



ORGANIZATION

Reproductive Health Uganda

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A youth Male Champion engaging young mothers in a group discussion on unsafe abortions and contraceptives to prevent unintended pregnancy.



implementation story:

Peer learning, community outreach, male champions and a one-stop facility model: a holistic approach to prevent unsafe abortions and increase uptake of post-abortion care in Uganda



“We ask clients how the abortion started and refer them to Reproductive Health Uganda when they have complications we cannot handle. We mobilize the communities and women with problems related to family planning (FP). The project has given me a lot of knowledge on FP and has helped me understand how people are suffering from unsafe abortions.”

— Ochira Winston Single, Male Champion, Pabala village

BACKGROUND AND CONTEXT

UNCLEAR ABORTION LAWS ARE BARRIERS TO SAFE AND NON-JUDGEMENTAL CARE

The Ugandan Constitution states that “no person has the right to terminate the life of an unborn child except as may be authorized by law” (1). However, it is not clear on which grounds the law permits abortions. A policy document from 2006 states that individuals with the following conditions or situations can get services for termination of pregnancy: severe maternal illnesses threatening the health of a pregnant person (e.g. severe

A youth Male Champion engaging young mothers in a group discussion on unsafe abortions and contraceptives to prevent unintended pregnancy.



Photo credit: RHU

cardiac disease, renal disease, severe pre-eclampsia and eclampsia); severe fetal abnormalities which are not compatible with extra-uterine life (e.g. molar pregnancy, anencephaly); cervical cancer; HIV; and rape, incest and defilement (2). However, the conditions set forth in this policy document are not supported in the law and it is unclear whether this document is in force (1).

Lack of clarity regarding the grounds on which abortion is legally permitted leads to confusion among women and girls, health workers and community members (3). Coupled with sociocultural values and beliefs, this results in health workers being reluctant to provide care (sometimes in fear of prosecution), local community leaders denying care regardless of the grounds on which people request an abortion (such as rape), and women and girls being driven towards seeking abortion that is performed under unsafe conditions (3).

COMPLICATIONS FROM UNSAFE ABORTION – A MAJOR PUBLIC HEALTH ISSUE

In a study conducted in 2003, it was estimated that in her lifetime, the average woman in Uganda would have a 50% risk of needing care for complications after an induced abortion (4). This was based on data suggesting that 28% of all women undergoing an induced abortion received treatment for complications (4). However, the share of women and girls who actually experience complications following an induced abortion is likely to be even higher, given that not all people who have post-abortion complications receive the care they need (3). Abortion stigma and limited awareness of and access to post-abortion services may affect whether women seek post-abortion care (PAC) in Uganda, and how they experience that care.



“I took my friend to the hospital because she was very weak, but we were not helped. My friend told the health workers that the bleeding started after she put certain pills under the tongue as she had been instructed at the pharmacy.

The health workers said it was a criminal abortion and threatened to involve authorities and have us write statements at the police. Luckily, we found a way to sneak out of the hospital. Another friend of mine told us to go to Reproductive Health Uganda to get metronidazole to stop the vomiting.”

– Client at Reproductive Health Uganda (RHU) clinic

UNINTENDED PREGNANCIES – AN ISSUE AMONG YOUNG PEOPLE

In 2010, it was noted that Uganda had the youngest population in the world, with 77% being under the age of 30 (5). This high proportion of young people has remained the same over the years: the World Bank concluded in 2019 that more than 75% were under the age of 30 (6). The forecast enormous growth of the total population in the coming decades will require investments in health and education for young people, for the country to reap the benefits of the demographic changes and to support higher economic growth (7). However, in 2019, the country faced one of the highest youth unemployment rates in sub-Saharan Africa (6).

The growth of the young population also indicates that teenage pregnancy and unintended pregnancy pose an increasingly pressing reproductive health issue in the country. Data from 2016 showed that 20.4% of women of reproductive age expressed an unmet need for family planning (FP). This problem was even higher among adolescents: 30.4% for married adolescents and 45.1% among sexually active unmarried adolescents. By the age of 19 years, 25% of Ugandan adolescent girls had been pregnant at least once (8).

Analysis of data from 150 countries between 2015 to 2019 showed that Uganda had the highest rate of unintended pregnancy among all the analysed countries, with 145 unintended pregnancies per 1000 women aged 15–49 years (9). It was also estimated that 30% of these unintended pregnancies ended up in an induced abortion (9). In turn, many of these induced abortions were unsafe. While maternal mortality has decreased in Uganda in the past years, it remains high (375 maternal deaths per 100 000 live births in 2017) (10) – and the Ministry of Health has stated that 9% of all maternal deaths in 2015–2016 could be attributed to unsafe abortion (11).

To add to the vulnerability of many women and adolescent girls in Uganda, gender-based violence is a critical issue in Ugandan society: according to a survey in 2016, more than half of all women (55.8%) aged 15–49, and more than 4 in 10 (41.5%) of adolescent girls, had experienced physical, sexual or emotional violence by their current or most recent husband or partner. Gender norms in Uganda result in many people believing that women need to seek approval from their male partners before using contraception or seeking other sexual and reproductive health



Photo credit: RHU

Women learning about intrauterine devices (IUDs) as a contraceptive method to prevent unintended pregnancies.

(SRH) services. Women do not always make autonomous decisions about FP services, but are often dependent on their partners in the decision-making process: for only 30.6% of married women was the decision to use FP primarily their own. 62% made the decision together with their husbands, while for 7.1% of the women, FP was mainly the decision of the husband (8).

A PROJECT TO PREVENT UNINTENDED PREGNANCIES AND ADDRESS UNSAFE ABORTION

In this context of high rates of unintended pregnancies and unsafe abortions, it is critical to protect the health and rights of women and girls, through improving access to services that prevent unintended pregnancies, and to prevent unsafe abortion. Available PAC is also needed to address the needs of those who have undergone an abortion. Such services include treatment of complications from unsafe abortion, and post-abortion family planning (PAFP) to prevent unintended pregnancies.

Reproductive Health Uganda (RHU) is a national non-profit organization that promotes universal access to rights-based SRH information and services to vulnerable and underserved communities, and especially young people. In 2016, RHU implemented an initiative to provide quality, comprehensive and rights-based abortion care services to address the burden of unintended pregnancies and unsafe abortions. RHU intended to do this by increasing uptake of safe abortion services, including provision of safe abortion within the legal and policy framework of Uganda, management of incomplete abortion, treatment of complications from unsafe abortion, and PAFP.

The initiative took a holistic approach, including peer-to-peer mentoring, values clarification and improved data use among providers, in the nine RHU clinics involved. The project also entailed media activities, male involvement and community engagement to challenge myths, misconceptions and gender norms, which put women and girls at risk of violence and pose barriers to safe abortion and the prevention of unintended pregnancies.

Teenage mothers invited to an SRHR community dialogue organized by RHU.



Photo credit: RHU

WHO ABORTION GUIDELINES AND TOOLS

In order to design and implement effective interventions, RHU used a range of evidence-based resources on abortion care, including WHO guidelines that include technical and policy recommendations, such as [Safe abortion: technical and policy guidance for health systems](#) and [Health worker roles in providing safe abortion care and post-abortion contraception](#),¹ [WHO Medical eligibility criteria for contraceptive use](#) (MEC) (13); as well as other PAFP resources from WHO partner organizations. These resources were selected as they are evidence-based sources that provide guidance on how health-care providers can deliver quality abortion care, including post-abortion care.

“All WHO guidelines are provided through the Ministry of Health. These guidelines have strengthened clinical skills among facility staff and have been used as reference in offering post-abortion care (PAC) services, including family planning.”

Health workers have been trained to provide PAC by linking practice to the guidelines. This has reduced the number of unnecessary referrals as well as of complications due to unsafe abortions.”

– Acting Assistant District Health Officer, Gulu District

The use of WHO abortion care guidelines was contextualized to suit the circumstances in Uganda. Service providers were oriented on the WHO recommendations, with a focus on the range of health workers that can provide abortion care including counselling; induced abortion within the legal and policy framework of Uganda; treatment of complications of unsafe abortion; treatment of incomplete abortion; and PAFP. These recommendations were then applied, taking into consideration the Ugandan Constitution and the policy document on abortion from 2006.



RHU health workers are mentored on the use of the Medical Eligibility Criteria wheel, to screen clients for initiation of post-abortion family planning.

In the peer-to-peer learning model, health workers with skills in SRH care provision are paired with other health workers who need more support to provide quality care.

IMPLEMENTATION STORY

USING WHO GUIDELINES TO UPGRADE CLINICS AND SERVICE DELIVERY PROCESSES

RHU's initiative focused on groups in vulnerable situations: primarily rural women and urban women with limited resources, young people, students, and people in humanitarian settings. It involved capacity-building and efficient involvement of a wide range of health workers, including nurses, midwives, clinical officers, community health workers (CHWs), village health teams (VHTs) and district health teams.



RHU
clinic,
Gulu

The project was implemented in RHU clinics in nine districts. RHU referred to the WHO guideline [Safe abortion: technical and policy guidance for health systems](#), and WHO recommendations related to medical and surgical abortion, treatment of incomplete abortion, initiation of contraception, and follow-up visits. RHU then compared these recommendations against the service delivery in its facilities. Each clinic underwent a holistic review of its limitations and opportunities, including an assessment of available resources, health provider competencies, supply

1 These and other WHO abortion-related guidelines have been replaced by the WHO [Abortion care guideline](#) (2022), a consolidated guideline on comprehensive abortion care across the continuum of care, spanning clinical care, service delivery, and law and policy. Additional resources on abortion care can be found [here](#).

chain strengths and weaknesses, and data collection mechanisms. The facilities were then equipped to better enable safe and respectful abortion care, including to help clients feel comfortable when seeking care. The facilities were upgraded with computers and improved water and electricity supplies. More efficient tracking and use of data improved commodity supply, ensuring adequate stock of misoprostol and mifepristone for medical abortion, equipment for manual vacuum aspiration, and contraceptives.

IMPROVING QUALITY OF CARE THROUGH PEER-TO-PEER LEARNING

Training programmes developed by RHU strengthened health workers' capacity in providing quality medical and surgical abortion services in line with available policy documents in Uganda and WHO guidelines.

In addition to clinical competency strengthening, much of the training focused on the importance of considering patients' experience of care. To ensure that abortion care is rights-based and respectful, RHU arranged values clarification and attitude transformation (VCAT) training. This enabled providers to understand common barriers to quality abortion care, including induced abortion and post-abortion care, and clarified the legal framework under which safe abortion care is permitted in Uganda. The training sessions were conducted through a combination of classroom-based and on-site learning, using a peer-to-peer model. RHU identified health workers who were competent in providing abortion and PAFP services, and these were paired with health workers who needed more support to provide quality care.

“The peer-to-peer training is a very good sharing initiative. You would go there, you learn from and copy how your colleagues are doing things differently.”

— Service Provider In Charge, RHU clinic, Gulu



A service provider demonstrates to other health workers how to correctly assemble a manual vacuum aspiration kit used to manage an abortion or post-abortion care.

These mentorships enabled providers to learn from one another on the job in a clinic setting, and motivated clinic teams to share working strategies and best practices. It also supported providers to interact with each other, and to collaboratively define action plans to improve the confidence and attitudes of service providers.

“A skilled provider is a confident provider. The trainings provided the health workers with additional skills and this enabled them to provide quality services, right from the counselling to the actual intervention. The practical sessions during trainings exposed the providers to a range of different scenarios.”

— Information Management Assistant, RHU clinic, Gulu



Health workers in a group discussion during a training session on abortion care including post-abortion care.

The peer-to-peer learning approach enabled health workers to transfer clinical skills and share best practices.

SUBSIDIZING ABORTION AND FAMILY PLANNING

RHU implemented a no-refusal programme, which means that, for three days each month, RHU clinics offer FP services (including PAFP) for free, and other abortion care services at a reduced cost. Through this policy, RHU improved equitable access to safe abortion and PAFP, regardless of the age and socioeconomic status of the care-seekers. This intervention was instrumental in attracting people from vulnerable situations to the clinics, and in particular those seeking long-acting contraceptive methods.

“I felt good about the way the providers handle the clients. They are so happy and know how to talk to us. Even when you don’t have enough money, they still go ahead and give you the service.”

— Linda, client, RHU clinic



RHU staff participating on local radio. Radio talk shows and announcements were used to sensitize listeners on contraceptives and other SRHR issues, and to inform the public about the subsidized services at RHU clinics.

DEBUNKING MYTHS AND STIGMA SURROUNDING FAMILY PLANNING AND ABORTION



Youth peer educators raising awareness about family planning.

Contraceptive use among adolescents is sometimes discouraged as it is believed to be a sign of promiscuity.

“Women used to fear us health providers, but we assured them of confidentiality. Most women have realized the importance of FP and we now interact with them freely.”

— Ochira Winston Single, Male Champion, Pabala village

For religious and cultural reasons, many people in Uganda believe that young people should not be sexually active. Through interaction with clients and community members, RHU noticed that FP is sometimes described in negative terms, as something that encourages sex before marriage. Demand for FP is seen as a sign of promiscuity and some providers refuse to prescribe contraceptives to unmarried young women. There is also misinformation about the safety of FP.

“People out there discourage others from using the services, saying that FP prevents you from ever being able to give birth in the future. That’s not true, you may set yourself to use the method for a year or two, it is better to take the method so that you can space your children and have another baby when ready. I advise women to seek accurate information from qualified providers.”

— Client, RHU clinic

To address social norms that pose barriers to uptake of FP services, awareness campaigns were launched targeting populations in vulnerable situations including rural communities that were at risk of low uptake of FP services. Through community dialogues, community leaders dispelled myths and misconceptions surrounding abortion and FP, including addressing legal considerations. Women and men (including young people) were sensitized on teenage pregnancies, FP, the risks of unsafe abortions, and how to access safe abortion in line with available policy

documents in the country. This empowered community members to understand their rights and make informed decisions about their reproductive health.

“Communities believe that abortion cannot be done due to religious reasons. Even if there are those who may not be comfortable talking about this, we inform them. We identify focal people – health workers, women leaders or religious leaders – who are pro-service, and we empower them to take a lead in discussing abortion in the community.”

– Reproductive Health Trainer, RHU clinic

Peer providers who could speak the local languages at all levels helped to translate information material (based on WHO guidelines) into easy-to-understand products, using simple and local language. This made SRH information more accessible and relevant to their target groups.

THE CHURCH, MARKET AND HOME – REACHING COMMUNITY MEMBERS IN THEIR EVERYDAY LIVES

“After prayers on Sunday, we request for an opportunity, in church, to provide health talks on SRH including family planning. We also target village markets and sports events during weekends to start dialogues.”

– Suzan Aciro, RHU Village Health Team

Before the RHU initiative began, some women did not seek the SRH services that they needed, partly because of long distances to clinics, something which was aggravated by the COVID-19 pandemic. By conducting house visits, going door to door in communities and asking about care needs, community health workers could identify women with unmet need of SRH services.

Approaching people in their everyday environments – where they work, study or socialize – was a key factor in community health workers' and Village Health Teams' success in reaching community members and initiating conversations about FP.



A religious leader calls for change in access to SRH services, including access to contraceptives to prevent unintended pregnancies.

RHU staff engaging community members on SRH services as part of an awareness campaign.



“We target Village Savings and Lending Associations and home-based income-generating groups, where women work with knitting and basket-making. And we target young people during football competitions. This gives us a chance to talk about different topics, we share our telephone number and they call for referrals or visit us.”

– RHU Village Health Team worker, Gulu

To reach students in higher learning institutions such as universities, school-peers helped to share information.

“Before, there were many people who got an unsafe abortion, and ended up becoming pregnant again. They were performing unsafe abortions on their own, especially university students, using herbs, bones or miso. Now they thank us when the job is done well and safely and they trust us.”

— RHU Village Health Team worker, Gulu

Other methods to make people aware of available services included radio announcements to advertise the days of free services at RHU clinics. In talk shows on local radio stations, RHU health workers and community leaders sensitized listeners on contraceptives and other sexual and reproductive health and rights (SRHR) issues. Referrals from satisfied RHU clients also played a critical role in spreading awareness of and generating trust in RHU services.

MALE INVOLVEMENT TO CHALLENGE HARMFUL GENDER NORMS

“A client can tell you ‘I cannot take the FP method, I need to consult my husband’. We inform the woman and encourage her to come with her husband. We counsel both of them, they accept to be helped by taking up a method of choice, so that they can have another child at the time they want. Partners can also witness how the method is inserted.”

— RHU Village Health Team worker, Gulu



A youth Male Champion capturing the attention of boda boda drivers (male drivers of motorcycle taxis) in a sensitization campaign on teenage pregnancies and unsafe abortions.

In response to the unbalanced power relations between males and females in Uganda, RHU integrated male engagement into its initiative as a way to support change in people's perceptions of SRH services and in their care-seeking behaviour. Women were ensured that their visits to the clinics were confidential, but were also encouraged to involve their partners in the process, so that negative attitudes and myths surrounding abortion and FP could be tackled.

“Some men assume that women using family planning (FP) are cheating on them with other men. So the women confide in us to be able to access services of their choice.

Women have been empowered to take control over their health through pregnancy spacing and this influences other women to come with their husbands to discuss services. We encourage men to participate with their wives in choosing FP methods. We enable them to set their reproductive health goals, and dispel myths and misconceptions.”

— Suzan Aciro, RHU Village Health Team



Photo credit: RHU

A youth Male Champion counselling a young mother on contraceptives.

Few women in Uganda make family planning decisions on their own. RHU Male Champions promoted gender equal relationships, and encouraged women and men to have open dialogues about FP.

“Male champions” were identified within existing youth groups and among religious, political and cultural leaders with influence in their communities. Through awareness-raising training sessions, dialogues and sensitization campaigns, these men were equipped with information on SRHR, including abortion and gender-based violence (GBV). In this way, these men were turned into SRHR advocates, empowered to be actively involved in addressing low contraceptive use, and in reducing unintended pregnancies, unsafe abortions and GBV. These “male champions” spread information and supported women to seek abortion services, including safe induced abortion in accordance with available policy documents in Uganda, treatment of incomplete abortion and PAFP.

The male championship initiative aimed at empowering both women and men to favour gender-equal relationships. Champions confronted gender norms, challenged the idea that SRH care decisions are to be taken by men only, and encouraged couples to have open dialogues about FP. RHU’s conversations with clients indicated that these activities contributed to a reduction in GBV.

“The intervention improved male attitude towards family planning and CAC services, with several men coming for services together with their female partners. Local leaders also supported and gave fellow men advice on FP during community awareness programmes. As a result, there has been a reduction in domestic violence related to family planning.”

— Brenda, Service Provider, RHU clinic, Moyo



Photo credit: RHU

Male champion Pastori together with his wife and other women in the community. Having a supportive family partner gives Pastori the confidence to contribute as a Male Champion in his community in Kyabugimbi, Bushenyi, informing women about quality post-abortion services.

A ONE-STOP SERVICE MODEL TO INCREASE POST-ABORTION FAMILY PLANNING

In an effort to minimize missed opportunities to reach people in need of services, RHU implemented a one-stop, single visit service delivery model in its health facilities. Women who visited RHU clinics for post-abortion care (PAC) were offered voluntary contraceptive counselling and services at the same time and location. This prevented high costs of multiple visits – a barrier that primarily affects vulnerable clients – and thus helped to minimize loss of follow-ups.



A RHU client filling out a consent form before receiving post-abortion care (PAC) services.

Women visiting RHU for PAC services were offered voluntary contraceptive counselling at the same time and location, which contributed to increased uptake of post-abortion family planning.

“Before, PAC clients would request to go back home and consult the husband about returning for FP. That makes them likely to return pregnant to the clinic. A peer told us that giving FP methods to PAC clients immediately was much better. This has resulted in an increase in PAFP counselling and uptake in our clinic.”

– Service Provider In Charge, RHU clinic, Gulu

Based on WHO guidelines, providers and community health workers were equipped with information that they could pass on to women, including what to expect during a clinic visit. They were also oriented on how to use tools such as flip charts and models in counselling. Much focus was put on how to provide information and voluntary counselling² in a respectful way: how to listen patiently to clients' needs and concerns, and how to answer questions using clear, non-judgmental and supportive language. These measures gave clients confidence in taking up the services.

“PAFP increases when you do in-depth counselling. We don't decide for clients but we give them a lot of information to make an informed choice. We help them appreciate that it may be good to rest between pregnancies, and the potential dangers if they do not.”

In cases when women want to consult their husbands, we encourage the men to be part of the decision process. Provision of information and counselling should start already when the client arrives and continue until she makes an informed decision.”

– Anicia Filda, Service Provider In Charge, RHU clinic, Gulu

The WHO Medical eligibility criteria for contraceptive use (MEC) (13) – the printed guideline, the wheel and the mobile app – were also successfully used to screen clients and determine which FP methods were suitable in each specific case.

“The Medical Eligibility Criteria wheel and app equipped service providers with skills to provide modern contraceptives and to check for eligibility for post-abortion FP. Clients were clearly told about underlying conditions that made their initial choice of FP less suitable, and they were able to make a choice for a more favourable method.”

– Brenda, Service Provider, RHU clinic, Moyo

² The provision of scientifically accurate and easy-to-understand information to all women undergoing an abortion, and non-directive voluntary counselling to anyone who requests it, is a core element of good-quality, human rights-compliant abortion services. When offering and providing counselling, it is essential to ensure that the individual is requesting the counselling and to make it clear that counselling is not required. (For more information on counselling, refer to the [WHO Abortion care guideline](#), 2022 (12).)

LEVERAGING USE OF DATA TO DRIVE SRH PROGRAMMING

An integral part of this initiative was to train staff at clinics on how to concretely collect, register and use quality data.

By inviting clients to leave comments in boxes outside the clinic, and to participate in exit interviews, RHU could capture how women and girls

SUGGESTION BOX

Photo credit: RHU

“They were very interactive sessions, where the participants were able to share their experiences. I learnt that for proper records and data, all client’s details and information need to be completed.”

– Patience, Information Management Assistant, RHU clinic, Gulu

Once robust data collection was in place, the data could be used to ensure evidence-based decision-making – both on a strategic programmatic level, and on an operation level in individual clinics. Data were used to identify barriers to care-seeking, assess client satisfaction, and map challenges and opportunities for improving access to and quality of relevant services. For example, it was noticed that many young girls appeared at the clinics with incomplete abortion following a self-managed medical abortion. Analysis of information from patients revealed that most of these girls had obtained the abortion pill misoprostol in drug shops. RHU decided to partner with drug shops to ensure that pharmacists providing misoprostol also made timely referrals to RHU clinics, so that women and girls could receive appropriate PAC, including FP if they wished.

“Data capturing has really improved, you can easily access and retrieve different categories of data, on young people. There is collective responsibility in ensuring data is correctly captured, and in acknowledging that data management is important to support decision-making.”

– Logistics Assistant, RHU clinic, Iganga

Another example was the use of peer-to-peer information to reach adolescents. RHU had already started recruiting in-school peers to spread information in educational institutions, but when data revealed that demand for services declined across clinics during school holidays, RHU recruited out-of-school youth peers. These were equipped with basic information on available SRH services so that they could sensitize and mobilize fellow young people, and refer them to RHU clinics to access SRH services.

Regular and consistent review of patient data also helped to identify clients who did not attend their scheduled follow-up visits at clinics.

“A follow-up book was created so that it would be easy to follow up clients who didn’t turn up for the appointments. Through phone calls and by the help of village health teams, clients are being contacted, and hence the majority of the clients are now followed up.”

– Brenda, Service Provider, RHU clinic, Moyo

RHU also implemented training on how to use data to avoid stock-outs of supplies, including how to record and monitor commodities, and how to calculate the average monthly consumption. These skills, in combination with an emphasis on mentoring colleagues in the monitoring of stocks, has greatly helped clinics to ensure that commodities are available at all times.

“The project supported procurement of all the necessary supplies, coupled with adequate supervision that helped to keep us alert.”

– Anicia, Branch In-Charge, RHU clinic, Gulu

Clients' experiences of care were also assessed, using a range of approaches such as exit interviews and inviting patients to leave comments in suggestion boxes at the clinics. The input from clients indicated high client satisfaction while enabling further improvements of service delivery.

A DRAMATIC INCREASE IN UPTAKE OF SAFE ABORTION AND POST-ABORTION SERVICES

The monthly reports from RHU clinics show that following the introduction of sensitization activities in the communities, there has been an increase in the number of women visiting RHU clinics for abortion services. In four years, the number of women visiting RHU to receive care for induced abortion, missed abortion, incomplete abortion, or complications from unsafe abortion, increased more than seven fold, from 1894 visits in 2016 to 15 328 visits in 2020. Among these clients, there was also a dramatic increase in uptake of PAFP information and counselling. In 2016, only half of the women (53%) chose to receive PAFP services. Just two years later, in 2018, nearly all PAC clients (97%) took up PAFP services, and this figure was maintained during 2019 and 2020. This means that almost 14 times as many women received PAFP in RHU clinics, compared to 2016 (14). Uptake of contraceptives more than quadrupled, from 16 701 cases in 2016 to 68 377 in 2020 (14).



A woman receiving post-abortion family planning (PAFP) counselling at a clinic affiliated with RHU.

“We have seen an increase in uptake of family planning services in the facilities, especially among the young people. This has really contributed to reducing unsafe abortions and unwanted pregnancies.”

– Acting Assistant District Health Officer, RHU Gulu District

Ultimately, these achievements have enabled women to take charge of the long-term health and well-being – of themselves and their families.

“Women tell us that RHU has helped them a lot. Some used to struggle with their budgets at home due to too many children. Now they are able to cater for other needs, so they keep on calling us to ask for services.”

– Suzan Aciro, RHU Village Health Team



A health worker providing family planning counselling to women to prevent unintended pregnancies, during community awareness.

LESSONS LEARNED

Task-sharing enables more equitable access to care. By training low cadres, services can be made available closer to the people, which improves timely access to care.

Interventions to change behaviours must be socially acceptable. Addressing stigma and social barriers can be done through locally adapted dialogues and awareness campaigns.

Peer-to-peer learning works. SRHR information can be successfully disseminated through people who are grounded in the community and who can relate to the target audience. For example, students or males can act as “influencers” who can connect with their peers and challenge attitudes in their communities. Health workers can learn from being mentored by other providers.

tips for SRHR implementation

- 01 A single-visit approach reduces client visits and missed opportunities for PAFP uptake.** This is a cost-effective approach, for both clients and clinics.
- 02 Strong information management systems are key to quality data.** Clinic staff should be trained in collecting and using data to improve services. Countries should incorporate PAFP indicators in their national health management information system (HMIS) database to be able to track the impact of PAFP services.
- 03 Adapt your communication to local audiences.** When creating information material based on WHO guidelines, invest in translating the material into local languages and use simple language – to support equitable access to SRHR information.



For more information and recent WHO resources on abortion care, please visit the [WHO Abortion webpage](#).

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Male champion Pastori promotes post-abortion family planning. Family planning prevents unintended pregnancies and unsafe abortions.



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Health worker describing different family planning methods to a group of women.

