

MAKING COMMUNITY PROVISION OF FAMILY PLANNING MORE SUSTAINABLE



Credit: WellShare/Laura Wando

WellShare's program manager (far right) with clients, midwives, and VHT members at Niabiri HCII in Iganga District.

This resource is intended for use by program managers, Ministry of Health staff, and other stakeholders (such as faith-based groups, implementing partners, family planning champions, and policy makers) who are interested in expanding community-based family planning (CBFP) care through community health workers in Uganda and other countries.

BACKGROUND AND APPROACH

In Uganda, where more than 80 percent of population lives in rural areas, there is less than one doctor per 10,000 people. Sixty-seven (67) percent of married women in Uganda would use family planning, but only 35 percent are using a modern method of contraception. Among sexually active unmarried women, 47 percent use a modern method. Unmet contraceptive need for unmarried women in rural areas is 35.9 percent, compared to 24.8 percent in urban areas (DHS 2016).

WellShare International Uganda (Wellshare) applied a cascade model to train 257 community health workers, called village health team (VHT) members in Uganda,

NOVEMBER 2018

to provide voluntary CBFP that included community-based access to injectable contraception and emergency contraceptive pills.

The cascade training model received great support from the districts' health offices and contributed to the sustainability of CBFP services through implementation near health worker and VHT places of residence and employment. When midwives were transferred to different facilities, they brought CBFP with them. Additionally, the project had very little VHT attrition, but when VHTs were lost due to circumstances such as moving, the local midwives trained new VHTs in CBFP care following MOH training guidelines.

CASCADE TRAINING MODEL

The cascade training model works with the existing Ugandan health care system and follows steps that help ensure full community ownership and sustainability:

1. Over the course of five days, central-level Ministry of Health (MOH) master trainers train district health team (DHT) staff to be master trainers using a condensed version of the government's VHT FP curriculum.
2. Trained DHT members use the same curriculum to conduct a five-day training for health workers who supervise VHTs.
3. The district selects VHT members who have completed the basic training to be trained in the MOH's VHT FP curriculum (see CBFP VHT profile above).

The graphic on the next page illustrates how the centralized implementation model differs from WellShare's cascade training model. With centralized implementation, implementing partners (IPs) coordinate training activities. With the cascade training model, health

WELLSHARE'S SCALING UP ACCESS TO COMMUNITY-BASED FAMILY PLANNING INCLUDING INJECTABLES PROJECT (2014–2019)

- Implemented in Iganga and Kumi Districts in East and East Central Regions of Uganda.
- First to use cascade training model to introduce CBFP.
- Trained 257 VHT members to provide CBFP.
- Trained 10 master CBFP trainers for Iganga and Kumi.
- Trained 46 health workers to train and supervise VHT members on CBFP.
- Approximately 28,125 new clients reached by trained VHTs, and 18,078.83 couple years of protection provided at community level (through June 2018) for both new and repeat users.
- 7 of 10 VHTs lost to attrition replaced and trained by local staff.
- Cascade training model saved as much as \$227 per VHT.

CBFP VHT PROFILE

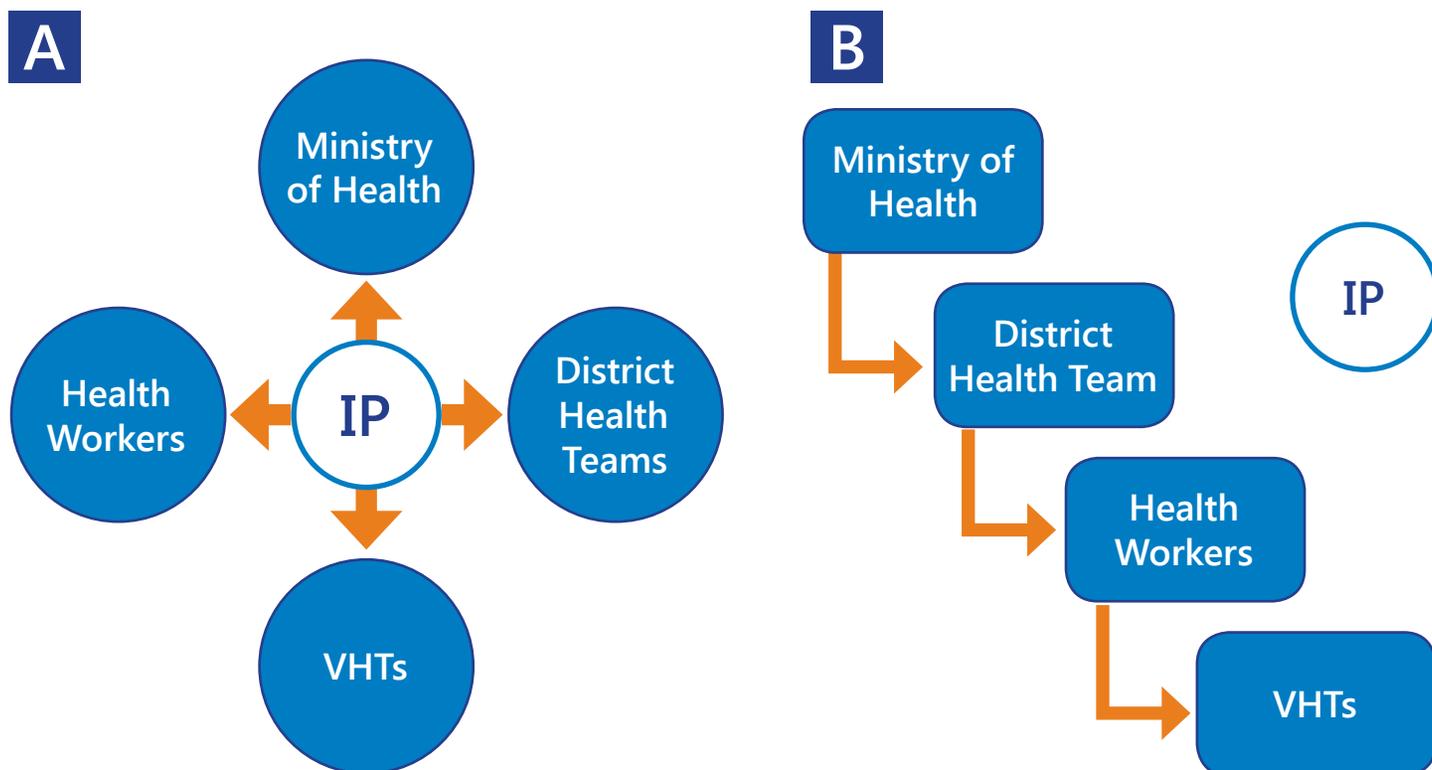
- Nominated by their communities.
- Literate in the local language and English.
- Completed primary school or more.
- Attached to health centers and supervised by midwives.
- Complete a 10-day FP training with a focus on services, especially safe injection techniques, client mobilization, monitoring and evaluation, USAID FP Compliance.
- Complete a 5-day practicum to practice CBFP care under supervision.
- Can administer short-term FP methods (cycle beads, lactational amenorrhea method, pills, condoms, injectable contraceptives, emergency contraceptive pills), make referrals for long-acting reversible contraceptives and permanent methods, and provide counseling on all methods
- Provided service kits that include counseling guides, registers, VHT shirts, and commodity storage boxes.

workers (such as midwives) based at health centers supervise VHT members from the initiation of training forward. The IP (WellShare) provides training support and functions in an advisory capacity.

Before introducing the cascade training model, Wellshare established:

- A memorandum of understanding with the MOH and the district that clearly outlined each entity's roles and responsibilities.
- A district-level assessment demonstrating readiness to scale-up CBFP.
- A monitoring and evaluation framework and community-level data tools developed in consultation with the MOH and DHTs that included provision of FP compliance oversight, quarterly supportive supervision at HCs by DHT/IP staff and household level by VHT supervisors (health center staff), and regular FP client satisfaction surveys for quality assurance.
- Joint work planning with the district through quarterly review meetings, and joint work planning and review with health workers and VHTs through quarterly sub-county level meetings.
- Support for forecasting FP commodity needs at community level and (supplementary) procurement using an alternative system, such as the Uganda Health Marketing Group's Alternative Distribution Strategy, which provides FP commodities to IPs.
- Functional health and logistics management information systems (HMIS/LMIS).

Centralized Training Model (A) vs. Cascade Training Model (B)



CASCADE TRAINING MODEL EVALUATION

CASCADE TRAINING MODEL EVALUATION RESPONDENTS

- 5 DHT members
- 8 health workers
- 16 VHT members
- 59 clients

In 2016, WellShare undertook an evaluation to identify the advantages and implementation challenges of the cascade training model for CBFP in Iganga and Kumi Districts, and to document lessons and recommendations for scaling the model in new districts for other CBFP IPs. Three stakeholder groups were interviewed: 1) DHT members who completed the master training-of-trainers (MTOT); 2) Health Center (HC) II and III staff who had completed the MTOT, trained VHTs, and were currently supervising them; and 3) VHT members who were currently offering CBFP services. Additionally, health workers conducted surveys with randomly selected clients to assess CBFP service quality and VHT performance in providing it.



Credit: WellShare/Laura Wando

Edward, a VHT member in Ibulanku S/C, prepares to inject his supervisor Evelyne, a registered nurse, during a cascading training as Betty, a registered midwife, looks on.

HC staff and VHT members were randomly selected for interviews. Separate questionnaires were developed for each group of respondents to assess strengths and weaknesses of the cascade training model, including the quality of training and CBFP services; inputs needed to implement the model; and its sustainability and replicability. Interviews were conducted during routine field visits (e.g., supportive supervision) over a two-month period. Interviews were conducted and recorded in English or in the local language and transcribed into English. Independent consultants collected data and analyzed them by stakeholder group. Analysis themes extracted generalizations about training, service quality, sustainability and replicability, inputs and costs, challenges, and lessons from the model. Key quotes were used to highlight major themes and subthemes.

KEY FINDINGS

Improved training capacity and relationships

DHT respondents noted that overall, the cascade training model roll-out was more practical, streamlined, and supportive of local ownership than the centralized training model. They also said that cascade training encouraged a continuous flow of knowledge between supervisor (health worker) and supervisee (VHT member), and standardized FP communication with the community, which built respect for VHT members and health workers. The model also helped establish rapport and trust between VHT members and midwives.

Holding trainings in the community saved time and money. “Workshop fatigue” was reduced because participants were able to go home after each training day, and training proximity to health centers reduced the burden on health workers who facilitated.

Improved quality of services

DHT respondents mentioned that ongoing review of the HMIS and LMIS systems were critical to implementation. They also suggested the health workers review/assess VHT member performance with the VHT members on a regular basis. DHT respondents mentioned positive outcomes from VHT members referring clients who experience adverse side effects from contraceptives, although some health workers said that VHT members needed additional training to know when to make referrals for managing side effects. Health workers noted that VHT members complied with good waste management practices because they were given safety boxes for disposal of sharps. Health workers also observed that VHT members were injecting and providing health education and counseling with confidence because they were known in the community.

Additionally, all respondents noted that the model allows clients to be involved in the continuous improvement of VHT services by noting their satisfaction or dissatisfaction with specific aspects of those services. Client satisfaction surveys indicated

“(Quality) is good because now the VHTs are doing their work. They carry out health education, [and] they provide FP materials like condoms that we give them from health units.”

-Iganga DHT respondent

“What worked well was that in each step we created ownership, like the health center staff felt they were part of the program, even the support staff from the DHT. It was ownership and sustainability of the program because everyone is involved.”

-Kumi DHT respondent

“Yes, I think this model can be sustainable, because WellShare has always come in with supportive supervision. But when you’re gone, it can be sustainable because the skills are already in the VHTs. They get their supplies in the HC and bring their reports to the HC and the HC reports to the district. So with or without WellShare, the thing is already planted and yeah we shall just continue to be weeding it.”

-Kumi health worker respondent, likening the program to a garden

“The VHT members are being trained by health workers and we can supervise them better than those who have been trained by other people. And it’s easy to know who is not doing good and who is doing good.”

-Iganga health worker respondent

that the quality of VHT and health worker services were “good” and corroborated that VHT members provided services with confidence.

Improved sustainability and replicability of services

Cascade training ensures that trained workers are available within the district (i.e., district master trainers, health workers, and VHT members) to implement/supervise/administer FP and to train replacement VHT members as needed. Respondents also found the cascade training model replicable because it is owned by and adapts to the communities it serves.

Reduced inputs and costs

Cascade training costs less to implement because it is conducted locally (see table below). The model also uses personnel within the health system and saves health workers’ time and energy by delegating tasks to VHT members.

While the cascade training model relies significantly on existing structures and staff, five essential costs/inputs should be included in nongovernmental organizations and/or district budgets:

1. Per diems, travel reimbursement, and meals during initial training of DHTs, health workers, and VHT members.
2. Transport for health workers to provide supportive supervision to VHT members.
3. Transport for VHT members to pick up supplies, meet supervisors, and submit reports at health facilities.
4. Manuals, supplies, and commodities (e.g., Depo, syringes, cotton rolls) for VHT training and implementation.
5. Venues for DHT trainings (provided by district and sub-counties); health worker trainings (cost-shared with the sub-county), and VHT training and practicums (provided by HCs).

Cost Analysis Centralized vs. Cascade for 10-day CBFP Training

PARTICIPANT	CENTRALIZED TRAINING MODEL*	CASCADE TRAINING MODEL*
	Related costs per person/day	Related costs per person/day
District level	Not trained	\$47.33
Health worker	\$284.11	\$33.74
VHT member	\$34.96	\$11.06

*From project budgets in 2014. Costs seem to decrease as more VHTs are trained with the cascade training model because no external trainer fee is needed at health worker or VHT level.

Challenges

One challenge encountered with using a cascading training model is the need to involve more staff at the HC level in anticipation of staff transfers/staff turnover. Additionally, some VHT members spend time on programs that provide more incentives (e.g., cash stipends). An adequate supply chain is vital to both training and implementation. Sufficient contraceptive stock ensures that providers/VHTs can meet all practicum

requirements and commence care delivery. Available contraceptives also ensure that clients can continue to use their method of choice. Additionally, outreach and referral services are essential for improving access to a full range of FP methods.

RESULTS AND LESSONS

Overall, WellShare trained 257 VHT members in 15 sub-counties; supported 46 health workers from 43 HCs to supervise the VHT members; trained 10 master trainers and 46 health workers in CBF; and trained seven replacement VHT members midway through the program.

Cascade training strengthens task-sharing of FP services at the community level

WellShare has used a centralized training model in past projects and found the cascade model to be more effective and responsive to challenges like staff turnover and poor relations between VHT members and health workers. The cascade training model bonds health workers to the VHT members they supervise, and establishes formal links for oversight, reporting, referrals, and quality assurance between facility and community health services. Because of the relationships developed, community feedback can be conveyed to the district level. Training VHT members to provide FP services in their communities builds client trust and increases demand for those services. Trained health workers, meanwhile, are better able to support VHT members.

Over the past five years, only 10 of 257 VHT members left their job. Two of these people left because of illness/death; one left to attend school; one was dissatisfied with her job; one was no longer willing to be a volunteer; four relocated; and one was forced to stop by her partner. Seven of these 10 VHTs have been replaced and trained on the job by fellow VHTs and HC staff.

Although initial inputs are more time/labor-intensive and costly, the cascade training model appears to be more sustainable and enabling of CBF than the centralized training model. VHT members are now seen as part of the solution and an extension of the HC, rather than an additional responsibility for health workers. Task-sharing allows health workers to focus on other critical health services.

Cascade training saved project funds because districts and health centers donated training spaces in the community, and HCs contributed contraceptive methods, cotton rolls, safety boxes, and penis models for trainings, and rooms for practical work.

Supply chain, HMIS, and LMIS are critical to implementation

Because systems facilitate the flow of commodities and information between the community, health center, and district, ongoing review of the HMIS and LMIS systems are critical. VHTs need transportation to bring monthly reports to the health facilities. Reporting allows the DHT to identify deficiencies redistribute commodities. This reduces stockouts, which improves access to community FP services, which increases reliability and use of the services.

The cascade training model should be scaled-up

Most respondents proposed that cascade training be used in other Ugandan districts and by the MOH/public health system because of its sustainability, cost-effectiveness, and compatibility with existing MOH structures.

NEXT STEPS

Recommended improvements to the cascade training model include:

- Phase training so fewer health workers are absent from the health facilities at the same time.
- Train VHT members on FP-related side-effect management.
- Strengthen community group education (through health talks, community dialogues, women's groups) as part of the FP training.
- Use social behavior change messages (through radio programs, social media, and information, education, and communication materials) to generate demand and promote CBFP care.
- Include financial incentives for VHT provision of FP services and reporting.
- Budget for supportive supervision of CBFP care in the district action plans that are currently being developed as part of the national Family Planning Costed Implementation Plan activities.



JSI Research & Training Institute, Inc.



Advancing Partners & Communities

November 2018

Advancing Partners & Communities (APC) is a cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360.