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Local Leaders: Untapped Resources for Family Planning

Program Evaluation Results from Bafia District, Cameroon

Contents

ACRONYMS

CHW	Community health worker
FGD	Focus group discussion
FP	Family planning
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HRH	Human resources for health
HRH2030	Human Resources for Health in 2030
LARC	Long-acting reversible contraceptives
LLMA	Local Leadership and Management Approach
MSC	Most Significant Change
OC	Oral contraceptives
RH	Reproductive health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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Local Leaders

Regular people selected by the community because of the respect and trust instilled in them. Local leaders are engrained into the cultural, social, economic, and religious weave of a community:

- Shop owners
- Hairdressers
- Carpenters
- School teachers
- Religious figures
- Wives
- Husbands
- Mothers
- Fathers
- Daughters

Introduction

Although more people than ever before are using family planning (FP) to satisfy their reproductive health (RH) intentions, the ambitious global goal of 120 million additional contraceptive users will not be met by 2020 (FP2020 Progress Report 2018). New and different partnerships and strategies are needed to improve the acceptability and accessibility of family planning.

Program Intervention

The USAID HRH2030 Program piloted a local leadership and management approach (LLMA) to test the hypothesis that the engagement of community leaders to support local health staff improves community awareness, acceptance, and interest in FP information and services.

HRH2030 provided technical assistance to build the capacity of the district health management team (DHMT) and local leaders around four urban and rural intervention sites in the district of Bafia in Cameroon to implement the LLMA at the district level using local resources (see Figure 1, below).

This technical brief reports on the findings from the evaluation of the LLMA, assesses the contributions of local leaders and the overall approach, and provides lessons learned for future country replications.

Description of the Local Leadership and Management Approach (LLMA)

An important barrier in FP service provision is the gap between the information about the methods offered by facility and community-based providers and the information necessary for women with unmet FP needs to make informed FP choices. Providers often lack the knowledge, contacts, and resources required for effective community mobilization. The LLMA centers on local leaders, a community-based human resource often untapped by health systems, focusing on strengthening their capacity to promote FP by bringing together providers, clients, and the community at large. Engaging community leaders from local government, schools, businesses, social services, NGOs, and traditional leadership positions has the potential to sensitize and mobilize community awareness, acceptance, support, and use of FP information and services. Community

FIGURE 1: Map of intervention sites in rural and urban areas of Bafia District in the Centre Region of Cameroon

leaders can bring new perspectives, local knowledge, and fresh ideas for exploring local solutions to FP challenges and empower women and families to consider FP and RH services.

Implementation in Cameroon

In Cameroon, the use of FP services remains low, with the 2011 Demographic and Health Survey documenting a contraceptive prevalence rate of 23% among married women using any method. The rate among married women using a modern method was only 14%.

According to the consultations with national, district, and community stakeholders, in the district of Bafia, like the rest of the country, FP services are available but are underused for several reasons: (1) husbands or partners, who are the primary decision-makers for women's RH, tend not to allow the use of a contraceptive method; (2) reluctance to seek FP services because of rumors or misinformation about methods (for instance, that they may cause infertility, cancer, or undesirable weight gain); and (3) structural constraints on health workers to educate potential beneficiaries about FP methods due to understaffing and high workload.

From October 2017 to June 2018, HRH2030 — with consortium partner Amref Health Africa — assisted stakeholders to implement the LLMA (Figure 2) to facilitate interaction, dialogue, and shared action of leaders from multiple social sectors to address issues of accessibility to and quality of FP information and services at the local level. Amref's leadership advisor led a workshop with local co-facilitators, including the chief medical officer, a health center director, and a FP unit manager for 68 local leaders to discuss the benefits of family planning, better understand the communities' misperceptions around FP, prioritize challenges to FP information and services, and develop FP strengthening action plans. The leaders were from the catchment areas of the four selected health facility intervention sites (Figure 1). They included local chiefs and dignitaries; heads of local women's organizations representing various sectors such as transportation, agriculture, and finance; community health workers (CHWs); and managers and health workers of the four health clinics.

A hairdresser (right) combs the hair of one of her clients in Cameroon. Photo Credit: Alain Ngann (2018)

FIGURE 2: Carrying out the LLMA for Family Planning

1. Identify priority issue reducing quality, accessibility, and/or acceptability of FP services
2. Assemble team of local leaders from multiple sectors at the district level
3. Analyze local characteristics of the problem
4. Build a shared vision of addressing the issue from multiple perspectives
5. Design a shared action plan
6. Strengthen leadership & management skills to collaborate on agreed-upon FP/RH agenda
7. Provide refresher training to FP providers, as needed
8. Manage and monitor implementation
9. Evaluate effects of implementation action plan on solving the issue and contributing to improved FP information and services

The participatory one-day workshop was held individually for the selected leaders of each of the four health clinics and their surrounding communities. The training workshop focused on steps three through six of the LLMA (see Figure 2, above). Through discussions during the workhop to analyze the local characteristics of the problem, the leaders identified several FP challenges, such as a lack of birth spacing due to limitations in awareness of the benefits of FP, couple's communication, and FP provider counseling skills.

To help develop a shared vision, workshop participants participated in small group exercises using simulations of real-life challenges and role plays. For example, one role-play exercise portrayed a community health worker visiting a couple at their

Three participants during a role-play exercise portraying a community health worker visit to a couple in Bokito, Bafia District. Photo Credit: Gilles Mathurien Bokpe

home to discuss family planning. The local leaders exchanged thoughts on FP issues, myths, and misperceptions within in their communities and discussed messages on the benefits of family planning and how to correct misperceptions.

With their shared vision to promote the benefits of family planning and the desire to address FP challenges in their communities, the local leaders defined a common set of expected results they hoped to achieve as a first step. The expected results centered on increasing the percentage of individuals who:

- Have heard messages about family planning
- Report positive impressions of family planning
- Say they may consider using a family planning method

> "If there were all these FP methods when I was younger, I would not have eight children. I use my life as an example to young couples and women. [To] have many children, is settling for poverty."
> *— Mireille, community leader, mother of eight, Bokito*

The facilitators assisted the local leaders to develop feasible, low-cost improvement action plans to implement with the support of the health workers. The local leaders were not provided with financial or other resources for implementation. Most intervention activities consisted of:

- CHWs conducting more frequent household visits to discuss contraceptive options with couples
- Community leaders involved with health workers in FP sensitization events to describe benefits of FP and express their support for FP use
- Women's organizations arranging discussions for couples to hear from health workers on the benefits of FP and support couples' RH decisions
- Local leaders organizing youth discussion forums on making responsible and healthy life choices

In addition to building participants' leadership and management skills by going through the process of working together as a multisectoral team to analyze a problem using root cause analysis, develop a shared vision, and identify and prioritize interventions to address some of the family planning challenges in their communties, the facilitators also led the local leaders through specific leadership and management sessions. The topics of these sessions included how to develop action plans, conduct effective meetings to monitor implementation, and coordinate and mobilize resources.

At the end of the training workshop, the local leaders — including the facility-based and community health workers — divided into working groups to implement their plan over the course of the next year. The HRH2030 team regularly followed up on the implementation of the action plans with the groups of local leaders and the district health management team. A follow up visit in February 2018 revealed a high engagement level of local leaders toward advancing family planning services in the district.

TRAINING FOR A MISSION

Michel Bayama is a local leader in rural Bokito, where the community leaders conducted sensitization campaigns, talked with women and accompanied them for consultations and counseling on FP methods, and gave talks at local high schools. With his training as a local leader, Michel is helping people in the community live healthier lives and helping the community reach its development potential. His training led him to realize the importance of FP in achieving these missions, especially the role of women: "It is important to elevate women… Today, we are giving women advice. We are not telling them to not have children, we are just letting them know of the importance of having children at the right time and when you have enough means."

Over the course of nine months, the local leaders liaised with the community and facility-based health workers to carry out public sensitization campaigns using megaphones, talking to couples in their homes, speaking with groups of men at their places of work, accompanying women to appointments for FP counseling, and conducting knowledge sharing and education sessions at local high schools about life skills and healthy behaviors.

Based on results from a rapid task analysis conducted during the baseline assessment, HRH2030 worked with the DHMT and the regional heath team to organize an FP counseling and services refresher training for the facility-based FP providers and CHWs associated with the four intervention health facilities. The purpose of the training was to update the health workers' knowledge and skills to better support the communities' FP sensitization events and improve quality of FP information and services for clients.

Women in Cameroon sign up to learn about FP methods. Photo Credit: Alain Ngann (2018)

Evaluation Methodology

The goal of the final evaluation was to demonstrate the effectiveness of the LLMA in the communities in Bafia district that received HRH2030 assistance. In the final evaluation, HRH2030 assessed the:

- Perception of local leaders and FP providers on the LLMA and any perceived changes in FP service use or uptake
- Feedback from FP clients of any perceived changes in the quality of FP information and services
- Community perspectives of any changes in FP interest, awareness, and perceptions based on the LLMA.

The program evaluation set out to answer the following questions:

1. Has the involvement of the community leaders through the LLMA helped to improve the interest in and demand for FP information and services?
2. To what degree were the activities in the local leaders' action plans implemented as planned?
3. Have there been any changes in how FP information and service are delivered at the clinics? If so, how do they correlate with the implementation of LLMA activities?

The evaluation used both quantitative and qualitative methods. The quantitative findings included a comparison of baseline and endline data for various FP indicators, as well as responses from structured exit interviews with FP clients from the four intervention clinics. The qualitative results were gathered through: (1) exit interviews with FP clients; (2) focus group discussions (FGDs); and (3) in-depth interviews with participating local leaders, FP clients, FP service providers, and DHMT members. Some FGDs followed the "most significant change" (MSC) methodology, which answers how and when change occurs by identifying the "most significant change" through participants' personal accounts.

In Bafia, the MSC methodology collected stories from FP clients, providers, and the multisectoral teams of local leaders. Each story is based on what participants thought was the greatest impact of the community leaders' engagement in activities to address local challenges and barriers to quality FP information and services. The methodology looked to evaluate what clients, clinic staff, and the participating local leaders, perceived to be the most significant change in leadership capacity, clinical capability, and other areas. These findings complement the clinical and client exit interview data, and these are presented together in this report.

This assessment, showing how local leaders and the overall LLMA contributed to the improvement of FP acceptability and accessibility, helps to provide lessons learned and recommendations for potential future refinement and scale up in Cameroon as well as possible replication in other countries and contexts.

Findings by Evaluation Question

1. *How has community leader involvement in LLMA helped to improve interest in and demand for FP information and services?*

Local Leaders' Perceptions. Local leaders felt that the most significant change brought about by the LLMA was, as one leader put it, "a new mission … to sensitize the women and couples on the benefits of FP." They credited the LLMA training workshop they attended, where they developed an action plan to address FP challenges in their community, with engendering this new sense of mission.

During the FGDs, local leaders also mentioned that they observed changes in FP service use which they felt correlated with their participation in the LLMA. These included a perceived increased in the uptake of FP services due to communication and sensitization activities; changes in client understanding of FP and FP benefits, and changes in FP clientele.

FP uptake. Local leaders attributed the perceived increase in FP uptake to their communication efforts. A local leader in Bokito cited an "increase in the awareness of the community about FP."

> "The sensitizations are very good because before, women didn't have the courage to ask for services. But then they heard about those services, and they go to the clinics. They are treated well, and they have the courage to continue going."
> — *Client participant in FGD*

The local leaders succeeded at "communicating well about FP" and sensitizing communities so that ignorance and "shame and taboo associated with reproductive health discussions and buying condoms" were reduced. According to a local leader, "word of mouth is helping FP adoption and [a] surge in users." Client exit interviews corroborated the local leaders' observations. As shown in Figure 3 (on the following page), of the 120 clients who said they were aware of the community leaders' FP advocacy efforts, the vast majority (84%) stated that they were motivated to visit the clinic because of the leaders' activities.

Client understanding. A leader noted that previously "people knew the term 'family planning,' but that's as far as their knowledge went." Now, according to the local leaders, through the LLMA there seems to be a better understanding of FP, that it is about preventing unintended pregnancies and about "improving opportunities" for a better quality of life in family and personal health, productivity, and financial health.

Client exit interviews reflected increased client understanding and supported the local leaders' perceptions. The percentage of clients who "strongly agreed" that they had a better understanding of their RH goals after their FP visit more than doubled, from 15.3% at baseline to 32.5% at final evaluation. This suggests that the combination of the local leaders' work and capacity building of the FP providers at the facility level helped to contribute to improving client understanding of FP.

A local leader in Bokito said that "people now think about the consequences of having more children than they can take care of." Another leader in Bokito said that practicing FP gives our children "the ability to have money to go to school and to take care of their health, to get dressed. That is the well-being of the family." Poverty reduction was also frequently identified in client exit interviews as one of the reasons clients believed the community leaders' work benefited the community.

FP Clientele. Another significant change noted by the local leaders was the perceived increased involvement of men in FP. Men were one of the leaders' target groups, as recounted by a female local leader in Ombessa: "As for the men, part of my

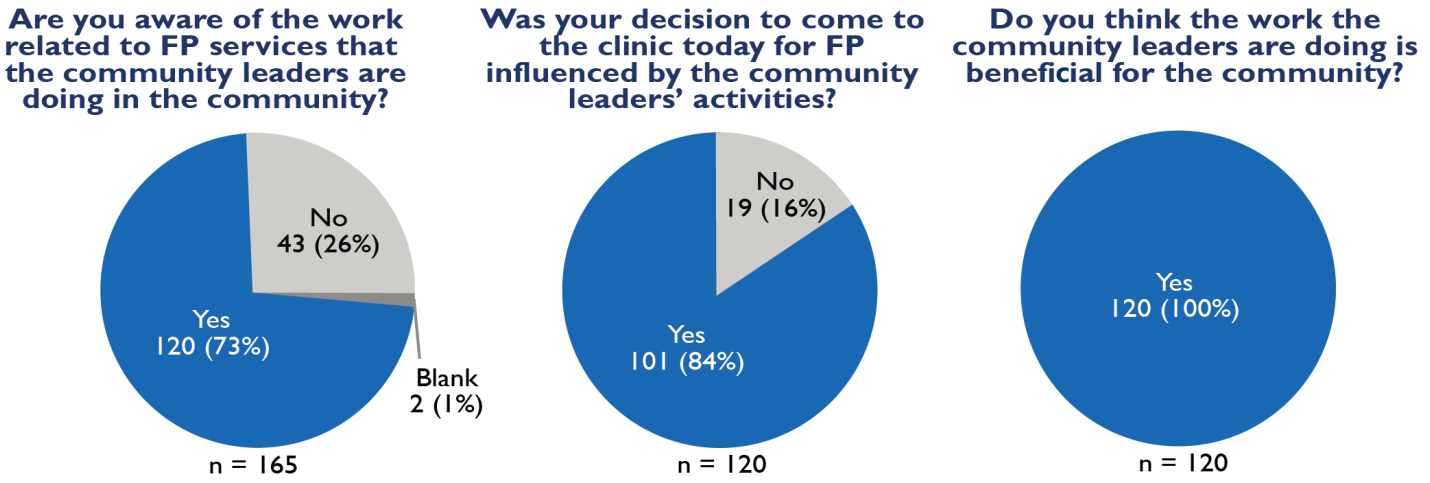
COMMUNITY SENSITIZATION, WORD OF MOUTH

Sandrine is a young mother who heard about family planning from her neighbor, who had used the Sayana press method for six months. She and her husband did not want to have any more children anytime soon. As Sandrine tells it, "I heard my neighbor talking about attending a community sensitization campaign where the local leaders talked about FP. The next day I went over to the leader's home and asked him for more information about FP." She and her husband then went to the health center in Ombessa and talked to the providers there about a method. Sandrine chose Sayana "because we do not have enough money … we want to be able to take care of our children."

Sandrine's readiness to approach a male local leader in his home suggests that community sensitization was helping to overcome the taboos and shyness typically associated with subjects like pregnancy and reproductive health. Her story is also a good example of LLM's "word of mouth" effect to reach community members. From her neighbor she learned not only of the availability of Sayana and that the neighbor had not experienced weight gain, a worrisome side effect, she and her husband were also empowered to make their own family planning decision and action.

FIGURE 3: Client Perspectives of Community Leaders from Exit Interviews

Note: The second and third charts only include responses from clients who were aware of the community leaders' work



work as a local leader took me to the mechanic's garage and other areas to speak to men about FP." In FGDs, the local leaders commented that "men seem to be more engaged in the health of their wives/partners and more have been coming together with wives to discuss the number of children [and] how to stop at three." This would enable families to "continue with other avenues in life (working in the market or on the farm)" and protect mothers from "being sick from having children back to back."

Clients' Perceptions. When clients discussed the most significant changes that they had experienced because of community leaders playing a more active role in advocating for FP, they found that the information provided by leaders and/or passed on by community members made a big difference in their decision to seek FP information and services.

The local leaders felt their work was being noticed and having some results, and information received from clients when completing their clinic visits supported the leaders' sentiments. Client exit interviews indicated a very high level of awareness of the community leaders' FP work. Nearly 75% of interviewees said they were aware of the leaders' efforts. As noted earlier, of those who were aware, 84% said the community leaders influenced their decision to come to the clinic for FP services, and 100% said the leaders' work was beneficial to the community (see Figure 3). These data points help to demonstrate the validity of our hypothesis: that local leaders can be very influential in promoting healthy behaviors, such as birth spacing and use of FP to meet individuals' reproductive intentions.

The most common examples of the community leaders' work given by the clients during the exit interviews were counseling sessions by FP providers, home visits from CHWs, general community FP sensitization, and community group discussions (for example, women's groups and youth groups). Client FGD participants reported seeing community leaders conducting community sensitization campaigns over megaphones, talking about birth spacing, discussing FP during vaccination activities, and orienting adolescents about healthy life choices and safe RH/FP practices.

Service quality. For women or couples who decided to seek FP information or obtain an FP method, they felt more information was being offered at the clinics. They noted that they heard about more options of FP methods. In general, "more conversations [were] occurring around family planning" in the communities. Feedback from FP clients on changes in quality of FP information and services at the clinic focused on communication and attitudes, counseling, and FP options. Clients reported a noticeable increase in the confidence of FP providers and that nurses were very available, friendly, and open, with no prejudice toward clients. They put clients at ease, making it "easy to talk about [reproductive] health." This was also reflected in client exit interviews. For example, the percentage of clients who strongly agreed that the FP provider treated them with respectful manners more than doubled from the baseline exit interviews to the endline interviews (see Figure 4).

Clients also felt that counseling sessions were longer "because providers have more information to give." Providers were equipped with prompts that enabled them to engage more deeply with clients in a two-way discussion and give them more information about more choices.

Community groups, couples communications, and school events were all also noted in the client exit interviews as ways the community leaders influenced clients' decisions to seek FP information and services, suggesting these activities implemented by the community leaders were promising ways to reach populations like youth and men that health systems often struggle to reach.

Leaders' major contributions. In response to FGD questions asking for the one major contribution and main positive feedback on the LLMA, clients mentioned increased awareness. One respondent said that although she herself did not practice FP, she believed that "it has caused people to think more about FP."

Positive feedback responses mainly centered on FP benefits to maternal health and family well-being. FP was valuable because it relieved clients from worrying about unplanned births. FP was important because it "helps with keeping down the birth rate when people give birth to too many kids" and because "there are too many maternal deaths and births and girls are dying." One respondent said that it was important for the community leaders to continue "their work to decrease the maternal mortality rate and teenage pregnancy." Another said, pointedly, "The people here are poor, [which] makes them suffer. You should have children when you want them."

Respondents also showed awareness of the value of birth spacing. One said, "It is good to help people space their births." Another explicitly credited the LLMA, saying, "For me personally, I have the courage to continue with the work that the community leaders started. It helps us … to space our births and to take care of the children we already have."

Furthermore, birth spacing was one of the most common responses to the exit interview question that asked clients to elaborate why the community leaders' work is beneficial (the other most common response to this question was that the leaders' FP work helped prevent risks, illness, and mortality).

DHMT Observations. The Bafia DHMT assisted local leaders in devising and implementing their FP strengthening action plans and were well positioned to observe the LLMA's reception in and contributions to the communities. As was the case in the leader, provider, and client interviews, DHMT members commented that the LLMA had inspired increased awareness and a new understanding of FP: "Most people before thought FP was just a means to prevent the communities from growing, but now see it in terms of the benefits it brings to them and their communities."

A district FP coordinator put this is in historical context, noting, "Before, people thought that family planning caused sterilization and that it was a way to make the Africans not give birth." Now, however, "the people think that it is beneficial because it lowers the rate of maternal mortality and poverty. [With] many children, sometimes people don't have the means to take care of them. … From a birth spacing perspective, the women have

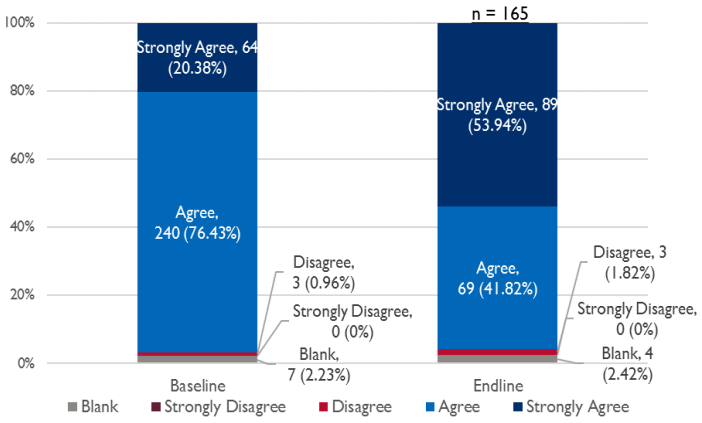
Elisabeth is a community leader raising awareness on FP methods in Bafia district. Photo Credit: Alain Ngann (2018)

LLMA EMPOWERS FP PROVIDERS

Giselle is a nurse and the head of the FP services in Ombessa. She had already been trained in FP about four years before arriving in Ombessa. But receiving new training in FP counseling as a health worker – making her a local leader – brought many new benefits, both personally to her and to the patients. This training, she says, "unlocked a confidence and legitimacy in me about how I do my job. [And] it doesn't end here at the clinic anymore … I'm available to discuss this with my community at any time. To me this has been the biggest change."

Giselle now feels more empowered on how to counsel clients. The LLM training taught her and other FP providers how to use a new counseling procedure that allows for greater discussion with the client, providing proper guidance without pushing the client to any decision. At the same time, knowing that health staff have had this training brings their clients "peace of mind," Giselle says.

FIGURE 4. The family planning provider treated me with respectful manners



enough opportunity to decide the frequency of their births."

The FP coordinator also observed that "the local leaders are a very good way to engage the community because they live in the community and know how best to engage in their community health issues. And when the community sees the leaders' involvement in an activity, they understand its importance and take it more seriously."

Another team member noted, "people don't take health workers as seriously as they take community leaders; some leaders have more than 10 children themselves, so they have the experience and legitimacy to talk about the importance of FP and be taken seriously." This experience and legitimacy played "a key role in changing behavior," the DHMT member said.

FP Providers' Perceptions. While some FP providers said they did not notice great changes in the services they provide or in client perceptions, attitudes, and questions, others said that they observed several changes in FP service use and uptake, including changes in number of clients, male involvement, understanding of FP and FP benefits, the FP setting, and client follow-up.

> "We have a huge number [who] now show up at the clinics to talk about FP. People are now very aware of FP, and this continues to increase."
> *— FP coordinator, Bafia DHMT*

Number of clients. A nurse at the Ombessa clinic noted that since the inception of the LLMA, she thought that there were "more women coming to the clinic, and more women who have used FP services. They are passing on this knowledge to other women in their area." The head of the Ombessa FP clinic felt that there was "more awareness that the FP clinic is available to serve them and more people visiting." Open responses from the client exit interviews indicated that in addition to providing general FP information, community leaders also directly referred community members to the clinics or even accompanied clients to the clinics, which may have influenced FP providers' perceptions of increases in the number of clients.

Male involvement. In discussing most significant changes, the FP providers also included men's involvement. One provider said that after the LLMA, three in 10 FP visits included the male partner, up from zero in 10 before the LLMA. The same provider also noted, "More men have become involved in FP. Men are also reminding women to go for their FP follow-up visits… Prior, many women would move to live with their parents after giving birth. FP options allow the mother and child to stay at home with the father, be intimate, and together care for their newborn and child's upbringing."

Understanding of FP and FP benefits. FP providers believed that the LLMA helped correct common misconceptions about FP, especially the association of FP with sterilization, and broaden knowledge of FP methods in the community. The head of the Ombessa FP clinic perceived that "as a result of activities of the community leaders on FP, more women have been coming into the FP clinics with a method already in mind because the community leader has spoken with them."

Health benefits beyond FP provision were also noted. A nurse in Ombessa stated: "While we work on FP, we also work with mothers with various health issues. For example, we follow mothers who have HIV/AIDS. After six weeks of those women giving birth, the clinic follows up with them to discuss family planning. We also do postpartum family planning." The FP providers also cited overall economic and social benefits for communities and that FP enabled parents to "take care of the children they already have."

FP setting. Several comments from health providers suggested that FP activities are going beyond the health facilities, and the information about FP benefits and services is reaching FP users in the communities:

- "When it comes to the local leaders, they go into the community to speak with people …" said a nurse from Ombessa
- "Now I'm delivering FP services sometimes to various people at their homes in the community … to talk about FP in the community," said the head of Ombessa FP clinic.

Client follow-up. Also mentioned as a perceived result of the LLMA was improved client follow-up. According to a nurse at Bahia District Hospital, "We don't lose contact with the clients, because when the clients don't come to the hospital for follow-up services, their community leader is able to follow up with them."

2. To what degree were activities in the local leaders' action plans implemented as planned?

A key step of the LLMA process is to design a shared action plan and manage and monitor its implementation using the resources local leaders have available. Local leaders were successful in implementing activities under the action plans they designed at the outset, and the subsequent activities helped bring about positive changes in the FP-related perceptions, attitudes, and practices in the community and among FP providers. Based on the evaluation, much of the planned activities were carried out, representing 30 home visits and 50 talks, which brought together over 700 people, including close

FIGURE 5: Activities Carried Out by Local Leaders*

	Activity	Audience	Organizers
CSIUB & HDB	Sensitization activities and special talks to discuss FP issues	180 women, 120 men, total 300	Local leaders with grassroots organizations
	3 educational talks on preveting unplanned pregnancy and use of contraceptive methods	100 students in 5 classes, Government Bilingual High School 50 students, *Lycée Classique Moderne* Customers and staff of 2 hairdressing salons	Local leaders
	Sensitization sessions	90 women, 30 men, total 120	Local leaders with grassroots organizations
CMA Bokito	Educational talk on Sayana Press, male condom, and other contraceptive methods	20-30 people., main roundabout, central Bokito	*Association des jeunes de Bokito*
	2 educational talks on FP and benefits of contraceptives	25-35 male and female Form 3 and 4 students, principal, teachers, *Cours Secondaire,* Bokaga 100 people, Tobagne market	Local leaders
CMA Ombessa	Sensitization sessions	190 women, 60 men, total 250	Local leaders with grassroots organizations
	2 educational talks	Local youth at 1) Government Technical High School - Ombessa and 2) *Lycée d'Enseignement Géneral de Ombessa*	Local leaders with grassroots organizations
	6 educational talks on unplanned pregnancy and use of contraceptive methods	29 customers and staff, 3 hairdressing salons, and 18 cutomers and staff, 3 tailor shops	Local leaders
	3 educational talks on use of contraceptive methods	30 customers, staff, and staff spouses, 3 car repair shops	Local leaders

*Note that the local leaders' groups also include health care providers.

to 500 women. Activities took place in homes, public places, learning institutions, hairdressing salons, tailors' workshops, and car repair shops. Figure 5 summarizes the individual and community sensitization and educational talks conducted by local leaders (including the health care providers).

It is worth noting further that, as mentioned earlier, birth spacing, FP counseling by the health worker local leaders, and involving young people, were singled out in the action plans as particular areas that local leaders wanted to address, and that they succeeded in doing so in each of these cases:

- Awareness of birth spacing (in addition to other maternal health benefits) was one of the most common themes clients cited as a benefit of the community leaders' work.
- FP providers and clients both cited more effective, empathetic FP counseling as one of the LLMA's most noticeable and impactful changes.
- Local leaders and FP providers credited the youth outreach activities for enabling them to talk with adolescents about healthy behaviors and safe RH/FP practices to prevent early childbearing.

However, it is likely that some activities were not completely implemented as envisioned, mainly due to lack of resources. Leaders could rely only on locally available resources without additional financial or other resource support from the project, to promote sustainabilty. One local community leader estimated that perhaps one-third of the local plan had not been fully implemented due to lack of resources for transportation, equipment such as megaphones for sensitization campaigns, or phone credits for client followup.

Without quantifying implementation under the action plan, a provider thought "the training and implementation was good as designed." A DHMT member thought that "the program as designed worked well," while also noting the lack of resources for transportation within the district and for informational materials, such as counseling brochures to hand out during awareness-raising campaigns.

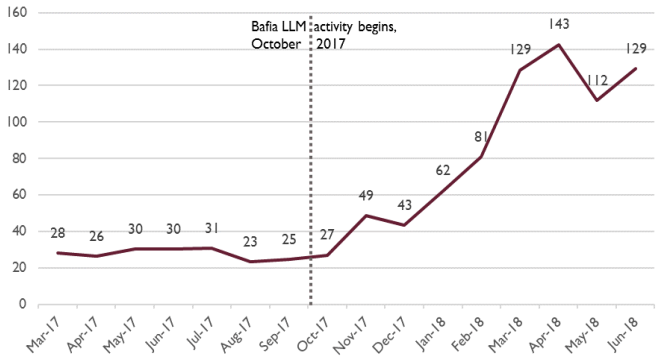
Overall, the accomplishments in action plan implementation suggest that the approach of strengthening local leadership skills to advance a commonly agreed-upon FP/RH agenda can indeed enable local leaders to effectively bring their talents to bear on focused agenda items.

3. Have there been changes in the clinics' delivery of FP information and services that correlate with the LLMA?

The FP data gathered from the four clinics demonstrated positive trends in some FP service delivery indicators. The

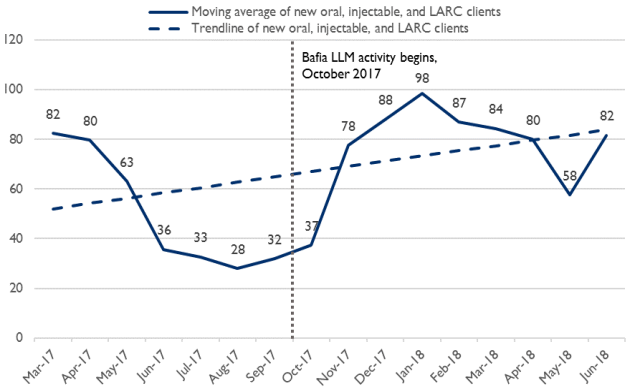
clinics experienced increases in the number of new clients who accepted an FP method from the baseline of October 2017 to the end-line evaluation of June 2018 (see Figure 6).

FIGURE 6. Moving average of the number of new clients who accepted a FP method



The data also also demonstrated an increase in the total number of new clients using oral contraceptives (OC), injectables, and long-acting reversible contraceptives (LARCs) [see Figure 7]. Note that there is a seasonal decrease beginning around April of each year; this corresponds with the beginning of the rainy season. In 2018, this seasonal decrease appears to be less severe than the seasonal decrease in 2017.

FIGURE 7. New oral contraceptives. Injectables and LARC clients



When disaggregated by method type, the clinic data demonstrated increasing trends of new LARC clients and injectable clients (see Figures 8 and 9). While the results indicated a decreasing trend in the number of new OC clients (see Figure 10), the larger increases in injectable and LARC clients, particularly in the number of new implant clients, more than compensated for this decrease. The increase in new LARC clients is particularly interesting, as community leaders observed that members of the community were historically wary of choosing LARCs as their contraceptive method.

FIGURE 8. New LARC Clients Including implants and IUDs

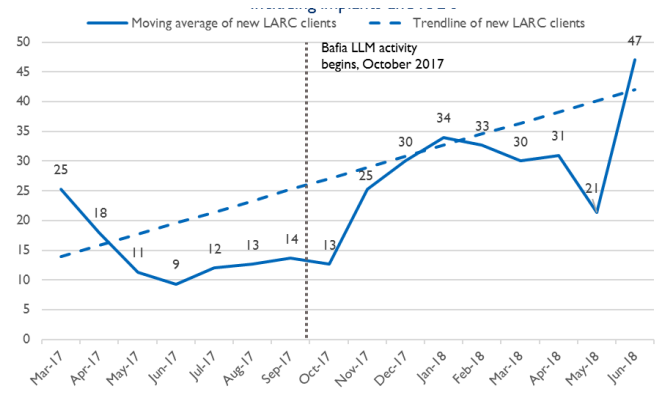


FIGURE 9. New Injectable Clients Including Depo Provera and Sayana Press

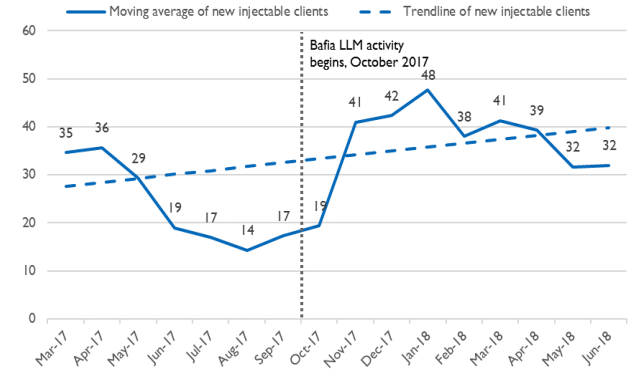
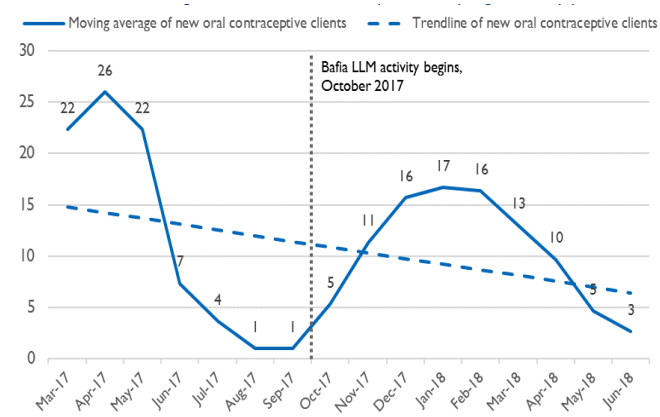


FIGURE 10. New Oral Contraceptive Clients Including combined oral contraceptives and progestin-only pills



For injectables, there was a decrease in new Depo Provera clients and an increase in Sayana Press clients over time; this transition is related to the Sayana Press rollout supported by UNFPA during this time period. Overall, there was a small increase in new injectable clients, which may have been influenced by this separate intervention. The number of oral contraceptive clients decreased for both combined oral

contraceptives and progestin-only pills. However, as the number of oral contraceptive clients was already relatively low and the decreases in these clients were not as substantial as the increases for other contraceptive methods, the overall trend in new clients for all methods still increased over time.

As described above, this is a theme that is echoed throughout the findings from interviews and FGDs.

While we do not have the evidence to attribute these changes to the LLMA, based on the results from the FGDs and client exit interviews, it is plausible that the LLMA may have been a contributing factor.

Challenges to Consider

Local leaders and DHMT members cited resistance from certain sectors of the communities as a challenge, though there was no general resistance from the communities. The resisting groups included traditional leaders, religious institutions, traditional healers to whom people had generally previously turned for RH advice, and husbands who wanted to control their wives' actions and decisions. The chief medical officer for Bafia district cited getting the traditional leaders to buy into the FP activity as the biggest challenge, especially given their historical view of FP as clashing with the local culture. Most of them had negative perceptions and incorrect understanding of the purpose of FP. With a change in that understanding, "most of them now say that having a lot of children [for whom parents] can't properly provide is poverty." The Bafia district FP coordinator added that gaining the basic acceptance of the community and getting people to listen — "some people would chase the community leaders away" — were also major challenges at the start. Thus, the LLMA's efforts to communicate to and sensitize the people were essential for the activity to take hold in the communities.

Insufficient funds and other resources were repeatedly mentioned as a challenge from all stakeholders, including the local community leaders, FP providers, and DHMT representatives. These could be funds for FP methods, counseling aids, informational materials, or phone and other ancillary expenses. A local leader in Ombessa said that "at times when you are working with the community, they want you to provide them with things like drinks. However, I don't have the means to be able to do so." While LLMA advocates for locally grown solutions and emphasizes reliance on locally available

Catherine Boyomo, a health worker, injecting a contraceptive to a woman who attends the local clinic. Photo Credit: Alain Ngann (2018)

Catherine Boyomo, talks to women attending a FP training session at the local clinic. Photo Credit: Alain Ngann (2018)

resources for sustainability, having access to additional external financial and other resources can be beneficial.

Local leaders and DHMT members also recognized logistics challenges, especially transportation, in carrying out the activity. "At times, the moving about in the community is hard," said one local leader. Bafia's chief medical officer also noted the "constraints in moving to different areas." Local leaders in Bokaga (part of the rural Bokito catchment area) cited distance, cost, and climate as posing related logistical challenges: "At times, there are those who pay CFA 8,000 round-trip in order to get around the area. When it rains like this, it is double the price."

Lessons Learned and Recommendations

From the wide-ranging responses of the diverse group of activity participants and stakeholders, a few "lessons learned" emerge from the LLMA in Bafia, foremost among them:

- *The LLMA, carefully followed and implemented along its various steps, can succeed.* Or, as one put it, "Despite the lack of financial remuneration, resolute and committed community leaders can provide additional support to health workers and qualitatively contribute to a shared result in family planning."

- *Through their position, leaders can raise FP awareness, provide credibility, and create favorable conditions for FP acceptance and use.* When a community sees its local leaders become involved in an activity, they come to take the activity more seriously. As one DHMT member noted, with the leaders' acceptance of the FP message, "everyone is receptive of their message and finds it useful and pertinent."

- *Identifying the right leaders and providing them with appropriate materials and support are crucial.* The district representatives cited success in identifying "really strong leaders" and reinforcing "their capacity and their ability to disseminate the information" as a strong point of the LLMA. Identifying strong leaders of high caliber was "paramount," they said, in enabling the activity to achieve its desired results. A DHMT member expressed the need for materials, such as brochures about FP methods that people can take home, job aids that demonstrate a method's proper use, and flyers with answers to "frequently asked questions" for distribution during sensitization sessions.

- *Local leaders' unwavering commitment without resource and financial support cannot be assumed.* A local leader noted that more resources and financial support for the leaders was necessary "so they are not doing voluntary work and using their own money to do it." An FP provider expressed concern that without motivational incentives, the leaders might not be able to continue: "They need some small incentives to repay them for the transportation and phone credit they use to reach the community."

> The DHMT has already recognized the community leaders in Bafia as "a source of partners we can count on for other activities. They have succeeded in something no else has done before, and we know they are able to do it." Without a formal arrangement, the local leaders "are already involved in various other activities throughout the district. They are closer to the local population and end up seeing more patients than us."
>
> ***– DHMT members***

- *Budgeting for costs of local leaders' activities is critical.* To consider how to cover the costs of leaders' activities, the LLMA can be modified to include a step, early in the process, of working with local leaders to identify sustainable financing approaches or methods. Local leaders and DHMT members can work together to identify the needs for additional financial or logistic resources and ways to mobilize resources from within the community to meet these needs prior to starting activity implementation.

- *Increasing coordination with health workers is also critical.* The district health officer said the community leaders need leadership and support from the DHMT. Without these, "their efforts might drop off." To sustain their work, he would recommend meeting with the leaders to come up with a calendar of activities

and a way "to evaluate the activities' success going forward, maybe every two months." It was also important for DHMT members to become FP leaders themselves and get involved in the LLMA field activities. By doing so, they would add weight and legitimacy to the importance of the community activities the leaders were carrying out.

- *Increasing collaboration with other health activities should be considered.* DHMT members also suggested that sustaining and scaling up LLMA activities might benefit from existing activities in other areas, such as maternal and child health or malaria. "Community agents" working in these areas can be reoriented to FP and become "community leaders" in FP LLMA activities — "they already have the capacity to mobilize and they have learned a lot of skills."

- *Maintaining leaders' skills in FP activities is necessary.* Since the local leaders' involvement is at the core of the LLMA programming, it is imperative that the leaders' skills in FP information and practice areas are maintained and kept current through periodic new or refresher training as appropriate and with adequate support tools.

- *FP clients also have ideas to contribute.* Clients suggested that the local leaders could enhance their response to community FP needs by going house to house to increase demand, going village to village "so that people are better informed," and using radio to spread their message.

Replicating LLMA in New Settings

Implementing the LLMA in new settings requires careful application of the multi-step approach, with special attention to (or adaptations of, as learned through the Bafia experience) the following areas:

- Identifying the stakeholders
- Selecting the local leaders
- Identifying sustainable financing
- Anticipating material resource needs, preparing to meet them
- Advocating with traditional leaders

Please refer to our Implementation Guidance for more detailed information on how to apply the LLMA.

Establishing the stakeholder team: Establishing a strong local multisectoral stakeholder team is essential for positioning the LLMA from the start, for identifying the specific local problem areas of need to focus on, and for working with local health stakeholders to find a common ground on moving forward.

Selecting the right local leaders: As seen in the earlier sections of this brief, the Bafia stakeholders and implementers repeatedly pointed out the importance of strong local leaders. The baseline community assessment can help identify the right people to be selected as leaders.

Identifying sustainable financing: In Bafia, the lack of financial and material resources to support activities was an oft-mentioned problem. Taking heed and as mentioned above, stakeholders in and implementers of new LLMA activities should include in their approach a step of working with local leaders and the appropriate health officials to identify sustainable financing approaches, methods, and resources that can be mobilized from within the community and municipality before LLMA activities begin.

Anticipating material needs, preparing to meet them: The Bafia local leaders and FP providers often noted that the lack of samples or models of FP methods, instructional posters, and informational pamphlets and brochures to hand out or display was a constraint to effective communication. For any new LLM activity to be implemented, such materials should be accounted for in the local leaders' action planning and budgeting.

Advocating with traditional leaders: As seen in Bafia, the potential opposition of traditional leaders to either FP itself or the emergence of new "local leadership" (or both) is real and should be anticipated. Advocacy with traditional leaders to gain their support or acceptance is therefore a recommended early step for the stakeholder and leader teams to take before getting started with the leaders' LLMA activities.

A baby receives medical attention at one of the meetings at the local clinic in Bafia District. Photo: Alain Ngann (2018)

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1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.

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