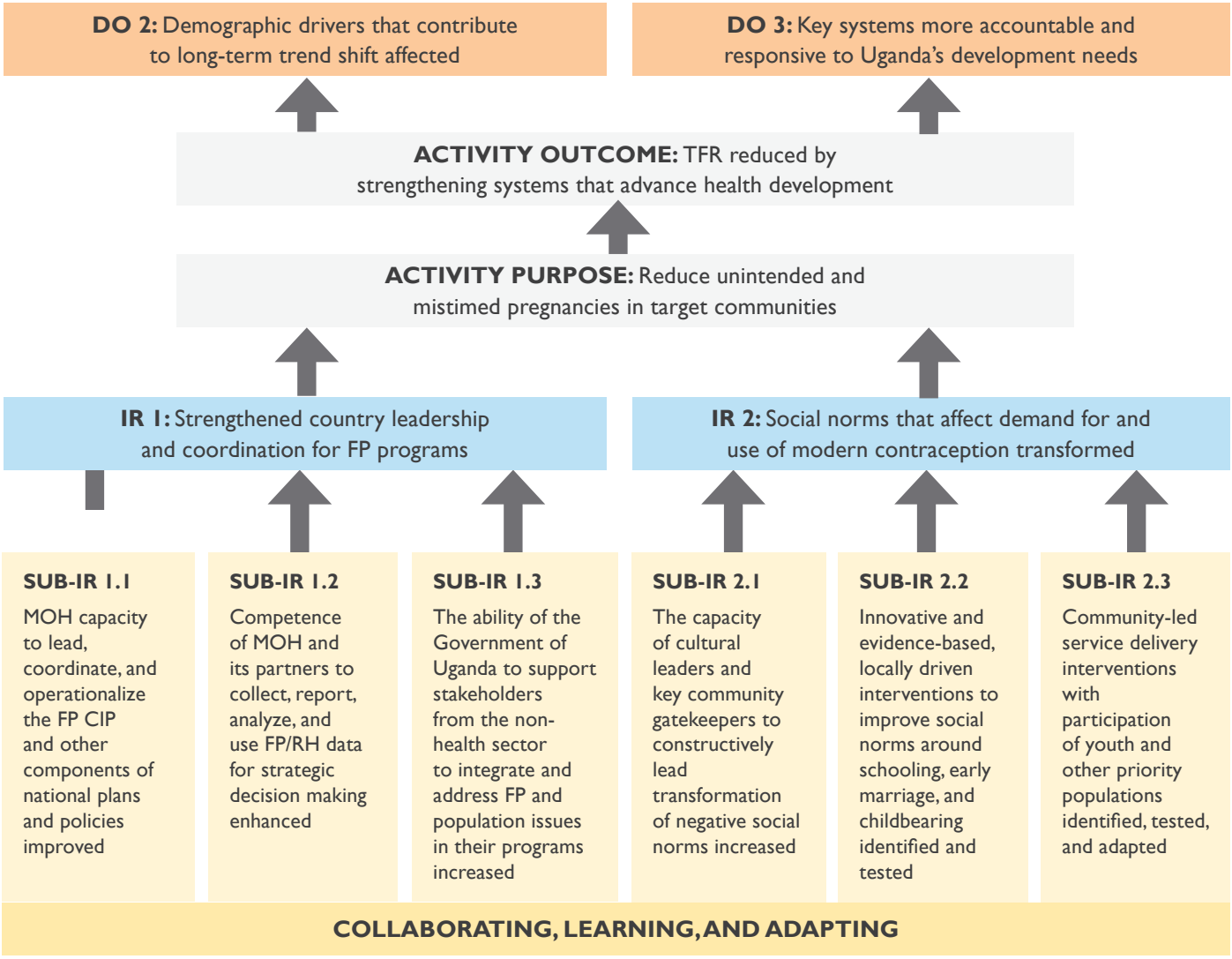
Figure 1. Strategic alignment of APC with CDCS 2.0



CDCS=Country Development Cooperation Strategy; DO=development objective; IR=intermediate result.

APC Uganda's programming principles were based on integration between health and non-health sectors, strengthened FP leadership capacity, local ownership at national and district levels, gender/youth/social inclusion, accountability, user-centered approaches, innovation in FP programming, collaboration, learning, and adaptation through a two-tiered results framework (Figure 2).

Figure 2. APC Uganda results framework



Critical assumptions are that:

- There will be full government/MOH support for the project.
- Funds will be available at all times during the project.
- The socio-political environment will be enabling throughout the project.
- Implementing partners and districts will adapt the identified and tested approaches.
- The demand for CBFP services will continue.
- FP commodities will be available in areas of operation.

CBFP=community-based family planning; CIP=costed implementation plan; DO=development objective; FP=family planning; IR=intermediate result; MOH=Ministry of Health; RH=reproductive health.

1.3 Summary of achievements

The following achievements are based on the USAID APC performance indicators (Table 1):

- National fertility hot spot mapping to identify regions and districts with the highest fertility rates and highest teenage pregnancy rates. A "how-to guide" was also developed for other implementers to adopt the approach. Upon selection of the hot spot districts (Buyende, Butaleja, Rubirizi, Kyegegwa, and Agago), a FP social norms exploration using the USAID Passages Social Norms Exploration Tool was conducted in each district. The results guided the development and implementation of differentiated and tailored approaches in all five project districts.
- Revitalization of the FP/reproductive health commodity security (RHCS) working group through revision of the terms of reference (TOR) 2018–2023, which laid a new structure focused on utilizing data for decision making and programming. APC also supported the group to hold seven routine bi-monthly meetings on schedule.
- Development of the MOH FP costed implementation plan (CIP) monitoring database, now fully functional, optimized, and user-friendly. The database was updated with retrospective data from 2015 to the present by implementing partners, anchored at the MOH server, and transitioned to USAID/Strategic Information Technical Services (SITES) activities.
- Multisectoral FP working groups are in place in each of the five districts, with participation by grassroots 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 (LCs)/political leaders. All five districts have committed to integrate FP into their work plans and budgets. Three districts have already committed FP funds for fiscal year 2019/2020. The project has developed a compendium for multisectoral engagement and action from the district level to the community level for stakeholders wishing to implement interventions in a multisectoral-sensitive manner.
- Approval from the NDA and MOH to conduct a 12-month implementation science study with 115 drug shop operators (DSOs) across 20 districts on the provision and administration of injectable contraception (intramuscular depot-medroxyprogesterone acetate [DMPA-IM] and subcutaneous depot-medroxyprogesterone acetate [DMPA-SC]). The study has concluded, and results are being reviewed by a task force, the MOH, and the NDA. The MOH and NDA are supportive of national scale-up, which could lead to policy change.
- 19,144 clients who have received FP services (i.e., 56 percent village health team [VHT] clients, 44 percent drug shop clients, 24 percent clients new to FP, 14 percent teenagers, 48 percent low-parity women). An estimated 1,901 unintended pregnancies, 45 child deaths, 4 maternal deaths, and 560 abortions were averted by APC-supported health facilities.

KEY RESOURCES DEVELOPED UNDER THE APC PROJECT

Identifying Fertility Hotspots in Uganda

Identifying Fertility Hotspots in Uganda - The How to Guide

Social Norms Exploration Report

Report on review of the FP-CIP in Uganda, 2015-2020 by FP Stakeholders

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

APC Uganda's series of technical briefs

- Using the improvement science collaborative model, development of five district charters with all FP key stakeholders and influencers committing and actively co-designing and co-implementing community-driven FP innovations.
- 260 people from Buyende and Kyegegwa Districts completed the Christian family life education (CFLE) curriculum (30 trainers of trainers and 230 community members). This work was done in collaboration with the Uganda Protestant Medical Bureau (UPMB) and the Church of Uganda — both local organizations able to continue this intervention after the project closes.
- 1,429 men trained on the Emanzi community male engagement curriculum across four implementation districts from 2017 to 2019. More than 4,000 men have been trained since APC started in 2014. This male engagement program addresses gender norms that relate to health-seeking behavior, FP use, HIV/AIDS, and gender-based violence, among other topics. The majority of the groups have continued to meet since the program ended and have formed savings groups or started income-generating activities, such as beekeeping and animal rearing, so they can buy household goods and pay school and hospital fees.
- 92 trainings on parenting and schooling models conducted, resulting in 352 community dialogues facilitated, reaching 8,800 parents. This intervention is in Tooro and Busoga Kingdom, which have very active cultural institutions that will be able to carry on this work after the project ends.
- Collaboration with Viamo to convert mobile for reproductive health (m4RH) short message service (SMS) messages to interactive voice response. During a six-month period, more than 150,000 interactions were captured, of which 75 percent were among those younger than 24 years. Engaging Viamo has resulted in m4RH information being made immediately available at no cost to more than 300,000 youth who have already been reached through Viamo's 1-6-1 service; this access will continue beyond the life of the APC project.
- Through a co-creation process, support for implementation of locally developed solutions to address barriers to demand and uptake of FP services through five innovation grants to local organizations. At least one of these grantees (Health Development Initiatives has been offered a contract to scale up their innovation under another USAID bilateral program.
- Provision of technical assistance with all the Regional Health Integration to Enhance Services (RHITES) activities on quality improvement (QI) for FP as well as FP data use for decision making. This was done through the dissemination of the PMA2020 results. In the North and Eastern regions, we conducted exchange learning visits with the members of the community-based FP (CBFP) center of excellence established during phase one of the project (2014–2016).
- Cultural and religious institutions (e.g., Tooro and Busoga Kingdom, dioceses of the Church of Uganda) trained and mentored to provide FP information, counseling, and referral. This capacity remains at the community level, and we expect religious and cultural leaders to continue campaigning for FP, now that they appreciate its value. In total, 258 complete referrals were made.

Emanzi graduates show chickens from the poultry project they started after completing the Emanzi program.

Photo credit: Chris Arnientwe, FHI 360.

Table 1. USAID APC performance indicators

	Indicator number	Indicator title	Fiscal year target	Fiscal year actual
1	APC1.14	Number of unintended pregnancies that were averted by the provision of contraceptive methods at APC-supported outlets	2,001	1,901
2	APC1.15	The FP technical working group (TWG) revitalized as a functional community of practice; all FP implementing partners will be enrolled as members, meet quarterly, and be accountable to the TWG with clear TOR	1	1
3	APC1.16	FP CIP operationalized at district and national levels	1	1
4	3.1.3-C-3	Number of clients provided with FP services	30,000	19,144
5	3.1.4-C	Percentage of sexually active women ages 15–49 who are using any modern method of FP	36.00%	35.00%
6	HL.7.1-1	Couple years of protection in U.S. Government-supported programs	4,300	5,481
7	APC1.1.5	Key milestones achieved by the MOH and government bodies to coordinate and improve FP programming	3	2
8	APC1.1.6	Percentage of drug shops that provide FP services meeting national or international quality standards	80.0%	73.00%
9	APC1.2.4	Percentage of FP partners reporting FP planning and financing data through the MOH CIP online database to facilitate decision making	80.0%	62.00%
10	APC1.2.5	Fertility hot spot mapping study conducted, and results used by APC and implementing partners for FP programming	1	1
11	APC1.3.6	Number of districts with integrated, costed multisectoral FP action plans	5	5
12	APC2.1.1	Number of religious and cultural leaders trained to constructively lead transformation of social norms that affect demand and use of modern contraceptives	202	260
13	APC2.1.2	Number of FP referrals made by religious and cultural leaders in APC-supported catchments	3,000	1,169
14	APC2.2.1	Percentage of innovative and evidence-based locally driven interventions that address social norms around schooling, early marriage, and childbearing identified and tested	80%	90%
15	APC2.3.1	Number of people reached with FP services through community-led service delivery interventions	25,000	28,841
16	APC2.3.2	Number of meetings held to share learning products, within and across sectors	5	5
17	APC2.3.3	Number of evidence-based program decisions made annually	5	4
18	APC2.3.4	Number of stakeholder representatives ages 14–35 participating in stakeholder engagement events	1,000	850
19	APC1.1.3.1	Number of youth reached with RH information through APC-supported platforms	35,000	24,860
20	APC1.3.1.1	Percentage of clients returning to health workers for resupply of FP methods on time	70.0%	56.0%
21	APC1.3.1.2	Number of health care workers who successfully completed an in-service FP training program within the reporting period	51	65

1.4 Contribution to CDCS results framework

APC's goal was to test scalable innovations that aim to reduce mistimed and unintended pregnancies in target populations, correlated with the CDCS 2.0 DO 2 but also contributing to DO 3, particularly intermediate results (IRs) 2.1, 3.3, and 3.4.

Fertility hot spot mapping was conducted in line with CDCS sub-IR 3.2.1, leading to the selection of APC intervention districts that had the highest TFR and high teenage pregnancy rates. This was done through secondary analysis of already existing data sets (Census 2014, UDHS 2016, and PMA2020). This approach ensured that APC generates and uses data for intervention targeting, but also supports USAID partners with information to guide their programming. A "how-to guide" has been developed to be used by any organization/program to conduct hot spot mapping for any other health intervention.

In line with CDCS IR 3.3, APC supported the revitalization of the national FP TWG and FP/RHCS working group. The groups' revised TOR 2018–2023 were reviewed by the MOH's RH and Pharmacy Divisions, discussed, and approved. The revised TOR clarified and streamlined matters such as membership to the groups; member roles and responsibilities; updates to the structure to reflect current implementation modalities; and alignment to new/emerging strategies, policies, and plans in the FP/RH sector. However, this activity was affected by lack of commodity security, and commodity stockouts were reflected in the project and the health management information system data for this reporting period.

FP social norms were explored (CDCS sub-IRs 3.4.4 and 2.1.4). APC adapted the Institute for Reproductive Health and Passages Social Norms Exploration Tool to the Uganda context and conducted social norms exploration to dig deeper into the drivers of high fertility, teenage pregnancy, and child marriage. Results indicated a strong emergence of another form of negative social norms for modern FP methods, related to FP service quality. Therefore, while negative norms around culture, religion, and tradition continue to hinder FP uptake and utilization, quality-related norms have been established and are now deeply entrenched. They are linked to side effects, poor quality of FP information, and myths and misinformation. This information is guiding interventions that are to be implemented by APC in the various districts.

A FP CIP web-based information system was developed and installed in line with CDCS sub-IR 3.2.1. APC supported the design and development of a FP web-based performance monitoring database designed to track resource expenditures, plan performance, and monitor financial commitments made by implementing partners and funders. The system has now been installed on the MOH server and is accessible to all implementing partners. As part of sustainability, working with the MOH's RH Division, APC conducted FP CIP database user and administrator trainings to equip stakeholders with skills to enter data, and to equip the MOH health information communication and technology (ICT) team with the necessary skills to support the system functionality.

In line with CDCS sub-IRs 2.1.3, 3.2.4, and 2.1.4, APC developed and signed collaborative FP charters with five fertility hot spot districts, with local stakeholders committing to support FP. These included religious leaders, schools, cultural leaders, non-health sector departments, police, VHTs, and facility-level health workers in target communities. They committed to actively support/promote FP use and pregnancy prevention messaging, and to monitor their progress every quarter, hence fostering social accountability.

Congruent with CDCS sub-IR 2.1.2, APC supported the MOH, NDA, and districts to train 150 VHTs and 118 DSOs to provide short-term contraceptives at the community level. To date, 8,102 clients have received short-term FP services from the APC-supported outlets. Additionally, 174 health workers received on-the-job mentorship on comprehensive FP and QI.

Key challenges

The need to be data-driven caused delayed commencement of activities in the districts. This was due to the selection of the target districts taking longer than anticipated after the fertility hot spot mapping was completed. APC had to wait for approval from USAID to commence activities. District selection was completed in April 2018, and activities began in May 2018.

The suspension of the social marketing activity that was implemented by Uganda Health Marketing Group (UHMG) affected the introduction of injectables in drug shops. Due to the suspension, drug shops ran out of stocks, and operators had to travel long distances to buy injectable contraceptives from pharmacies; thus, they increased the price of the contraceptives. In addition, the project was unable to DMPA-SC for drug shops. This was due to delayed introduction of the socially marketed product because of overbranding issues with the manufacturer. However, in March 2019, USAID approved a one-month supply from Joint Medical Stores (JMS), which supported the activity.

The project was unable to fill the two seconded MOH positions included in the Year 3 work plan and budget due to bureaucracy within the MOH. The RH Division and the Community Health Department were supportive, but there was apprehension in this particular aspect at some senior levels. APC hired consultants to support implementation of these activities, all of which were conducted successfully.

1.5 Service implementation results

APC has been supporting FP provision through two channels — VHTs and DSOs.

Analysis of service data (Table 2) showed that 19,144 clients were reached with short-term FP services from these outlets. The project targeted teenagers and women of low parity in the five hot spot districts (innovation sites). The results indicated that 9,198 (48 percent) were women of low parity, while 13 percent were older adolescents ages 15–19.

Table 2. Service implementation data

District	Number of clients	Percentage new to FP	Percentage low-parity women	Percentage teenagers (15–19)
CBFP through VHTs				
Agago	2,171	27%	48%	19%
Butaleja	2,530	39%	56%	16%
Buyende	2,557	24%	65%	18%
Kyegegwa	1,960	27%	56%	10%
Rubirizi	1,491	16%	43%	7%
Drug shop operators				
Agago	438	13%	42%	6%
Budaka	275	10%	35%	16%
Bugiri	408	15%	29%	12%
Busia	353	7%	39%	8%
Butaleja	510	16%	40%	9%
Dokolo	385	19%	48%	7%
Kamwenge	1,166	29%	36%	14%
Kanungu	325	13%	46%	8%
Kasese	258	6%	39%	11%
Kayunga	320	6%	44%	8%
Kyenjojo	422	17%	41%	10%
Luwero	434	6%	47%	8%
Mayuge	427	14%	23%	11%
Nakasongola	142	15%	52%	10%
Ntungamo	232	16%	40%	7%
Oyam	451	14%	44%	9%
Pader	394	10%	47%	6%
Rukungiri	442	7%	41%	5%
Sembabule	360	4%	38%	7%
Sironko	693	14%	36%	14%
Total	**19,144**	**22%**	**48%**	**13%**

The fact that we reached a relatively small proportion of older adolescents with services (13 percent) points to the need to implement more adolescent-friendly interventions, innovate more around schooling and peer-to-peer interventions, and use an integrated approach for reaching out-of-school adolescents with FP and pregnancy prevention services. It also points to the fact that APC interventions in school were more about behavioral change, empowerment of girls through dialogues with senior women teachers and health workers, and model parenting being scaled in a targeted manner.

It should be noted that a smaller proportion of older adolescents from the West than from the East and North (regions with higher fertility) accessed services, which is a good indication. Furthermore, 20 percent of the clients were new to FP, with Butaleja ranking highest. FP use through drug shops was low due to stockouts of DMPA-IM and Sayana Press, but the situation was worsened by the closure of the social marketing activity. This led to increased prices and low use of DMPA-IM.

Analysis also showed that 8,017 (95 percent) of the drug shop clients still preferred three or more children. This suggests that provision of FP in drug shops should be sustained, but that there should be a strong element of behavioral change as well as adaptation of a multisectoral FP service provision language.

This preference could be addressed by talking to these clients in a multisectoral manner, so that they could appreciate and have a mental view of what their quality of life would be if they chose a bigger or smaller family. This is an approach that should be piloted and adapted for FP programs in the private sector.

Given Uganda's demographic pyramidic structure, APC was designed to focus on teenagers and youth, to be able to harness the demographic dividend. As such, the intervention was intentionally implemented with and for young people. Analysis of service data showed that 12,465 (65 percent) of the clients were younger than 30 years, 7,668 (40 percent) were younger than 25 years, and 13 percent were teenagers 19 years or younger (Figure 3).

This also points to the fact that although APC has been successful in targeting all age categories, more innovation and approaches are needed for teenagers in and out of school. In line with promoting free choice and voluntarism, APC trained all providers to give full information to clients as they received them. This allowed the clients to have a range of methods to choose from based on their circumstances and needs, hence a better method mix. It should be noted that during implementation, this was affected by stockouts in both the public and private service delivery points. Figure 4 shows the method mix by service delivery point.

Figure 3. Clients served, by age group

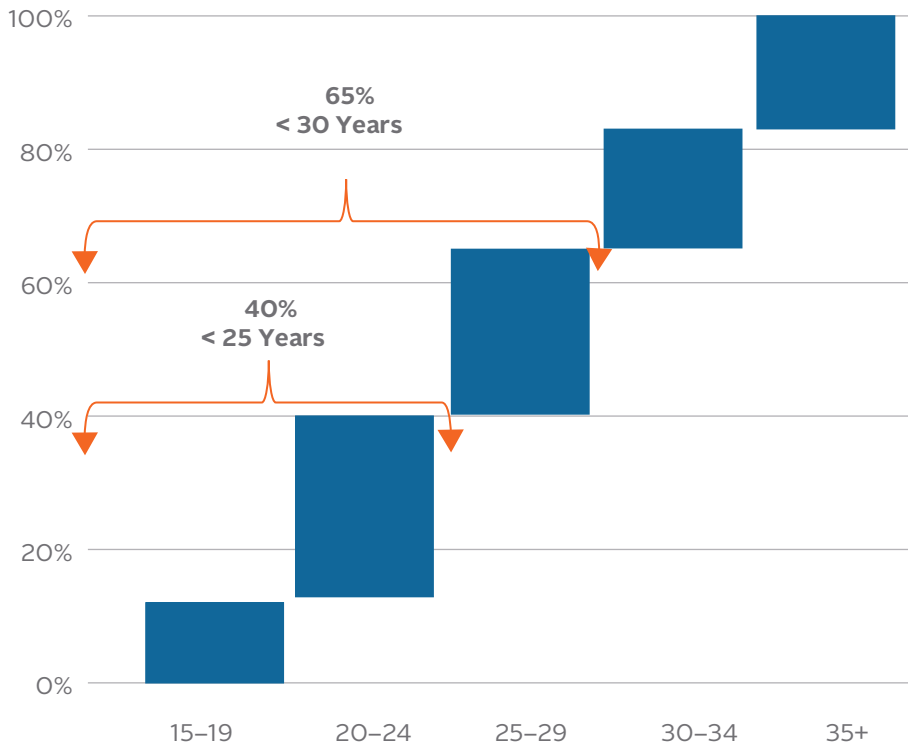
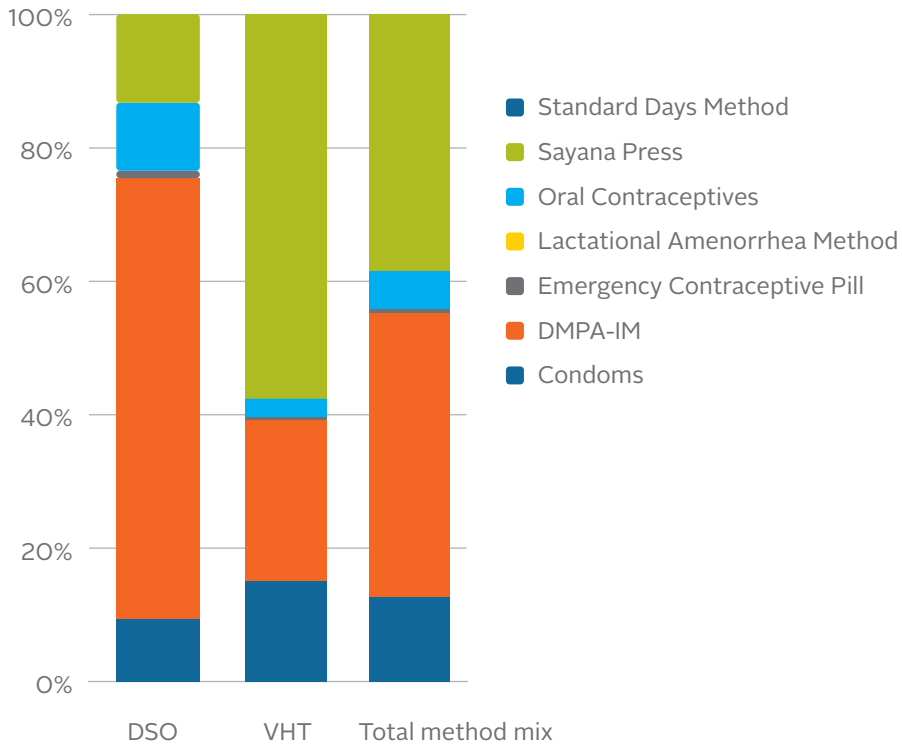


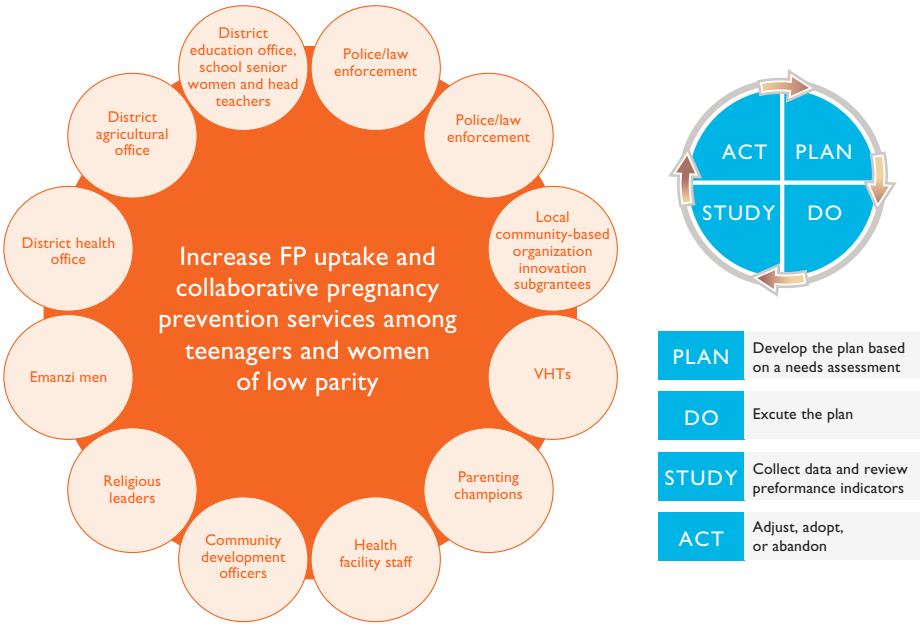
Figure 4. Method mix, by service delivery point



From the social norms exploration, the drivers of teenage pregnancy and high fertility that emerged were around poor parenting, financial factors, culture, gender, religion, schooling factors, political influencers, FP myths and misinformation, and poor-quality FP services. The negative social norms around quality of FP services, particularly side effects and poor-quality information about FP, allowed myths to spread and be entrenched. These are very multi-dimensional and thus needed to be approached in a structured manner. APC adapted the collaborative improvement approach to bring together all stakeholders identified in the exploration, and signed improvement charters with each district to get commitment from key influencers to act on the negative norms. We chose the collaborative improvement science model to guide the collaborative because it allows local innovation, is community-driven, is data-driven, fosters accountability from the district level to the community level, is context-specific, and brings multiple stakeholders together to address a common objective or problem.

Religion, culture, schooling, and male partners were identified as having the potential to accelerate behavioral change, largely because of power, influence, respect, and trust. Therefore, FP and pregnancy prevention messaging and services need to be designed with these four areas in mind. The social norms exploration process is a good way of unearthing and categorizing deeply rooted negative norms around modern contraceptive use and identifying key influencers and reference groups. FP programs should innovatively apply it within the framework of experience-based co-design for community acceptance and higher chances of success. Thus, with this multi-dimensional mix in drivers and negative norms towards FP, we designed a socially oriented, multisectoral, community-driven, and inclusive approach to address social norms while increasing FP uptake. Figure 5 is a visual of the collaborative.

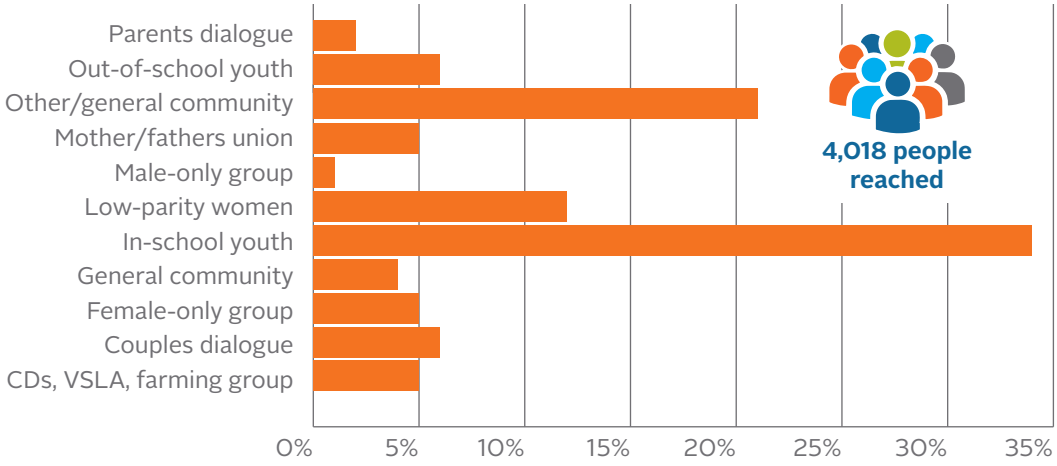
Figure 5. USAID APC FP and pregnancy prevention collaborative framework



Each of the structures and stakeholders identified in Figure 5 developed FP work plans, largely integrated in their routine activities, ranging from method provision to sensitization, counseling, and FP referral. This element was very successful because it adapted a multisectoral approach, even at the community level.

In terms of impact, APC has had significant impact on the communities and systems supported over the past two years. All the capacity building and training was focused on service delivery; as such, every member of the APC collaborative was actively doing something that supported FP (i.e., information, counseling, referral, method administration). Figure 6, for example, shows the number of people reached through myth-bursting dialogues at the community level.

Figure 6. Targeted integrated dialogues by collaborative partners

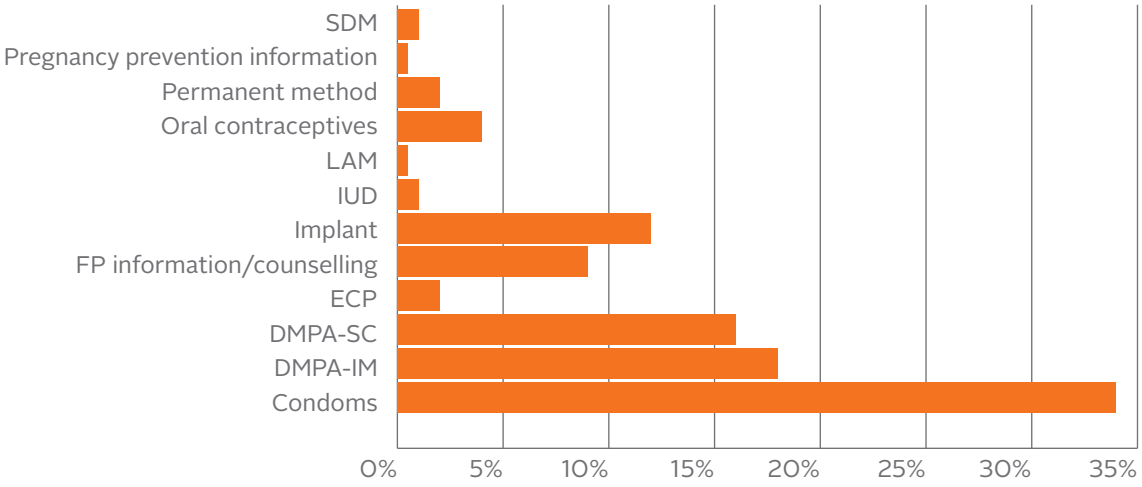


CD=certificate of deposit; VSLA=village savings and loan association.

The intervention was designed in a targeted manner, focusing on the areas identified in the social norms evaluation, as well as the hot spot mapping exercise. Poor parenting was identified as a driver for teenage pregnancy and early marriage; thus, APC adapted a parenting model to reach targeted parents in a bid to change their behavior. All community dialogues were targeted to change behavior and attitudes of the community influencers and target beneficiaries towards contraceptives and FP. Additionally, from January 2019, within the expanded collaborative, APC teams established multisectoral working groups at the district level and engaged community-level multisectoral actors to take action in FP use. A referral and linkage network was established, fed by the integrated dialogues by health workers, religious leaders, CDOs, LCs at the community level, and school senior women teachers.

Between January and May 2019, 1,169 complete referrals were made by the collaborative stakeholders. Figure 7 shows the percentage of clients who received different FP methods as a result of these referrals.

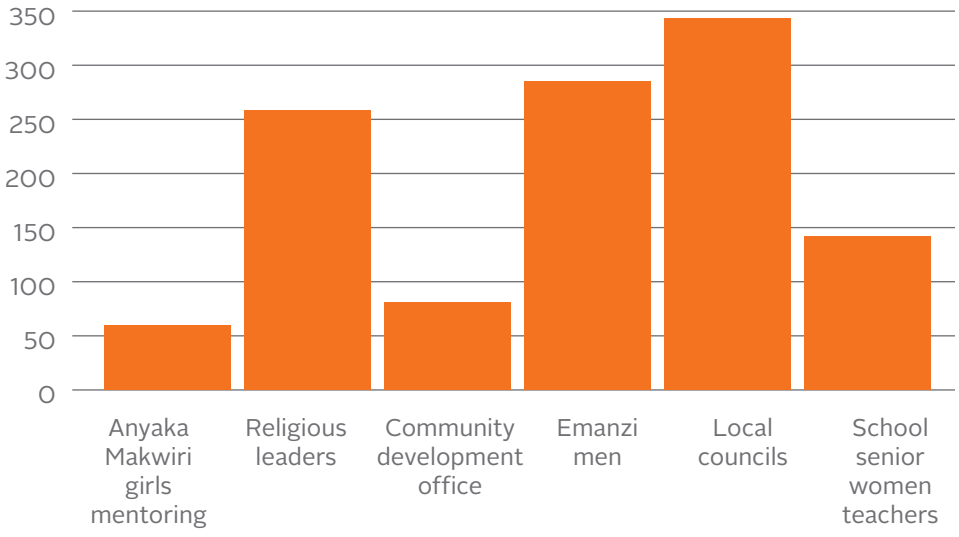
Figure 7. FP services received as a result of referral by collaborative stakeholders, by method



ECP=emergency contraceptive pill; IUD=intrauterine device; LAM=lactational amenorrhea method; SDM=standard days method.

APC established a tracking system for activities of the collaborative partners, and the health facility was the service delivery point in each innovation subcounty. Between January and May 2019, LCs, Emanzi men, and religious leaders referred the most clients among the collaborative partners. This suggests that office bearers have the capacity to influence FP if engaged from a health and development manner. For example, we learned that LCs have more power and influence than VHTs, hence the need to engage them to collaborate for better results. Therefore, the collaborative improvement science model can be adapted in complex programs for community ownership and greater program effectiveness. Figure 8 shows complete referrals by person/entity making the referral, highlighting that non-health sector players can support FP and reductions in teenage pregnancy.

Figure 8. Number of complete referrals, by person/entity making the referral (n=1,169)



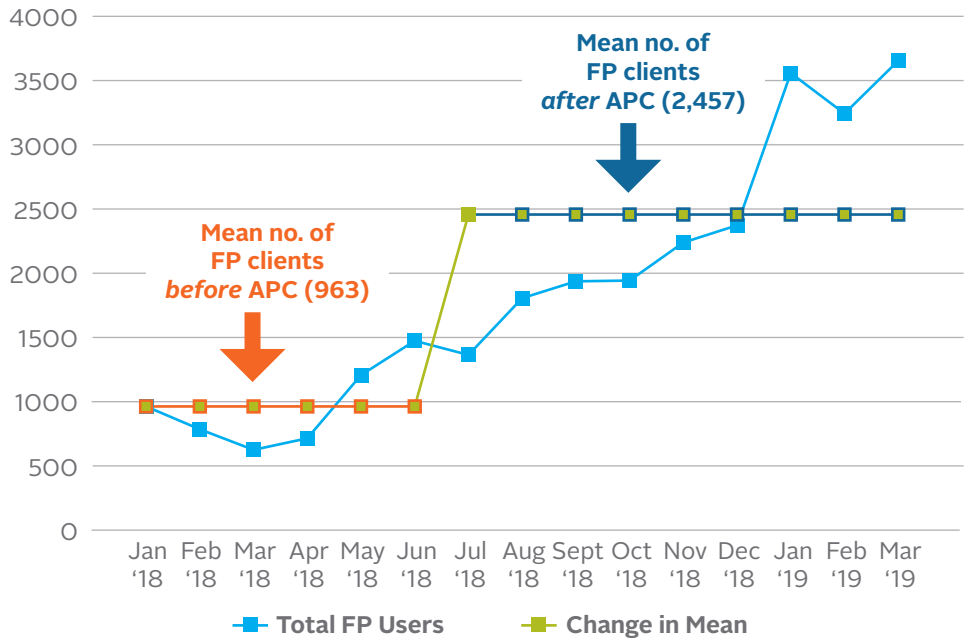
In terms of impact, APC used the MSI impact estimator (v.5) to measure the impact of the interventions. Results showed that we had prevented an estimated 1,901 unintended pregnancies, 560 abortions, 4 maternal deaths, and 45 child deaths and saved health care costs amounting to 465,465,000 Ugandan shillings. Additionally, analysis of district health information system (DHIS) 2 data showed that before USAID/APC interventions, the mean number of FP users was 963 per month, increasing to 2,457 per month with APC innovations as shown (Table 2 and Figure 9).

Table 2. Estimated impacts of FP uptake in USAID/APC innovation sites

Demographic impacts	
Unintended pregnancies averted	1,901
Abortions averted	560
Drug shop operators	
Maternal deaths averted	4
Child deaths averted	45
Unsafe abortions averted	427
Demographic impacts	
Maternal DALYs averted (mortality and morbidity)	251
Child DALYs averted (mortality)*	3,806
Total DALYs averted	4,057
Direct health care costs saved (GBP 2018)	101,026
Couple years of protection	
Total couple years of protection (FP only)	5,482

DALY=disability-adjusted life year.

Figure 9. FP users before and after USAID/APC interventions



Source: HMIS 2015

Using an outcome harvesting approach, the main outcome domains were practices that favor FP (Figure 10). For example, it is now good practice for men to escort their wives for FP, and is common for LCs to talk about FP in their localities. According to APC collaborative change agents, the top two outcomes were increased access and uptake of FP and active involvement of non-health stakeholders, as reflected in Figure 11.

Figure 10. USAID/APC outcome domains

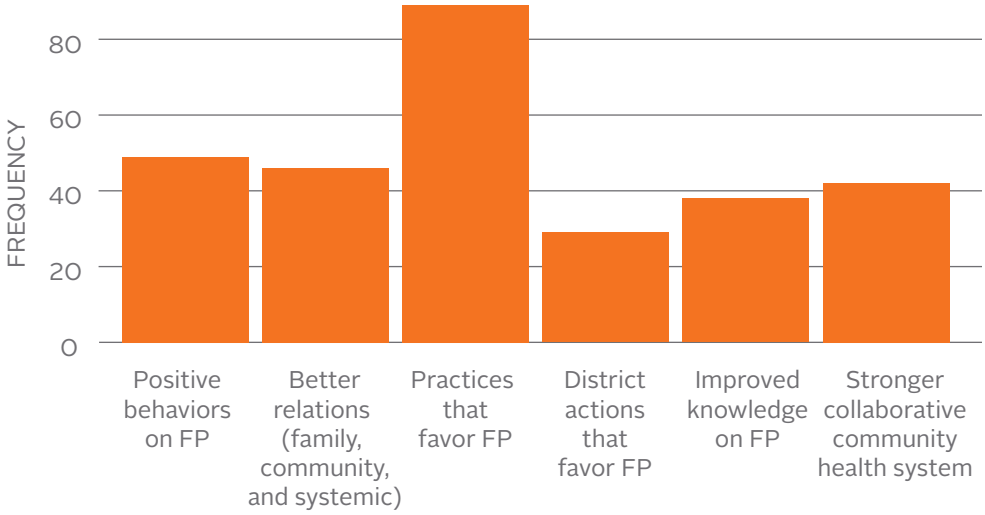
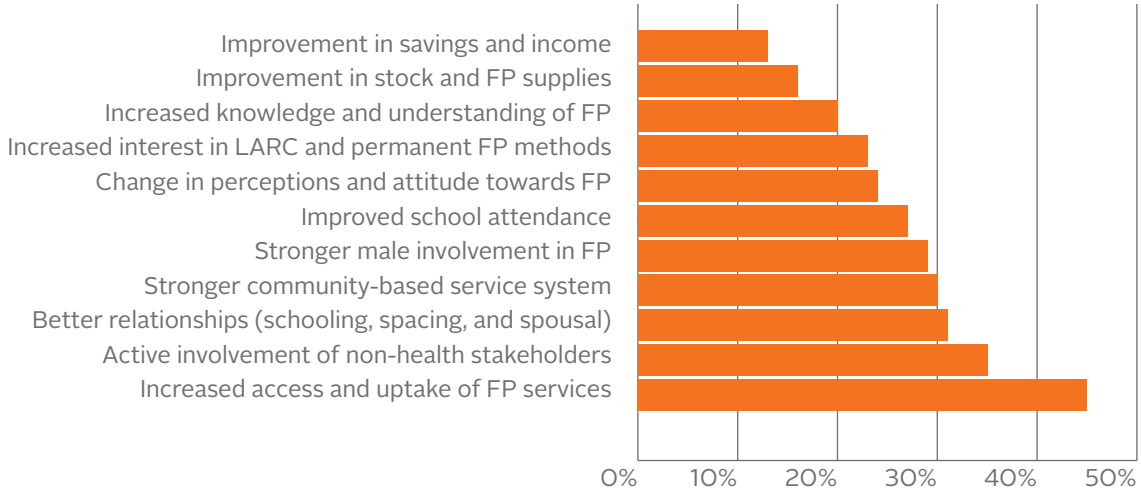


Figure 11. USAID/APC outcomes by rank



LARC=long-acting reversible contraception.

There is no doubt that our innovations, combined with localizing and applying improvement science, were proven to work for APC across the five regions, leading to increased FP uptake as per MOH DHIS 2 data.

2. RESULT AREA NARRATIVE

IR 1. Strengthening effective country leadership and coordination for family planning programs

1.1. Improved MOH capacity to lead, coordinate, and operationalize the FP CIP and other components of FP national plans and policies

- **Revitalization of the FP TWG**

  APC supported the revitalization of the FP/RHCS working group. APC evaluated performance of the group and supported revising the TOR for 2018–2023, as the previous TOR had expired. The new TOR redefined the new structure and guiding principles on which the group would operate through a consultative process with its members. The commissioners of both the RH and Pharmacy Divisions of the MOH signed off on the new structure and TOR.

- **Operationalization of the FP CIP**

  APC led the operationalization of the FP CIP at the national and district levels, working with the MOH and partners, including the USAID RHITES projects, to support national FP CIP coordination and bi-annual review meetings. APC supported the development of the FP CIP monitoring database that is meant to track resource mobilization for the FP CIP by different FP implementing partners. APC trained monitoring and evaluation officers, program officers, and other officers from implementing partners on how to input data into the FP CIP database. The database was also optimized and upgraded to be more user-friendly and to produce reports that show outputs as compared to planned activities. Additionally, APC supported handover of the FP CIP database to the MOH, data analysis, and data reporting in collaboration with the USAID/SITES project. A performance review was conducted for the CIP to assess the performance of partners and to develop action points for 2019. Through partnership with the National Population Council (NPC), all five districts developed and monitored the implementation of district FP CIP action plans that addressed all six thematic areas and allocated budgets. Initially, implementing partners were not inputting data into the system. However, through continuous capacity building and optimization of the system, their responsiveness has increased.

1.2. Enhanced competence of the MOH and its partners to collect, report, analyze, and use FP/RH data for strategic decision making in advocacy, planning, and programming

- **Fertility hot spot mapping and social norms exploration**

  APC in collaboration with Makerere University School of Public Health conducted the mapping activity to identify regions and districts with fertility hot spots. Existing data sets (Census 2014, UDHS 2016, and PMA2020) were

analyzed to identify regions and districts with high fertility and high teenage pregnancy rates. Results led to the selection of the APC project districts. A qualitative inquiry to identify social barriers to FP as well as socio-economic characteristics (e.g., poverty, literacy status) that may influence the TFR was also conducted in all five districts. Following the fertility hot spot mapping, APC applied the USAID PASSAGES Social Norms Exploration Tool in five districts with key influencers and other target audiences, including women of low parity and women younger than 24 years to understand the causes of low uptake of contraceptives and high teenage pregnancy rates. The social norms exploration led to the design of differentiated interventions in the districts.

- **Development, implementation, and testing of innovative solutions to identified problems**

  Using FHI 360's SCALE+ whole system in the room approach, diverse stakeholders (e.g., religious leaders, other implementing partners, USAID RHITES projects, young people, representatives from the education sector, leaders) were brought together to understand the hot spot mapping results. They identified key stakeholders important for supporting and moving forward the FP agenda. From the stakeholders who participated, the multisectoral FP working groups were formed. Through the social norms exploration, APC developed and continued to test interventions to address social norms affecting FP demand and use: Emanzi, CFLE, parenting and schooling interventions through religious and cultural leaders, m4RH, girls mentoring programs, and innovation grants. These interventions were not the same across districts, as per the results of the social norms exploration. Additionally, APC through the collaborative charters engaged non-health sectors, as part of the expanded QI collaborative, in actively sensitizing and referring clients to health centers and VHTs for FP services.

- **CBFP service delivery and expanded QI collaborative**

  APC continued to support the provision of CBFP as a best practice, as well as RH services and information, in the five APC districts. The emphasis was on reaching young people and women of low parity, strengthening referral systems for long-acting reversible contraception (LARC), and improving data quality. One hundred fifty VHTs and their respective supervisors (i.e., midwives) from 15 health facilities in 15 sub-counties were trained on CBFP services. APC scaled up the collaborative QI as a high-impact practice using plan-do-study-act cycles. It was also expanded to actively engage non-health sector players, such as senior women teachers, LCs, police, religious leaders, and Emanzi men, as part of QI at the community level, working together with the VHTs and midwives. Illustrative changes that APC tested included improving mentoring and supervision of VHT members, reaching young people, strengthening CBFP referrals for LARC and permanent methods, preventing rapid repeat pregnancies, and improving data quality. Through the expanded QI collaborative, 1,169 clients were referred for services.

- **Support to MOH and districts on data for decision making**

  APC worked with the NPC to establish a process that led to enhanced data use for decision making and mainstreaming of FP across different stakeholders. The NPC supported key districts in developing their models regarding resources for awareness on population impact on development, which helped districts appreciate the impact of high fertility on other sectors. This triggered districts, through the multisectoral FP working groups, to develop their district CIP action plans and allocate funds. This process was led by the district planning units working in tandem with the district health office and chief administrative officers. The process led to the development of a compendium of resources for building capacity in evidence-informed policymaking and cross-sectoral partner collaborations to connect decision makers with data sources. Additionally, APC Uganda worked with Makerere University School of Public Health to conduct regional meetings to disseminate the most recent PMA2020 data and results from the fertility hot spot mapping and social norms exploration. The meetings were jointly organized with the RHITES projects. District leaders from 69 districts from RHITES Southwest, East, East Central, North Acholi, and Lango regions participated. Districts had an opportunity to review their health management information system data, enabling district leaders to develop resolutions for improving FP services in their respective districts. This also enabled RHITES partners to access and apply the most recent FP data to their programs.

Multisectoral FP working group working on RAPID modeling.

Photo credit Dennis Kibwola, FHI 360.

1.3 Increased ability of the Government of Uganda to support selected non-health sector stakeholders to integrate and address FP and population issues in their programs

APC provided technical assistance to the NPC to conduct district-level landscape analyses to inform cross-sectoral integration of FP. These efforts led to the formation of multisectoral FP working groups and identification of FP champions, leading to integration of FP into wealth creation, environment conservation, production, education, community development, and other relevant sectors.

IR 2. Social norms that impact demand for and use of modern contraception transformed

2.1 Increased capacity of cultural leaders and key community gatekeepers to lead activities that transform negative social norms

- **Engagement of faith institutions**

  APC worked with UPMB to establish memoranda of understanding with two dioceses of the Church of Uganda, Ruwenzori and Busoga dioceses. Thirty faith leaders from the two dioceses were trained using FHI 360's newly updated CFLE master trainers' curriculum. CFLE was originally developed by FHI 360 under the YouthNet Project in 2006. The training gave these

leaders skills to train youth leaders (CFLE educators) in church using a six-session workshop guide and a participant handbook that encouraged open discussion about puberty, RH, and HIV in the context of the Christian faith. In total, 192 CFLE educators were trained, and they sensitized fellow young people in their communities about teenage pregnancies and utilization of FP services using the Christian approach. The sessions provided a forum to clarify Christian values while providing accurate technical information. This work was done in collaboration with UPMB and the Church of Uganda — both local organizations able to continue this intervention after the project closes.

- **Engagement of traditional cultural institutions**

  Results from the social norms exploration indicated that parenting was one of the key drivers of teenage pregnancies. APC learned that working within the existing structures of cultural institutions to engage parents on good parenting practices and address negative attitudes towards schooling was important in developing contextual interventions. APC established memoranda of understanding with Busoga and Tooro Kingdoms in three APC project districts — Kyegegwa, Buyende, and Butaleja — to engage parents on better parenting approaches. APC worked with the cultural institutions to develop concepts and action plans, including community mapping to engage key gatekeepers on using parenting and schooling to prevent teenage pregnancies and early marriages. As a result, 120 parenting dialogues and 180 schooling dialogues were conducted. The cultural institutions have pledged to continue the dialogues through their various structures and fora.

Princess Lydia Naisanga Muloki from the local cultural institution sharing her experiences with conducting parenting community dialogues and supporting menstrual hygiene activities in hard-to-reach communities within the Busoga Kingdom.

Photo credit Leigh Wynne, FHI 360.

- **Constructive male engagement**

  The Emanzi (male role model) strategy was scaled up in four districts — Kyegegwa, Rubirizi, Agago, and Butaleja. The intervention targets men with partners, ages 18–45, to positively influence their attitudes and the attitudes of other men in their communities. It used a mentoring approach with two VHTs, for a group size of 10–14 men, selected by communities to be taken through the nine-session curriculum. Twelve master trainers and 24 subcounty supervisors were trained on the curriculum. They then supported the implementation and training of 72 VHTs that facilitated the Emanzi sessions, with 1,319 men completing the nine-session curriculum and graduating between 2017 and 2019. An unanticipated outcome of this intervention was that most groups continued to meet after the APC activity was completed to discuss gender issues, health, and income-generating activities. They also started savings groups and income-generating activities including beekeeping; rearing chickens, pigs, and rabbits; and pooling funds to buy household goods and pay school fees. The income-generating activities have continued, helping to sustain the positive changes resulting from this intervention.

  This strategy was implemented and evaluated by FHI 360 under the first phase of APC. The evaluation found men's attitudes towards gender norms improved significantly from pre- to post-intervention (~three months)

and continued to increase six months after completing the curriculum. This statistically significant finding demonstrates that men retained the information learned through Emanzi and had lasting improvements in gender-equitable attitudes. Similarly, shared household decision making and FP uptake significantly increased.

The Emanzi graduates were also part of the expanded collaborative charters, through which they also referred clients to health centers and VHTs for FP services. Next steps are to have the current approach adapted by FHI 360 under USAID's Youth Power Action (YPA) award for older adolescents and unmarried young men. The YPA approach will use Emanzi graduates to mentor young men. In addition, USAID bilateral projects, such as RHITES-East, have already started implementing Emanzi, and other RHITES projects have indicated that they plan to do so as well.

A drug shop operator in Luwero District demonstrating with DMPA-SC. This DSO is one of 115 that were trained across 20 districts to provide and administer injectable contraceptives as part of APC Uganda's implementation science pilot.

Photo credit Leigh Wynne, FHI 360.

2.2 Implementation of innovative and evidence-based, locally driven interventions to improve norms around schooling, early marriage, and childbearing

- **Scale-up of injectables in drug shops**

FHI 360 also collaborated with the MOH and partners in Uganda to achieve approval for DSOs to stock and administer injectable contraceptives in 20 districts. As part of the approval, the NDA requested a 12-month implementation science study on the introduction of this approach. APC Uganda conducted this implementation science research to explore the acceptability, readiness, and feasibility of drug shops as a channel for FP provision at scale, as well as to understand both the best way to scale up this approach and its effect on reaching new categories of users. The NDA is reviewing the implementation science findings, and we anticipate the MOH and NDA to scale up this practice, which could lead to policy change.

As part of this portfolio, APC assisted the NDA and MOH in developing a plan for training and expanding provision of both DMPA-IM and DMPA-SC by DSOs in up to 20 districts. Since 2014, FHI 360 under the APC project has been leading the task force supporting the phased expansion plan for drug shop provision and administration of DMPA-IM and DMPA-SC. A DSO training curriculum was developed and used to train 115 DSOs on the provision of injectable contraceptives (DMPA-IM and DMPA-SC) and other short-acting FP methods; this training was endorsed by the MOH and NDA. Training emphasized improving FP knowledge and counseling skills, training on proper waste management, improving communication with clients, and strengthening record-keeping and referral systems. Supportive supervision was conducted with NDA, MOH, and task force members in

areas where improvement was needed, such as safety, infection prevention, and management of data and records. The results of client satisfaction interviews helped modify the intervention.

The biggest challenge faced during the study was stockouts of FP commodities, which were due to the suspension of the social marketing activity that was the main source of commodities for the drug shops. This led to some operators traveling long distances to buy from pharmacies, which led to increased prices of the commodities at the drug shops. With support from USAID, a two-month supply of DMPA-IM and DMPA-SC was obtained from JMS, which helped to bridge the gap until the study concluded. Recently, FHI 360 received funding through the Clinton Health Access Initiative's Catalytic Opportunity Fund to scale up the provision and administration of DMPA-SC and DMPA-IM in these 20 districts. FHI 360 also has plans to introduce self-injection, which is the next frontier for drug shops.

Francis Nsanga of Health for Development Initiatives-Uganda presenting on the results of an innovation grant using a peer-to-peer family planning model in which peer educators conducted outreach in coordination with a family planning service provider.

Photo credit Leigh Wynne, FHI 360.

- **Innovation grants**

A portion of the project funds were devoted to five competitively awarded six-month (short-term) sub-grants to test locally relevant innovations to improve knowledge of, access to, and utilization of healthy RH options, including FP use, among youth and people with disabilities. Through a competitive co-creation process in close collaboration with USAID, five local youth-oriented organizations were awarded grants to develop and test innovations with community gatekeepers, low-parity women, and women with disabilities with the aim of addressing socio-cultural and structural barriers to demand for and uptake of FP services. Table 3 summarizes the innovation grants.

Table 3. Summary of five grants awarded to local youth-oriented organizations

DISTRICT	ORGANIZATION	SUMMARY OF INNOVATION	RESULTS OF THE INNOVATION
Buyende	Health Development Initiatives	Health Development Initiatives, working with the local organization HOLD Uganda, implemented the peer-to-peer model in Bugaya subcounty, Buyende District. A key aspect of this model was that peer educators conducted outreach in coordination with a private-sector FP service service provider. Other FP demand creation included community dialogues.	Over the six months, 1,162 clients received modern contraceptives; 67 percent were young adolescents and teenage mothers ages 15–24. For long-term methods, up to 228 Implanon insertions, 2 intrauterine device insertions (low number due to lack of equipment), and 168 Jadelle insertions were provided. For short-term methods, 325 DMPA-SC (Sayana Press) and DMPA-IM (Depo Provera) injections, 79 oral contraceptives (Microgynon), and 365 condoms were provided. Health Development Initiatives has been offered a contract by USAID's RHITES North Acholi to implement an adapted peer-to-peer innovation in three DREAMS districts (Agago, Omoro, and Gulu).
Butaleja	Straight Talk Foundation	Straight talk Foundation worked with the African Women Service Trust to implement the pregnancy calculator innovation in Kachonga subcounty, Butaleja District. They took communities through the cost of one pregnancy from conception to birth, challenging them to think about how many resources they would need to take care of the children they desired to have. They also used radio talk shows to drum up support for sexual and RH (SRH) and FP services to people beyond Kachonga subcounty. They then linked clients to health centers and VHTs for services.	1,274 clients (577 male and 697 female) directly reached with information and 681 linked to services at the health facility, VHTs, and drug shops.
Kyegegwa	Western Uganda Faith-Based Organization Networks	Western Uganda Faith-Based Organization Networks implemented the Ensingato nisobora in Kyegegwa District. The "one village at a time" innovation focused on youth livelihood activities using expert couples, faith leaders' wives to counsel and refer young people, women of low parity, and people with disabilities for FP information and services. They also engaged people with disabilities groups to conduct mobilization, referral, and follow-up of FP services for people with disabilities.	1,284 clients took FP methods as a result of the innovation (789 took short-term methods and 495 took long-term FP methods) during the project period. 10,440 attended "one village at a time" outreaches and received information on FP.

Table 3. Summary of five grants awarded to local youth-oriented organizations *(continued)*

DISTRICT	ORGANIZATION	SUMMARY OF INNOVATION	RESULTS OF THE INNOVATION
Rubirizi	EXP Momentum Uganda	EXP Momentum Uganda, working with COVOID (a local organization in Rubirizi), implemented a social change project using top-down advocacy and bottom-up demand while engaging key influencers and gatekeepers to address myths and misconceptions. They used the Education Through Listening innovation to identify key intervention needs of beneficiaries for the attention of gatekeepers. They also utilized the existing girls group "the bonga girls" to extend FP services.	126 key influencers (81 male and 45 female) were identified and trained; 7 gatekeeper meetings were conducted, reaching 235 gatekeepers (226 men and 9 women); 4 radio talk shows were conducted and 161 mentions at Voice of Kamwenge were recorded; and 9 youth mentorship forum meetings were held with youth influencers, reaching 456 youth/ adolescents in and out of school, 687 home visits, and 59 people with disabilities.
Agago	Action for Community Development	Action for Community Development, working with NUWOSO in Agago District, used the community cluster model to reach young people and adolescents with FP information. Each cluster included 20–35 adolescents. The formation of these clusters resulted in peer counselors' direct engagement with many adolescents purposely discussing major FP topics and other SRH issues related to safer sex, HIV testing and counseling, sexually transmitted infection management, and treatment in health service points such as Omot HCIII.	As a result of involving VHTs, they were able to increase uptake of FP and other SRH services among 834 young people (498 female and 336 male). In addition, peer counselors directly reached out to 306 adolescents within clusters, creating awareness on FP.

2.3 Effective community-led service delivery interventions identified, tested, and adapted with participation of youth and other priority populations

- **Mobile for Reproductive Health (m4RH)**

  m4RH is a menu-driven, on-demand SMS communication program developed by FHI 360 in 2009 that works on the simplest mobile phone. APC adapted m4RH messages for young people in Uganda in 2015, and they were reviewed and approved by the MOH in 2016. Previous evaluations of m4RH in Kenya and Tanzania had demonstrated that users found the program an acceptable format for receiving SRH information and appreciated the convenience and privacy of this channel. APC launched the m4RH platform to provide information for young people during the first

phase of the project using SMS through sub-grant Text to Change. In 2018, FHI 360 Uganda initiated a collaboration with Viamo to convert the SMS messages to IVR, although the SMS remained available as well. Through this approach in Uganda, SRH information has been made immediately available at no cost to more than 300,00 youth who have already been reached through Viamo's 1-6-1 service; this access will continue beyond the life of the APC project. From December 2018 to June 2019, there were 150,120 interactions, of which 75 percent were among those under 24 years. The average FHI 360 content listeners are largely male, ages 18–24 years, and nine out of 10 interacted with the platform via IVR. Seeing as SMS is used so little to access content (0.2 percent), it would be beneficial moving forward to focus solely on IVR and USSD methods of information dissemination for mHealth innovations.

- **Positive girls' development (Anyaka Makwiri)**

  APC scaled up USAID's YPA's evidence-based Anyaka Makwiri—a girls mentoring program, in Agago District to address the unique needs of adolescent girls and ensure that they had access to resources for health, education, and economic empowerment. This intervention was implemented and evaluated under YPA and was found to have led to statistically significant positive improvements in comprehensive HIV knowledge and savings behavior. There are 26 sessions, covering a range of topics, including gender equality, financial literacy, managing stress, anger and conflicts, menstrual hygiene, and FP. APC worked with district officials who coordinate the DREAMS activities to avoid any duplication of activities. Sixty young women were trained and empowered to be mentors. Fifteen groups of young girls and/or women were formed and facilitated by approximately four mentors working together. Participants developed savings plans that included income-generating activities such as selling food stuffs (e.g., salt, sugar, bread), gardening, and selling livestock (e.g., goats) on market days. On average, each group was able to save 800,000 Ugandan shillings (~US$200) as a result of the financial literacy skills attained. Additionally, 60 participants were referred for FP services, of which 58 started a method. There were also linkages between Emanzi and Anyaka Makwiri, as there were members of couples who each participated in their respective mentoring group.

3. PARTNERSHIPS AND COLLABORATION

3.1 Partnership, collaboration, and stakeholder engagement

From inception, APC was guided by the collaborating, learning, and adapting (CLA) approach, mainstreaming it across all components of the intervention. We designed interventions to learn, fail for re-adjustment, and scale up promising/proven interventions promptly. This meant that we had to intentionally embed CLA at the heart of all activities. Below is a summary of how we approached collaboration and partnership.

Collaboration concepts between APC and the RHITES projects were developed. The concepts stipulated areas where the projects were to complement each other, and where APC was to provide technical assistance. In RHITES Lango, Acholi, East Central, and Eastern, APC provided technical assistance on QI for CBFP service delivery, building on its experience with establishing the learning sites in Busia and Oyam during the first phase of the project. Subsequently, APC worked with all RHITES districts to improve data use through regional FP data dissemination dialogues and action plans for the different regions; this activity included the dissemination of PMA2020 results. All the RHITES monitoring and evaluation officers were trained on the FP CIP framework and use of the monitoring database to report their FP activities. APC developed and shared knowledge materials around fertility hot spot mapping, social norms exploration, the multisectoral engagement compendium, religious leaders' briefers, the CFLE curriculum, and Emanzi male engagement.

At the national level, APC collaborated with the NPC to conduct a landscape analysis and a capacity needs assessment in all five districts. This resulted in the identification of key FP stakeholders and formation of the district multisectoral FP working groups. The FHI 360-NPC collaboration also included co-leading the development of district-level FP CIP action plans in all five districts using the RAPID model and multisectoral engagement. This approach has been very effective and resulted in NPC's senior leadership approving national scale-up of multisectoral engagement with the RAPID model, and UNFPA has tasked them with doing this in all 127 districts. To date, NPC has introduced RAPID modeling to an additional 20 districts.

Because the client is a key stakeholder in FP service uptake and continuation, APC engaged teenagers, low-parity women, and youth in the social norms exploration process and through experience-based co-design. The aim was to understand the drivers of teenage pregnancy and high fertility from their perspectives, so that interventions could be designed to address issues coming from the target beneficiaries. Experience-based co-design enabled clients to tell the stories of their experiences with health services, which revealed unexpected plan-do-study-act cycles for APC's QI collaboratives. For example, in some areas of operation, young women preferred a younger female provider, and some

young people preferred meeting providers in spaces where they spent their leisure time. Engaging and listening to the client augmented the success of the QI collaborative.

APC expanded the QI collaborative to include non-health stakeholders and civil society organizations that were identified by the social norms exploration as influencing FP utilization. The expanded multisectoral collaborative was formalized by having members develop an expanded QI charter for FP — a document that all mapped stakeholders (district, subcounty, and community levels) signed, articulating the members' commitments and actions to reduce teenage pregnancy and high fertility. These multisectoral QI collaboratives serve to promote collective efforts towards further agreed-upon aims/objectives.

APC also collaborated with UPMB in processes for engaging faith-based institutions to introduce the CFLE curriculum. Through engagement with UPMB, APC also mobilized religious leaders from two dioceses of the Church of Uganda in Buyende and Kyegegwa Districts who were trained on the CFLE curriculum. This work complemented the APC core funded activities that provided FP education and counseling services within the church structure, targeting dioceses, parishes, and church-based programs.

Christian Family Life Education trainers and some of the youth they have engaged with sharing their experiences with CFLE.

Photo credit Leigh Wynne, FHI 360

FHI 360 is an active member of the DMPA-SC partners meetings convened by PATH to discuss progress and challenges with the DMPA-SC national scale-up plan. We have also collaborated with PATH on the continuation study comparing DMPA-SC to DMPA-IM as well as the 2018 private-sector self-injection study that included drug shops. FHI 360 worked with Tooro and Busoga Kingdoms to introduce parenting support and guidance in response to high indicators for teenage pregnancy, child marriage, adolescents with HIV, and children dropping out of school. The project facilitated discussions with kingdom officials, ministers, local leaders, and church officials on the best ways to implement parenting activities in the communities. Participants signed commitments to support approaches related to FP and agreed to supervise and monitor the community dialogues and are committed to continuing this work even after APC ends.

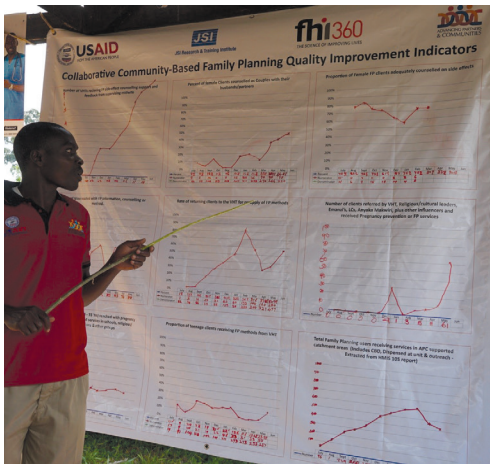
The project introduced short-term innovation grants to support local organizations that engage youth in 2018. With support from USAID Uganda, APC facilitated a workshop during which organizations presented their innovations and got feedback to finalize their innovations. The five that were funded (one per district) represented a diverse group of stakeholders, such as religious leaders, to introduce and integrate FP concepts. These organizations were Action for Community Development, Straight Talk Foundation, Health Development Initiatives, Western Uganda Faith-Based Organization Network, and EXP Momentum Uganda. In addition, each of these local organizations engaged a civil society organization in its district to support implementation. This approach allows for the innovation to continue beyond the life of the six-month grant.

APC collaborated with Makerere University School of Public Health to disseminate PMA2020 results and conduct the national fertility hot spot mapping exercise.

During the first phase of APC, FHI 360 collaborated with WellShare Uganda to adopt the job aids on community health worker provision of emergency contraceptive pills. The integration of this service continued into the second phase of the project.

3.2 Learning and adaptation

In line with guiding principle one (to apply a holistic approach to CLA), following the fertility hot spot mapping that guided district selection, APC conducted a social norms exploration exercise in all the target districts. This exercise was conducted to understand the deeper norms and drivers of teenage pregnancy, child marriage, and high fertility. It was not enough to know where the fertility hot spots were located; it was even more necessary to understand the factors that were entrenching negative norms around FP, and to co-design strategies with communities to address those factors. Although we thought that the social norms that affect FP are mainly around religion and culture/tradition, we found that even more negative norms are built around poor quality (i.e., poor counseling on side effects, miscommunication, myths and misconceptions) and negative experiences that people have while using FP that become accepted as true at the community level. Even the religio-cultural norms are further entrenched by norms established over time by gaps in FP quality. Thus, from the root cause analysis, we now have norms related to service quality that affect FP utilization. APC also learned that parenting was a key factor in preventing teenage pregnancies and partnered with cultural institutions to develop appropriate interventions.



VHT presents the collaborative CBFP QI indicators.

Photo credit Leigh Wynne, FHI 360

In seeking to do business differently, APC expanded its collaborative improvement model to include non-health stakeholders and influencers. The drivers of teenage pregnancy, child marriage, and high fertility are multisectoral; thus, all stakeholders involved needed to have a model that focused on a common aim and objectives. We therefore signed collaborative charters with religious leaders, political leaders, non-health sector players, health workers, cultural leaders, and district technical teams — all focused-on strategies to reduce teenage pregnancy, high fertility, and child marriage, and to increase the dissemination of FP information through their platforms and link communities to contraceptive access points. Religious leaders and schools were not supportive of FP but were very positive about ways of reducing teenage pregnancy and child marriage. Thus, they designed and implemented prevention interventions. This approach was also in line with USAID's guiding principle of applying a facilitative approach to development and minimizing direct service provision over time.

In harnessing youth-appropriate approaches so that they are included in all APC activities, APC adapted experience-based co-design — a client-centered approach used in QI to actively engage teenagers and youth in designing interventions that best suit them at the community level. In all districts, groups of teenage mothers and young women of low parity were engaged in designing interventions that were context-specific and attractive to youth. APC learned that teenagers require multiple service delivery models if they are to be reached with services. Some noted that they preferred younger VHTs (so APC linked them to young VHTs or peer providers), while others preferred older VHTs or DSOs because they were motherly/experienced. Some preferred meeting

the providers in spaces where youth spend leisure time (e.g., sports grounds, water-fetching points). We learned that it is critical to listen to the target population and co-design interventions for greater efficiency and effectiveness, as earlier demonstrated.

3.3 Inclusive development

APC applied the USAID PASSAGES Social Norms Exploration Tool to target populations including women of low parity, young mothers, men, young fathers, women and men with disabilities, and religious leaders to identify key barriers to demand for and utilization of modern contraceptives in the five implementation districts. Outstanding barriers to FP uptake and utilization of other RH services were male partner dominance and poor engagement of community influencers/gatekeepers in RH services. To address this problem, APC applied the Emanzi male model, which has been successful in both addressing gender norms that affect FP use and reducing gender-based violence. We also expanded the improvement collaborative charter to include all voices.

APC recognizes that quality of leadership and level of involvement are key determinants of development at all levels and that they facilitate transformational change towards inclusivity. To this end, APC's collaborative model constructively engaged leaders from community/village, subcounty, district, and national levels in FP activities. Key targeted subgroups were involved through the social norms exploration process and the qualitative phase of the hot spot mapping. APC identified and actively engaged new but powerful structures that had large influences on communities (i.e., religious cults like that of Owobusobozi in Kyeggegwa, beach management units, Bulungi-Bwansi community development initiatives). These were used as platforms to pass FP information to clients and link them to services.

Through landscape mapping, APC identified key multisectoral stakeholders to engage to support FP advocacy at the community level (e.g., district farmer associations, fishery associations, dairy farmers within target districts). These structures are critical if no one is to be left behind in FP.

In terms of youth inclusion, APC rolled out the girl empowerment program (Anyaka Makwiri) in Northern Uganda, and girl peers are already referring their colleagues for FP information and services. APC also engaged teenagers, low-parity women, and youth in the social norms exploration process and through experience-based co-design to improve access and service delivery to FP services. In addition, the innovation grants were developed through a co-design process to specifically reach and engage young people meaningfully with FP information and services. For the inclusion of other vulnerable groups, the innovation grantee that we contracted in Rubirizi District used the Education Through Listening approach to understand the FP/RH needs of disabled women and co-develop solutions to enhance their access to services.

3.4 Science, technology, and innovation

Activities and outcomes

Table 4 summarizes and describes the impact of activities by IR that have a focus on science, technology, and/or innovation.

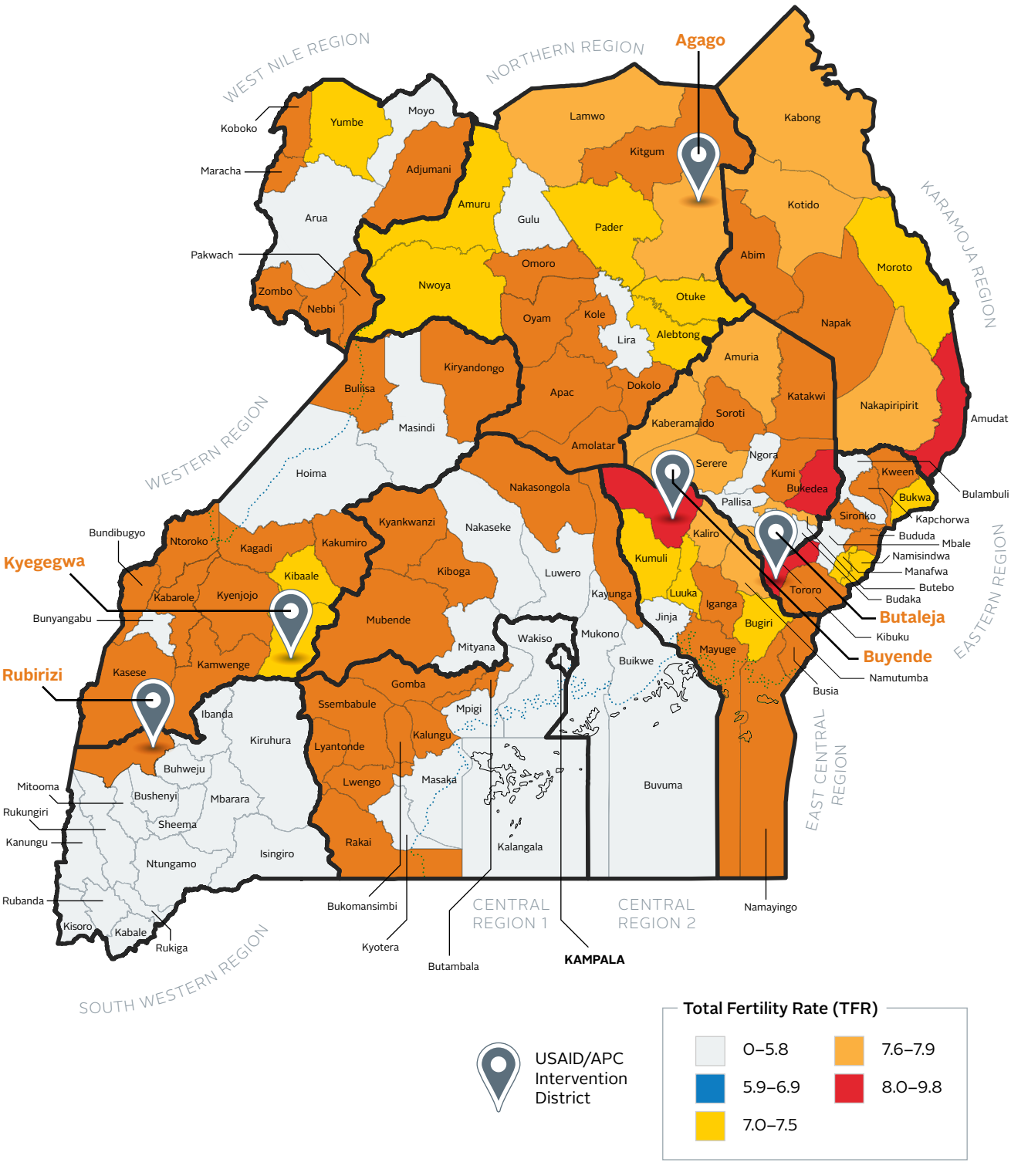
Table 4. Science, technology, and innovation activities, outcomes, and achievements

ACTIVITY RESULT AREA	SCIENCE, TECHNOLOGY, INNOVATION ACTIVITY/ TASK DESCRIPTION	PLANNED OUTCOME	ACHIEVEMENTS
1.1. Enhanced competence of the MOH and its partners to collect, report, analyze, and use FP/RH data for strategic decision making in advocacy, planning, and programming	Expanding the QI collaborative to include non-health actors. APC's approach to innovation relies on social innovation. Due to the nature of the activity and problem (norms that affect FP demand) at the community level, the QI collaborative was adapted and expanded to include non-health actors. It was designed to address community-centered issues but also client-centered issues.	Communities have taken charge of innovations and interventions (i.e. plan-do-study-act cycles) that address/reduce teenage pregnancy, child marriage, and high fertility.	Charters were developed and signed by all the districts. Each category of influencers and stakeholders came up with community-level innovations, linking 1,169 clients to FP services.
Sub-IR 2.2: Innovative and evidence-based, locally driven interventions to improve social norms around schooling, early marriage, and childbearing identified and tested	Conducted 12-month implementation science study on DSO administration of injectables to explore the acceptability, readiness, and feasibility of drug shops as a channel for FP provision at scale, as well as to understand both how to best scale up this approach and its effect on reaching new categories of users.	Supportive supervision data demonstrated good adherence to NDA quality and safety requirements, which improved throughout the year. Client satisfaction surveys demonstrate consistent high performance on measures of quality service delivery, including informed choice of a method, counseling, and correct waste disposal.	Close collaboration with the task force, the MOH, and the NDA on the implementation science study resulted in buy-in from the MOH and NDA for national scale-up, which could lead to policy change.
	APC also provided grants to five local organizations to implement innovations that addressed social barriers in the intervention districts.	Increased utilization of modern contraceptives through community-driven interventions.	All grantees engaged civil society organizations in a meaningful way, allowing innovations to continue in the communities beyond the life of the grant. In addition, at least one grantee has received funding to scale up its innovation in new districts.
2.3 Effective community-led service delivery interventions identified, tested, and adapted with participation of youth and other priority populations	Collaborated with Viamo to convert m4RH SMS messages to IVR.	Use of the Viamo 1-6-1 platform enabled m4RH information to be made available nationally at no cost to users, of which the majority were youth. IVR messages can reach non-literate users, and data show they are accessed much more frequently than SMS.	During a six-month period when the innovation was "live" under APC, more than 150,000 interactions were captured, of which 75 percent were among those under 24 years. m4RH services are available beyond the life of the project.

Mapping for better results

APC received technical assistance from the implementing partner USAID/ Communication for Healthy Communities on the use of a geographic information system (GIS) for mapping fertility hot spots (Figure 12).

Figure 12. GIS mapping of fertility hot spots



Staff, research assistants, district linkage officers, and community linkage officers were all equipped with, oriented on, and trained to use ArcGIS desktop software, ArcGIS online software, and GPS-enabled smartphones to report on APC-implemented activities. The GIS component accompanied quarterly and annual performance reporting, in which APC submitted project and activity location data. The information collected under the GIS component included type and/or name of activity, photograph, and location of activity. Recording discrete locations is essential for establishing an effective method of managing, analyzing, and communicating project and activity information.

3.5 Transparency and accountability

In its operation, APC observed a high level of transparency. All job vacancies, consultants, and research assistants have gone through the appropriate procurement processes.

The innovation grant finalists went through three stages of screening, including review of the initial 22 applications by headquarters staff and FHI 360 contract management services. A co-creation process with the seven finalists was conducted with technical support of the USAID learning advisor, district health officers, and senior officials from the RH Division of the MOH, followed by selection of the five final awardees.

APC worked with communities and district-based personnel such as VHTs, midwives, and CDOs to implement activities and provided facilitation. The personnel were paid/facilitated according to the approved rates for the Government of Uganda, irrespective of their positions.

In terms of activity implementation, APC's collaborative approach ensured that all stakeholders, including clients, were part of the intervention design, that joint monitoring was conducted, and that client satisfaction interviews were conducted by drug shop and VHT supervisors to assure the quality of the FP services provided.

In the five target districts, we involved district health teams, the MOH, the NDA, and other stakeholders in monitoring and supervising activities. APC also reported to the drug shop task force on the progress of drug shop provision of injectables across the regions.

As part of its end-of-project closeout activities, APC organized an interactive learning session with panel discussions and world cafes to disseminate key findings, lessons learned, tools, and materials. The project also organized a field visit that gave a range of stakeholders, including RHITES partners and USAID mission teams, the opportunity to engage with different project structures and validate activities on the ground.

4. LEADERSHIP DEVELOPMENT

Table 5 summarizes and describes the impact of leadership development activities under APC.

Table 5. Leadership development outcomes and indications

LEADERSHIP DEVELOPMENT ACTIVITY/TASK	PLANNED OUTCOME FOR THE REPORTING YEAR	INDICATIONS/ EXAMPLE RESULTS
Build the capacity of the MOH to lead and direct the country FP program.	Develop a FP CIP online database, train the MOH and partners to use the database, and install it on the MOH server for management.	The database was designed and installed at the MOH. Users were trained, and the database is fully functional.
	Revitalize the FP TWG as a community of practice.	The FP TWG was revitalized and is being transformed into a community of practice.
	Support the recruitment of key staff in the MOH RH Division who will be retained by the MOH after APC activities end in September 2019. The recruitment is now in advanced stages.	Job descriptions were developed, and a proposal sent to the permanent secretary is awaiting approval.
	Support the MOH in conducting a pilot intervention for introducing injectable contraceptives in drug shops.	The drug shop pilot for the provision of injectables is underway, with good success so far.

5. ENVIRONMENTAL COMPLIANCE

APC developed a waste management plan and environmental mitigation and monitoring plan, which stipulated mitigation measures resulting from the provision of community-based injectable contraceptives and other short-term FP methods by VHTs and DSOs involved in the pilot study. During provision of CBFP services, health care waste is generated, including used syringes, needles, cotton swabs, vials, and gloves. If the sharps are not handled and disposed of well, they can be dangerous to the environment.

As a way of mitigating such hazards, APC incorporated training on health care waste management and infection prevention into trainings for VHTs, DSOs, and health workers. The trainees were further provided with waste bins/containers for disposal of non-sharps waste, and with safety boxes for sharps such as syringes and needles used for provision of injectable contraceptives. The VHTs returned the filled safety boxes to the supervising health facility for proper disposal to avoid injuries from needle sticks. A trained midwife from the supervising public health facility supervised the DSOs and VHTs monthly, and waste management and infection prevention were included on the checklist used during supervision.

6. AWARD-SPECIFIC REPORTING REQUIREMENTS

APC Uganda met the USAID reporting requirements. This included submitting quarterly and annual reports; work plans; and a monitoring, evaluation, and learning plan.

7. ACTIVITY MONITORING, EVALUATION, AND LEARNING PLAN UPDATE

The learning agenda and activity monitoring, evaluation, and learning plan were revised, reviewed, and approved by the learning contract and the agreement officer's representative. They were then uploaded into the USAID performance reporting system, and data have been updated.

8. LEARNING FROM CHALLENGES

- Commodity security was an impediment; therefore, the commodity supply chain needs to be streamlined for both private and public sectors. APC pushed for alternative distribution strategies as well as re-distribution within the districts to continue service delivery. This worked, but a longer-term, sector-wide solution is needed.
- Transitioning project activities at closeout was challenging in some districts, especially in non-RHITES districts like Kyegegwa. APC's collaboration with non-health stakeholders and district leadership enabled joint development of local sustainability plans. Our project found that it was key to work with activities not funded by the U.S. government and that local organizations can help ensure sustainability and self-reliance.
- Because the process of changing community perceptions was more time-intensive than originally presumed and changing social norms is slow, innovative approaches were needed, for example pairing each innovation grant with a local civil society organization. This approach was not part of the original concepts, but came out of the co-design process. This realization informed how we designed the monitoring, evaluation, and learning plan for this second phase of the project.
- The MOH was unable to approve two positions the project had planned to second to the RH Division, partly due to bureaucracy and the uncertainty of future funding for the positions. As a result, the pace of work was rather slow at the national level during the first year of phase two (2018); however, this was addressed by engaging competent consultants who were respected and recognized by the MOH to lead on those tasks.
- National and district-level support of MOH leadership is critical for FP programs implemented at scale. Through our interventions, we learned that national and district leaders from non-health sectors can appreciate and learn from data to improve programming and policy.
- The collaborative approach imbedded in improvement science took a long time to take shape and be appreciated. The fact that APC made the approach community-driven/-owned contributed to its success in driving FP use.
- Local innovations allow for FP access in non-conventional ways, which increases coverage. For example, we learned that young girls prefer accessing services confidentially rather than during group settings such as outreaches; hence, trust has to be built before presenting them with FP information and services.
- APC was a catalyst for locally designed processes, which led to locally generated results, as seen with the FP working group and FP champions'

action plans. The dedication of local actors suggests that the likelihood of their continuation is stronger. The FP working group actors brought their own resources to the table in the form of local knowledge, commitment, time, and money. This is precisely the type of situation envisioned by USAID's Journey to Self-Reliance.

- DSOs are a new feasible channel for reaching previously underserved, hard-to-reach populations with FP services. This is key for increasing access.

9. CONCLUSION AND RECOMMENDATIONS

- Social norms affect broad health outcomes in addition to FP alone. For example, health-seeking behavior, HIV/AIDS, and maternal and child health (which are related to FP) are all affected by societal norms. Thus, in the spirit of integration within health programming, it is important to address social norms across the continuum of care, without a silo mentality. This especially applies to integrated programs, because norms around child health or HIV can affect FP, watering down the programs' efforts. Working with academia to embed social norms as a key area of teaching and research is critical.
- At the national level, for ownership and sustainability of FP efforts, strengthening of the FP TWG and the technical capacity within the RH Division needs to continue. This will lead to better coordination, use of data for programming and policy, and management and ownership of FP by the MOH and other government actors. It will reduce duplicative efforts and competition for the FP space.
- For sustainability and local ownership for shared responsibility, collaborative charters for commitment, guided tracking, innovation, and implementation should be signed at design, inception, and implementation stages. District and local stakeholders are willing to play a major role, but they need to be engaged in a structured manner.
- It is vital that health and development programs focused on social care not be prescriptive. Once communities understand their problems and are part of root cause analyses, they are capable of coming up with brilliant solutions. This allows re-design based on context for improved effectiveness.
- Drug shops complement facilities and community health workers in the provision of short-acting FP methods. Thus, the MOH and NDA should urgently consider a guided and phased national scale-up for FP provision in commercial drug shops. It is also possible to explore whether commercial drug shops can provide additional public health services in a bid to attain universal health coverage.

- The FP CIP database, if well utilized by all partners, will be a key resource for evaluating the fidelity of the goals, priorities, and key activities that were described in the plan.
- Fertility hot spot mapping is an important resource for Uganda's FP programs. The mapping will help target programs in areas where desired outcomes can be attained more quickly, and in a differentiated manner.

10. FINANCIAL MANAGEMENT REPORTING

Monitoring financial conditions is one of the most important, yet often neglected, areas of management reporting. The information contained in Tables 6 can be utilized to make management decisions, particularly related to future work on and funding for the project. The information provides a valuable and timely snapshot of financial conditions and complements (but does not replace) the SF-425.[1]

Table 6. Activity financial analysis (U.S. dollars)

AWARD DETAILS	
Total Estimated Cost	$ 10,109,301.17
Start/End Date	Nov-15-2013/Sept-30-2019
Total Obligated Amount	$ 10,093,000
Total Expenditure Billed to USAID/Uganda	NA
Expenditure Incurred but Not Yet Billed	NA
Total Accrued Expenditure (both billed and not yet billed); sum of lines d and e	**NA**

Average Quarterly Expenditure	Actual Quarter 1 *(Oct-Dec '18)*	Actual Quarter 2 *(Jan-Mar '19)*	Actual Quarter 3 *(Apr-Jun '19)*	Projections *(Jul-Sep '19)*
	$627,664.87	$822,833.20	$1,007,625.68	$25,875.55

[1] Note: The financial data provided in this section estimate financial conditions and do not constitute contractually required financial reporting as defined in the award notice.

11. MANAGEMENT AND ADMINISTRATIVE ISSUES

11.1 Key management issues

During Year 4, APC planned to recruit two officers from the MOH to support coordination of FP activities and to help with knowledge management. A memo about this was submitted to the permanent secretary, but no progress was made. More discussions have been held with the RH Division to have the positions filled in Year 5. APC hired three consultants: an MOH consultant for revitalizing the FP working group, a knowledge manager, and a consultant for engaging religious and cultural institutions.

The MOH consultant supported the MOH in revitalizing the FP working group through organizing routine meetings and revising the expired TOR for the group. The knowledge manager supported APC in organizing knowledge management events and preparing various knowledge management products, such as project briefs. This manager also supported the innovation co-creation event. The consultant for the religious leaders and cultural institutions spearheaded the engagement of religious leaders in signing memoranda of understanding with cultural institutions and the introduction of CFLE in Buyende and Kyegegwa Districts. APC recruited two district-based staff (i.e., community linkage officer, data and learning assistant) per district to ease coordination of project activities at the community level.

APC Uganda introduced innovation grants to support local organizations in all five districts to engage youth. Twenty-two concepts were received in response to a call for applications. With support from USAID Uganda, APC facilitated a workshop during which the seven final organizations presented their innovations to a panel of judges. The five that were funded (one per district) engaged diverse stakeholders, such as religious leaders, to introduce and integrate FP concepts. This was an extensive process, made longer because the hot spot mapping and district selection took longer than anticipated.

APC developed collaboration concepts to guide working relationships (support and technical assistance) with RHITES and SITES, and they have successfully adopted some of the best practices and innovations from this project, like HDI's peer-to-peer model, Emanzi and the CIP database.

11.2 Resolved management issues

Stockouts of supplies to drug shops: The biggest challenge faced during the study was stockouts of FP commodities, which were due to the suspension of the social marketing activity that was the main source of commodities for the drug shops. With support from USAID, a two-month supply of DMPA-IM and DMPA-SC was obtained from JMS, which helped to bridge the gap until the study concluded. The drug shops were successfully supplied to complete the implementation science activity. Also, as a result of this challenge, APC needed an extension to the study. This extension was granted and the study concluded successfully in June.

12. SUCCESS STORY

Pullout quote

"One of our VHTs visited our home and told me together with my husband to attend a pregnancy calculator dialogue through which we were given more information on family planning," explains Tapi. "I was so happy that my husband accepted that we should start using FP so that we can first save some money and resources and improve our household income, but also to enable me [to] regain my health and have enough time and opportunity to love and provide attention to my husband and the baby."

Tapi from Butaleja District benefited from one of APC's innovation grants.

Photo credit Luke Twesigye, Straight Talk Foundation.

Contact information

Submitted by Chris Arineitwe, FHI 360 Senior Technical Advisor
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Title: Adolescents Learn Value of Family Planning through Pregnancy Calculator Dialogue by Straight Talk Foundation — an APC Innovation Grant.

Tapi, while still in school, became sexually active and soon found that she was pregnant. Now 16, Tapi lives with her husband and 10-week-old baby in Butaleja District, Uganda. After a difficult pregnancy, she is grateful today to be using a family planning (FP) method and regaining her strength.

"What surprised me is that most of my friends who lured me into sexual acts did not get pregnant, but for me it happened...I had to get married so that my husband [could] take care of my pregnancy because I could not remain at my parents' home without care since [there] were very many children at home," explains Tapi

Tapi is thankful to the Straight Talk Foundation's six-month program in Kachonga Subcounty, which began in November 2018 to introduce and implement a pregnancy calculator innovation through ebimeza (derived from ekimeza, which means debate or roundtable) group sessions and radio talk shows. During program, facilitators guided married female adolescents, young mothers, and women with disabilities in critical reflections of their lives versus their dreams, including discussions on income, unplanned pregnancy, and family stability.

"In January 2019, one of our VHTs visited our home and told me together with my husband to attend a pregnancy calculator dialogue through which we were given more information on family planning," explains Tapi. "I was so happy that my husband accepted that we should start using FP so that we can first save some money and resources and improve our household income, but also to enable me [to] regain my health and have enough time and opportunity to love and provide attention to my husband and the baby."

"For the two weeks I have been on FP," says Tapi, "I have not found any problems, and even if I happen to experience some, I would be able to visit the nearby health facility or VHT for counselling because I am aware that some FP methods may pose some side effects for some people but can be given help by trained health workers from the health centers."

Straight Talk Foundation, whose primary target audience is young people ages 10–24, is an indigenous organization focused on the design and management of health and development communications programs. The group received one of five innovation grants from USAID's Advancing Partners & Communities (APC) project for local youth-oriented organizations to test locally relevant innovations designed to improve knowledge, access to, and utilization of healthy reproductive health options, including FP.

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