Snapshot: The Process of Changing National Family Planning Policy to Support Community-based Access to Injectables (CBA2I) in Uganda

The following insights are drawn from FHI's experience promoting community-based access to Depo Provera (or DMPA) and working with the Ugandan government and other partners to change national family planning policy.

1. Policy change is one step in the scale-up process. The goal is scale-up, which can happen with or without policy change. In Uganda, addressing policy change was a parallel process and not a prerequisite to introducing and scaling up this high-impact practice.

2. Champions are critical. Save the Children, the implementing agency of the pilot CBA2I project in Nakasongola district, and FHI, the research partner, identified a *champion*—an influential, high-level official from the Uganda Ministry of Health (MOH) Division of Reproductive Health. This champion was supportive of CBA2I and wanted to be involved in the intervention from its inception, including as a co-principal investigator on the original pilot study. Despite ongoing opposition, the champion helped mobilize other key stakeholders, including district health officials. He provided invaluable knowledge about the MOH systems and opportunities for advancing both service implementation and policy change efforts. Also, engaging advocates at all levels helped build support. A supportive and experienced district health officer, clinic staff supervising community health workers (CHWs), and husbands and wives benefitting from the service made presentations to MOH senior management about the advantages of CB2AI.

3. A committed, supported resource team, including donor, is critical. A national CBA2I core team, comprised of interdisciplinary representatives, was established early on. The team was instrumental in engaging the MOH, keeping the issue visible, solving problems, and tracking and informing each step of implementation and advocacy. FHI, with funds from USAID, served as the central coordinator for key project elements of advocacy, research, and implementation.

4. More evidence might be required. After the successful pilot in 2005, the MOH wanted to see outcomes at a larger scale (early horizontal scale-up) and later, with different types of implementing partners. Such evidence was gathered, packaged, and presented over time, and various messengers were employed to reach key audiences locally and nationally.

5. Educational tours are very effective. For Uganda's change process and for neighboring countries as well, site visits to see CBA2I practiced firsthand were very useful and allowed decision-makers to hear testimonials, ask questions, consider potential barriers and benefits, and envision steps needed to advance the initiative. Armed with direct experience and knowledge, tour delegates were better prepared to promote the practice.

6. Advocacy must be strategic, documented, and flexible. Sustained and varied efforts were needed to continuously engage and cultivate supportive colleagues and address opposition.

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Over time, as the context, players, and objectives changed, the advocacy campaign evolved frequently to meet the needs of stakeholders and take advantage of beneficial synergies and events in Uganda's public health environment. For example, needs arose to convene more targeted sensitization meetings and site tours than originally envisioned in order to address concerns and ensure support from in-country stakeholders. The advocacy strategy and activities used in Uganda were documented and reported.

7. It's all about relationships. Fostering collaboration with multiple partners over the life of the project was also essential. The process of policy change benefitted from partnerships with organizations whose mission is to improve the policy environment for family planning and reproductive health with funding from donors such as The David and Lucile Packard Foundation, The Bill and Melinda Gates Foundation, and USAID. Partners for Population and Development (PPD)/Advance Family Planning (FP) invigorated a recent policy push in late 2010. Of particular importance was the relationship between the PPD director and the director general of health services at the MOH. We engaged in one-on-one discussions to obtain final sign-off of the amended policy.

8. Each country will experience a unique process of policy change. It is not possible to say how long it will take for other countries to achieve similar policy change. In Uganda, the policy change process started in 2005 with recommendations from the original pilot study calling for amendment of policy and scale-up. A strategic advocacy campaign in 2006-2007 drew attention to, and dedicated support for, policy change. In 2008, the USAID mission supported another phase of advocacy and scale-up. In December 2010, the Uganda MOH's director general signed the amended national policy, which had been unanimously agreed upon in September 2010.

Key actors over time:
(1) *Pilot study*, 2003-2005: MOH, Save the Children, FHI
(2) *Scale-up evidence and early advocacy*, 2006-2008: MOH, FHI, Save the Children, Minnesota Health Volunteers (now Wellshare International), and Conservation Through Public Health
(3) *Public sector scale-up and ongoing advocacy*, 2008–2010: MOH, Bugiri and Busia districts, FHI, PPD/Advance FP, and five additional districts. The CBA2I practice currently operates in at least 13 districts and in both private- and public sector CBD programs. In 2009, CBA2I was added to the FP bilateral with Management Sciences for Health.

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