THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

INVESTMENT CASE FOR PRIVATE SECTOR ENGAGEMENT

IN FAMILY PLANNING IN UGANDA **2024-2030**

UNFPA Supplies Partnership

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Operational Definitions

Demand generation. This refers to increasing clients' desire to use family planning by changing their attitudes or perceptions about family planning or increasing their awareness or knowledge about family planning methods. Demand generation is needed when the modern contraceptive prevalence rate (mCPR) is low.

Market Share: Percentage of all women of reproductive age using modern contraception served by the commercial sector

Market Size: Percentage of all women of reproductive age served by the commercial sector

Modern contraceptive methods. are technological products or medical procedures that affect natural reproduction. These are classified as: (1) short-acting reversible contraceptives (SARC), including contraceptive pills, injectables, condoms, diaphragms, spermicidal agents and emergency contraception; (2) long-acting reversible contraceptives (LARC), including implants and Intra-Uterine Device (IUD); and (3) permanent methods, comprised of male and female sterilization.

Partnership. The formal relationship between two or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources and/or skills for the purpose of achieving these common goals.

Private sector engagement: refers to "a partnership between the public and private sectors to achieve a specific goal", direct interaction between the state actors and the private sector, as well as private to private collaborations that are properly regulated. In general, there are three broad categories of private sector engagement: including private actors in developing public health policy; development of ownership and contractual arrangement; and influencing behavior of private sector actors.

Private health sector is defined as all non-state providers of health services, which includes for-profit (both formal and informal) and not-for-profit (NGOs, faith-based organizations, community-based organizations), domestic or international entities

Public-Private Partnerships. Describes a spectrum of possible relationships between the public and private actors for integrated policy dialogue, planning, provision and monitoring of services widely defined as not only clinical services but also other activities performed in the health sector (e.g. production of human resources in health, supply chain of health goods and medicines). describes a spectrum of possible relationships between the public and private actors The essential prerequisite is some degree of private participation as well as transfer of risk to the private sector in the delivery of traditionally public domain services.

Private Health Providers. In the context of this document, private health providers (PHPs) are synonymous with private-for-profit (PFP) health providers. The MoH defines PHPs as all cadres of the health profession in Clinical, Dental, Diagnostics, Medical, Midwifery, Nursing, Pharmacy, and Public Health disciplines who provide health services outside Government and PNFP establishments.

Service delivery. This refers to the provision of family planning services, information, and methods at public and private points of care.

Total Market Approach (TMA). is when public and private players coordinate to jointly meet the healthcare needs of a population and leverage the strengths of each player to maximize the reach and quality of services. This approach helps grow the market for health products by better targeting free or subsidized products, reducing inefficiencies and overlaps, and creating room for the private sector to increase its provision of health commodities.

Acknowledgment

Acknowledgement of both the Department of Pharmaceuticals and Natural Medicines, the Division of Reproductive and Infant Health and the Total Market approach Taskforce. Special Recognition to the following taskforce members Dr. Seru Morries (MoH), Dr. Mugahi Richard (MoH), Dr. Martha Ajulong (MoH), Kasule Timothy (UNFPA), Precious Mutoru (PSI), Catherine Muhindi (ACORD), and Dr. Muwonge Moses (Consultant).

Preface

Investment in commercial sector family planning service provision is a SMART INVESTMENT for both women and actors (public sector, private not for profit and private for profit)

Investment in commercial sector is a SMART investment that will result in increased access to family planning services. The commercial sector comprises of more than 79% of the health sector health facilities, pharmacies, drug shops, clinics in addition to non-tradition outlets for condoms. Further more, investment in commercial sector leads to reduction in out-of-pocket expenditure due to increased availability (supply side) of a full method mix in commercial sector thereby reducing demand that in turn leads to reduction in markups.

Investment in commercial sector is a SMART investment for commercial sector players because of observed growth of commercial sector infrastructure taking up 79% of health facilities (drug shops-57%, retail pharmacies-8%, and private for-profit health facilities-15%) in the entire country. The growth of commercial sector health facility infrastructure is coupled by observed increase in buying power of women of reproductive age group (WRA) demonstrated by approximately 1.5 million WRA paying for contraception in 2023. This represents 40% of all WRA using modern contraceptives with the number expected to increase to 1.6 million in 2024. The increase in buying power is partly attributed to the increasing middle class in the rural areas from 27% in 2010 to 32% in 2020. The increased buying power is also reflected in the forecasted increase in demand for family planning products by 103% from USD 96 million in 2020 to USD 196 million in 2025.

Government of Uganda investment in commercial sector; in partnership with development partners and civil society organizations, is a SMART investment in that all scholarly papers point to the fact that investment in commercial sector does reduce equity and inequality in access to family planning services. Further, investment in commercial sector will lead increased number of women served with family planning services from current 5% (in 2023?) to 11% in 2025 resulting into USD 7.4 million saved in subsidies with an additional 0.2million women reached through commercial sector. Interventions in the commercial sector will result into 3,175 maternal mortalities averted, 0.2 million abortions saved, 0.4 million disability adjusted life years (DALYs) averted and a total cost saving of USD 107 million.

With the above, I call upon the private sector to implement innovative optimized supply chains in order to reduce inefficiencies and scale up distribution, generate market analytics to drive growth, ensure full method mix and work towards reducing the exorbitant markups on family planning products and services.

The ministry of health will improve the regulatory and policy framework, strengthen stewardship of total market approach and support human resource capacity building in commercial sector.

Dr. Olaro Charles

Ag. Director General Health Services

Ministry of Health

Executive Summary

The Investment Case for Private sector engagement in Family Planning in Uganda focuses on mobilizing stakeholders and resources effectively. It emphasizes the role of government in policy-making, quality assurance, and capacity building, while highlighting opportunities for private sector growth and market expansion. By fostering a mature commercial sector through targeted strategies and market segmentation, the plan aims to significantly boost mCPR and enhance access to family planning services nationwide.

The development of the Investment Case involved extensive consultation and analysis, including literature reviews, key informant interviews, and validation sessions with relevant stakeholders. This inclusive process informed the strategic direction and recommendations of the Investment Case, ensuring alignment with national health priorities and market dynamics.

The core objectives of Uganda's Investment Case for Family Planning (FP) are as follows:

1. **Documenting Country-Level Data:** The first objective is to compile comprehensive data on current financing and commitments within Uganda's private sector aimed at advancing national family planning goals. This includes assessing existing financial contributions and identifying gaps that need to be filled to bolster private sector involvement.
2. **Defining Needed Investments:** The second objective is to articulate the specific investments required within Uganda's broader development frameworks to facilitate increased private sector participation in family planning initiatives. This involves aligning investments with national strategies and priorities to optimize impact and sustainability.
3. **Presenting a Compelling Case:** The third objective is to construct a persuasive rationale, supported by a robust return on investment analysis, for a prioritized set of investments essential to achieving family planning targets through enhanced private sector engagement. This entails demonstrating the economic and social benefits of targeted investments to key stakeholders and decision-makers.

Cost-effective modelling using tools such as the Health Policy Plus Total Market Approach Projection Tool and the Family Planning Market Analyzer projected potential impacts of increased private sector investment in FP. These models underscore the economic benefits and health outcomes associated with expanding commercial sector involvement in family planning service delivery.

Utilizing cost-effectiveness analysis, the investment case demonstrates significant return on investment such as averted pregnancies, maternal mortalities, and abortions, contributing to disability-adjusted life years (DALYs) averted. The anticipated increase in commercial sector market share from 3.9% to 15.9% by 2030 translates to substantial commercial market value and public/donor subsidy savings.

Strategic Recommendations include Advocacy for policy reforms to support private sector engagement, including regulatory adjustments and incentives, promoting competitive market dynamics through systemic corrections and ensuring equitable distribution of FP commodities and pprioritising investments in high-impact FP interventions based on cost-effectiveness and alignment with national health priorities.

In conclusion, the Investment Case presents a comprehensive framework for advancing family planning goals in Uganda. By leveraging public-private partnerships and strategic investments, the plan aims to achieve substantial improvements in mCPR, contributing to broader health and development objectives outlined in national and international agendas.

Section One: **Introduction**

1.1 Background and Rational

Uganda developed the second National Family Planning Costed Implementation Plan II (2020/21-2024/25) to address the unfinished business from FP CIP I. The development of the FP CIP II was informed by the need to operationalize the Government of Uganda declaration of the Uganda FP2030 Commitments, renewed global strategy for women's and children's health, and the enhanced momentum to achieve the sustainable development goals. The FP CIP II is explicitly aligned to the National Development Plan (NDP) III (2020/21 – 2024/25); Ministry of Health (MoH) Strategic Plan 2020/21 - 2024/25; Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Sharpened Plan II and the 2030 sustainable development goal 3 (target 3.7 on universal access to SRH and FP).

Uganda has progressively registered increase in modern contraceptive prevalence rate (mCPR) as reported by the Uganda Demographic Health Survey of 2022 which indicates an increase in Modern Contraceptive Prevalence rate among currently married women (age 15-49) from 35% (UDHS 2016) to 38% (UDHS 2022). However, there was a registered decline in mCPR among among sexually active unmarried women from 47% (UDHS 2016) in 2016 to 40% in 2022 (UDHS 2022). The FP CIP II set to achieve three ambitious goals (1) To increase national mCPR from 30.4% in 2020 to 39.6% for all women by 2025; (2) To increase national mCPR for married women or women in union fro m 38.7% in 2020 to 46.6% by 2025; (3) To reduce the unmet need to 10% by 2025.

The FP CIP sets out three technical strategies to achieve the above ambitious goals that included (1) strengthening multi-sectoral collaboration that positions FP as a social -economic development issue; (2) Universal Health Coverage and sustainability; (3) sub regional focus to address inequities.

The government of Uganda at the highest policy level, firmly believes in the Total Market Approach to family planning for sustainability. It's for this reason that under the technical strategy 2 (Universal Health coverage and sustainability), one of the main interventions is to transform the current nascent FP market into a mature commercial sector. Further the government of Uganda developed the FP Total market Approach Strategy, the Total Market Approach Monitoring and Evaluation Strategy and undertook the FP market segmentation strategy.

The investment case has been developed to galvanize stakeholders around the efficient, cost-effective interventions to spur the private sector and especially the commercial sector in increasing its market share and increasing access to FP information and services. The investment case sets out to give clarity on the role of government and where government investments provide value for money (policies, ensuring quality of care, capacity building, providing leadership, coordination and stewardship), it sets out private sector opportunities and how to harness them.

It is hoped that the growth of the private sector will tremendously increase the Modern Contraceptive Prevalence Rate.

1.2 Process of development of the Investment Case

The three phased approach to the development of the investment case was a highly consultative and all-inclusive process coordinated by the Ministry of Health and facilitated by a local consultant.

i. Planning phase

A concept note was developed that galvianised actor around the need for the investment case. Therafter, a national consultant was hired to undertake the development of the investment case. The consultant drafted an inception report with detailed approach and methodology hat was presented to the relevant technical working groups within the ministry of health.

ii. Implementation phase

A situational analysis was conducted that included a literature review followed by key informant interviews with the private not-for profit, Commercial sector and public sector were conducted. The results of the situational analysis were presented to the national TMA steering committee, the FP/RMNCAH TWG, the National Condom Coordination Committee for validation. The results of the situational analysis and recommendations formed the basis for the investment case.

iii. Advocacy and communications.

Throughout the drafting and approval of the investment case, there was ongoing advocacy and communication between stakehokders/actors on the modelled figures and targets.

1.3 Value for Money and Cost-effective Modelling

The modelling was undertaken to establish the return on investment for the private sector using various models/tools as described below;

Health Policy Plus Total Market Approach Projection Tool: was used to understand how the desired shifts in market share among the public, cost recovery, social marketing, and commercial players can lead to increased contraceptive prevalence rate and equity. It was also used to estimate the FP and financial impacts of increased commercial sector investment in FP.

The Family Planning Market Analyzer combined data from Demographic and Health Surveys and FP2020's projections of modern contraceptive prevalence (mCPR) to allow users to explore potential scenarios for a total market approach (TMA). The tool was also used to generate various scenarios for modern contraceptive methods use and linking it to key results—for example, if the private sector doubled its role in implant provision, how many more services would need to be provided?

Private Sector Counts used the Demographic and Health Survey data to illuminate the important contribution of the private sector to family planning service delivery. It further helped to explore the role of private sources to overall attainment of the country's ambitious FP goals.

Section Two: **Situational Analysis**

2.1 Existing Policies and strategies to guide private sector investments in Family planning

Uganda has pursued a Private Sector-led approach to its economic policy and management over the last three decades. This has put the Private Sector at the forefront of the growth and development process of the Country. It sets out a comprehensive scheme for coordinating the growth and development of the Private Sector in Uganda. This is well demonstrated in the national Private Sector Development Plan 2017/18-2021/22 whose overall goal is to "increase the competitiveness of the Private Sector and enhance its contribution to economic development".

At the health sector level, the Ministry of Health acknowledges the private sector as a critical partner in service delivery as portrayed in the MOH Strategic Plan 2020/21-2024/25.It's from this strategic commitment /aspiration that the MOH developed the national policy on public-private partnership in health and the national strategy for public-private partnership in health that operationalizes the policy.Further, the MOH recognizes the importance of the private sector in health services sustainability which is explicitly expressed in the health financing strategy 2015-2025. The health financing strategy aims at strengthening mechanisms for harmonized and effective partnerships in the financing and delivery of health services, including external and private sector actors. The health financing strategy under the strategic priorities for strategic purchasing of health services, recommends the private providers to be given incentives to operate in underserved areas as part of building partnership arrangements between public and private sector to ensure availability of quality care for all.

Despite all the above progressive policies geared towards spurring the private sector engagement and market expansion, the health sector recognized family planning services as one of the critical elements that face sustainability risks due to over-dependency on external partners in terms of procurement and distribution of contraceptives and the fact that less than 10% provision of family planning services was from the commercial sector. This realization resulted in the development of the Family Planning financing strategy 2020-2025, the Total Market approach strategy for Family planning, and the second family planning costed implementation plan where MOH commits to implement interventions that will result in the Uganda family planning market growing from a nascent FP market to mature FP market by 2025. In addition, the MOH has developed national self-care guidelines that support access through the private sector.

Despite the progressive policy environment for the private sector, there is a need to amend the National Drugs Policy and Authority Act 1993 which categorizes contraceptives as prescription drugs. As a short-term gap measure, the National Drugs Authority through a circular permitted the provision of contraceptives over the counter. However, there needs to be a comprehensive review of the NDA policy and Authority Act 1993 to regularize the over-the-counter provision of contraceptives.

Summary list of relevant Policies and strategies

1. Ministry of Health (MoH) Strategic Plan (SP) 2020/21 – 2024/25
2. National Health Policy recognizes Public-Private Partnerships (PPPs)
3. National Strategy for Private Sector Development 2017/18-2021/22
4. National Policy on Public Private Partnership in Health
5. Uganda's National Strategy for Public-Private Partnerships in Health
6. Health Financing Strategy 2015-2025
7. National Total Market Approach (TMA) Strategy 2020-2025
8. Family Planning Financing Strategy for Family Planning Services in Uganda 2020/2025

2.2 Family Planning Service Delivery in the Private Sector

The public sector remains the main source of modern contraceptives for women in Uganda. The UDHS 2016 report indicated that 59% of the women 15-49 years who currently use a modern method of contraception last obtained it from the public sector. However, the private sector made a contribution of 39% among the women using modern contraceptives (Figure 1). The private sector is the main source of contraceptive pills (76%). The private sector is also a significant source of injectables (45.6%) and male condoms (40.3%). Details are in Figures 1 and 2.

Figure 1: Public-Private source of modern contraceptive methods

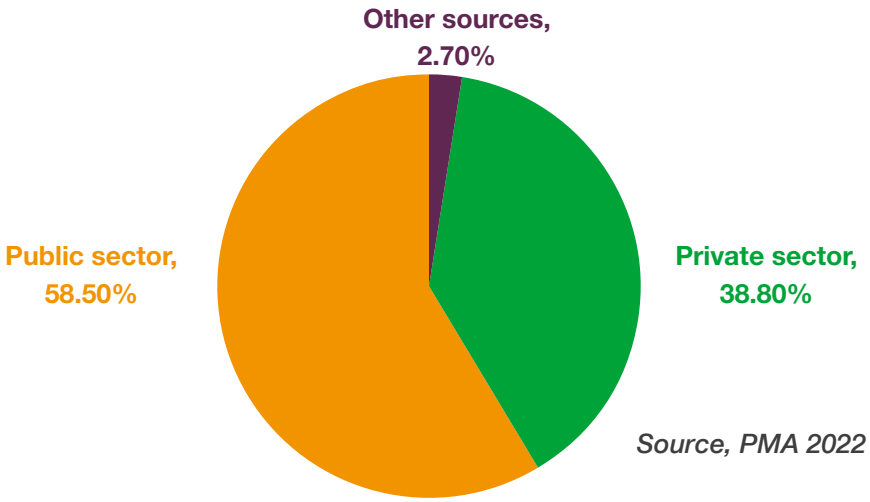
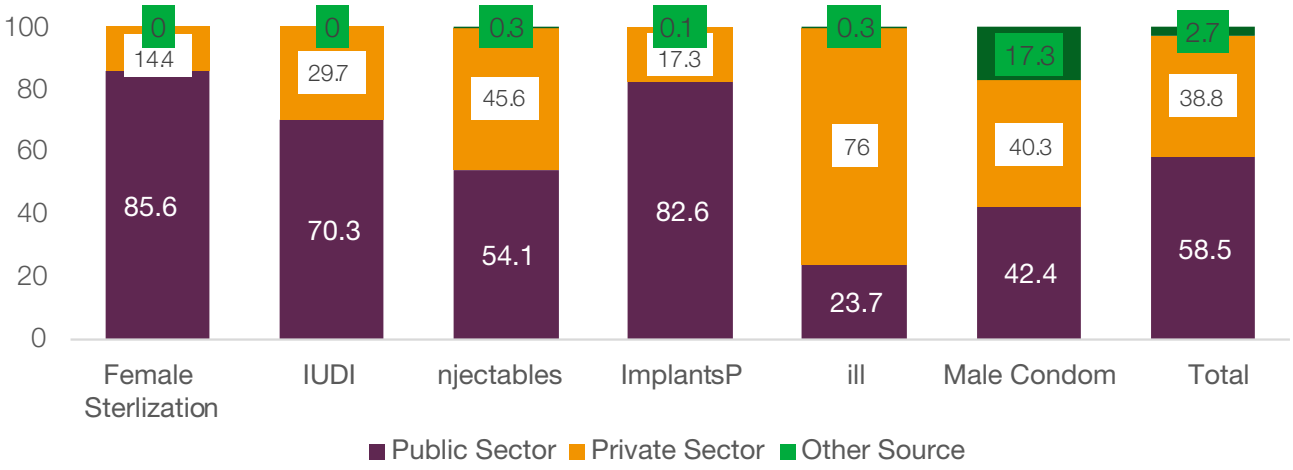


Figure 2: Percent distribution of users of modern contraceptive methods age 15-49 by the most recent source of methods, according to method, Uganda DHS 2016



Within the private sector most contraceptive methods, especially those that are medical provider-dependent (Injectables (41%), IUD (29%), and Implants (15%) are provided through private hospitals and clinics. However, 25% of all pill users access them through the pharmacy/drug shops. Details are in figure 4.

Figure 3: Percent distribution of users of modern contraceptive methods age 15-49 by category of private sector source, according to method, Uganda DHS 2016

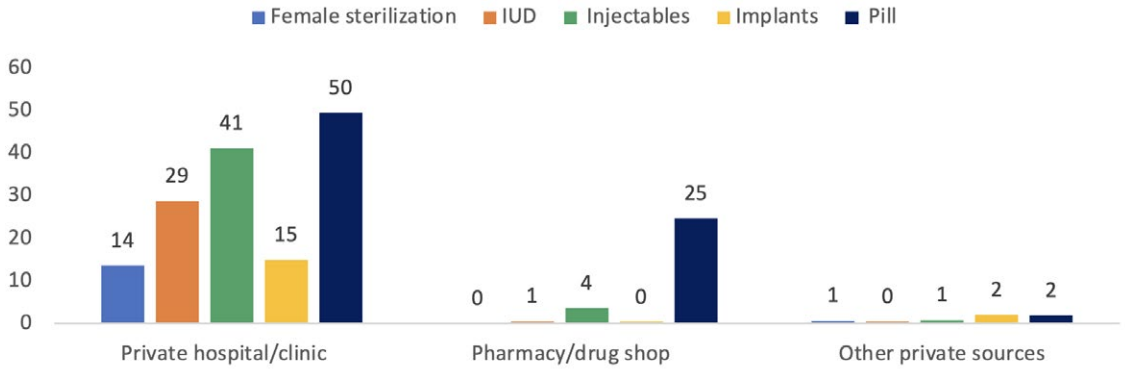
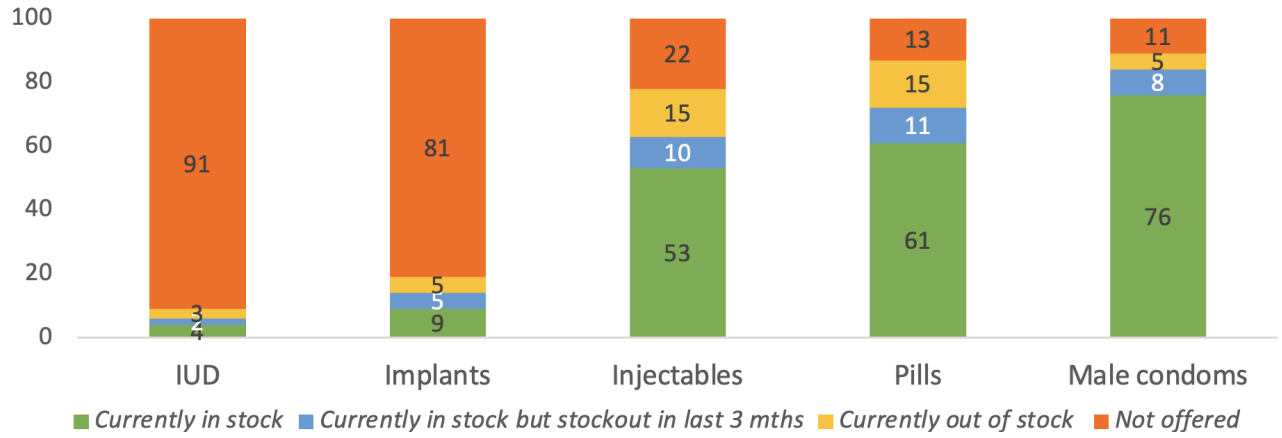


Figure 1: Public-Private source of modern contraceptive methods

Figure 3: Percent distribution of users of modern contraceptive methods age 15-49 by category of private sector source, according to method, Uganda DHS 2016

The private sector largely provides short-term methods and these are the commodities that are readily available and stocked in private health facilities including male condoms (76%), pills (61%), and injectables (53%). A significant proportion of private facilities do not provide long-acting reversible methods, including IUDs (91%) and Implants (81%); and yet implants are among the most preferred methods in Uganda. This is a missed opportunity to harness the private sector to increase access to a wider range of modern contraceptive methods.

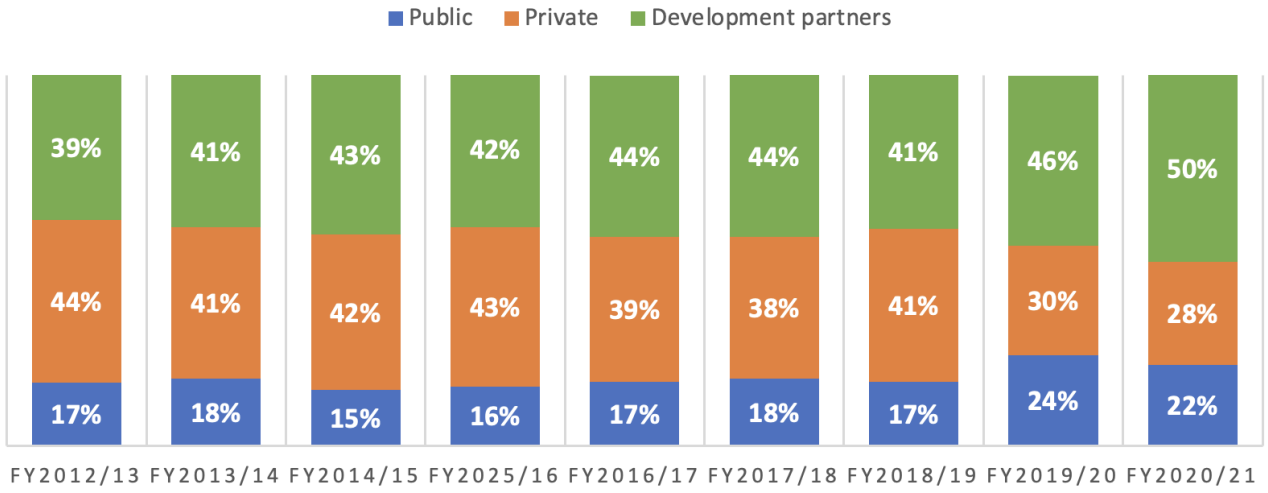
Figure 4: Method availability at private health facilities (Percentage), PMA 2022



2.3 Private sector Financing to achieve the National family planning outcomes.

Donor dependent Health financing → In Uganda's case, Donors or HDPs contributed the largest share of Current Health Expenditure (CHE) by contributing 43.6% in 2016/17, 43.7% in 2017/18 and reduced to 41.4% in 2018/19. This was followed by the private sector (incl. households) which contributed 39.1% in 2016/17, 38.3% in 2017/18 and increased to 41.4% in 2018/19. Government or public resources formed the least percentage, overall, by bringing in 17.2% in 2016/17, 18.0% in 2017/18, and reduced to 17.2% of CHE in 2018/19. In 2019/20 and 2020/21, the contribution of the Development partners increased to 46% and 50%, while the contribution of the private sector reduced to 30% and 28% respectively. These changes during the years 2020 and 2021 could be attributed to the COVID-19 pandemic with significant contributions from the Health Development Partners towards epidemic control. Details are shown in Figure 9.

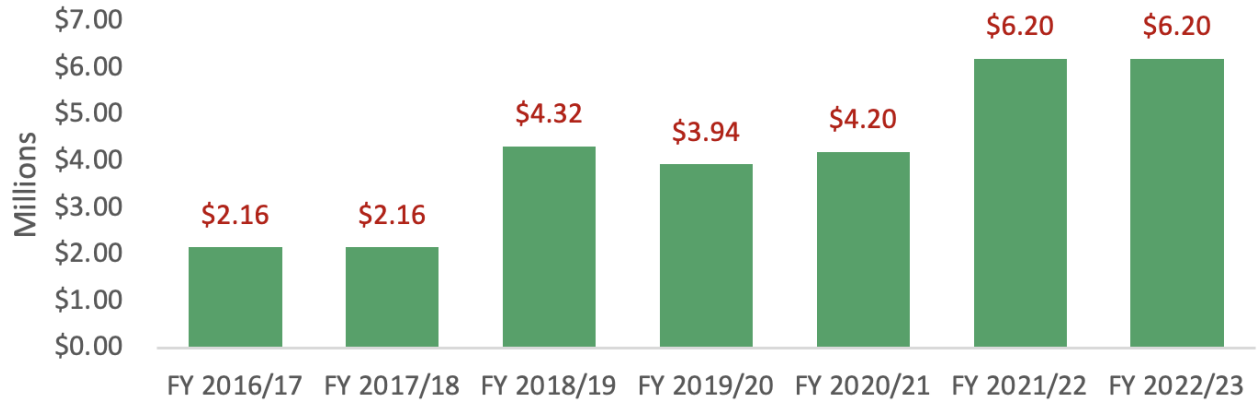
Figure 5: Health Expenditure Shares in Uganda, 2012-2021



It should be noted that while the private sector category includes expenditure from households and private companies, household expenditure forms the largest share which was 95 percent in 2020/21 as compared to the share of private companies at 5 percent. The findings above, generally, show that the health system is heavily dependent on resources from external sources which do not agar well for sustainability purposes.

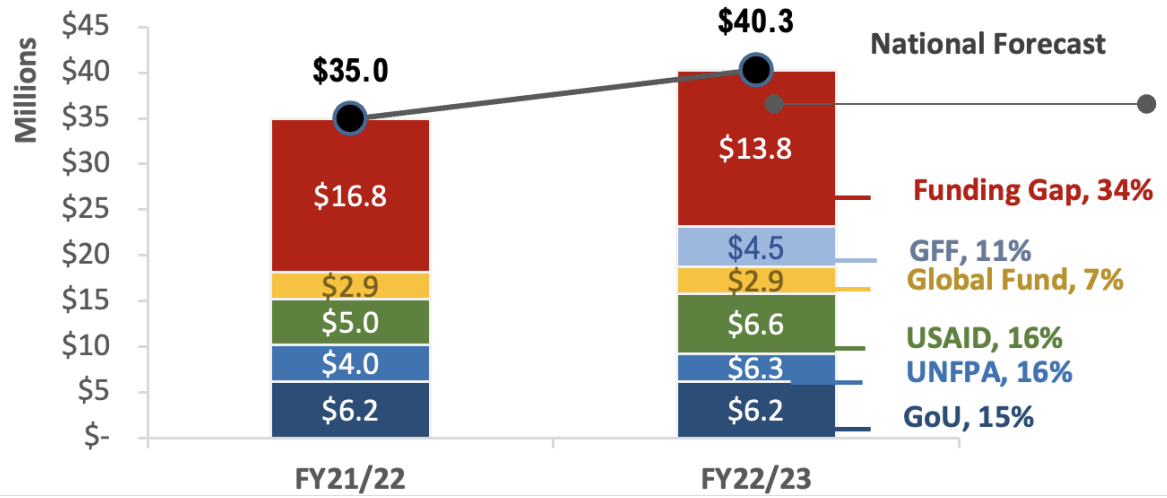
FP Private sector funding is predominantly out of pocket → Despite the Government commitment to increase the funding for family planning and the donor funding support, there is a high funding gap for family planning commodities estimated at $16.8 and $17.1 in FY 2021/22 and FY 2022/23 respectively.[1] It is important to note that much of the funding for FP commodities for the private sector is out-of-pocket.[2] The Government of Uganda covers only 15.4% of the national contraceptive need. Details of GoU annual allocations towards RH commodities are shown in Figures 7 and 8.

Figure 6: Government allocation for RH commodities



Source: QPPU 2023

Figure 7: Funding Landscape for RMNCAH Commodities in Uganda (USD)



Overall, there has been a progressive increase in FP financing from UGX 78.8 billion in 2016 to UGX 183.4 billion in 2019, though, it decline to 149 billion in 2021.[3,4] The amount realized for family planning more than doubled the 2017 commitment of UGX USD20 million annually by both development partners and the government. The international organizations remained the main source of income for Family Planning activities in Uganda, accounting for 86.9% of the total income in 2019/20. The out-of-pocket expenditure increased from UGX 2.3 billion in 2016 to UGX 10.1 billion in 2018; but this reduced to 6.9 billion in 2019. This accounts for only 3.8% of the total FP income received in 2019. This also highlights some of the contribution of the private sector to the current FP program.

[1] *MoH QPPU Reports 2022 and 2023*

[2] *National Total Market Approach (TMA) Strategy*

[3] *UBOS. Resouce Flow Surveys*

[4] *Ministry of Health 2021. National Health Accounts, 2019/20 & 2020/21*

Figure 8: Source of income Received for Family Planning Activities, 2016-2019 (UGX 'Billions')

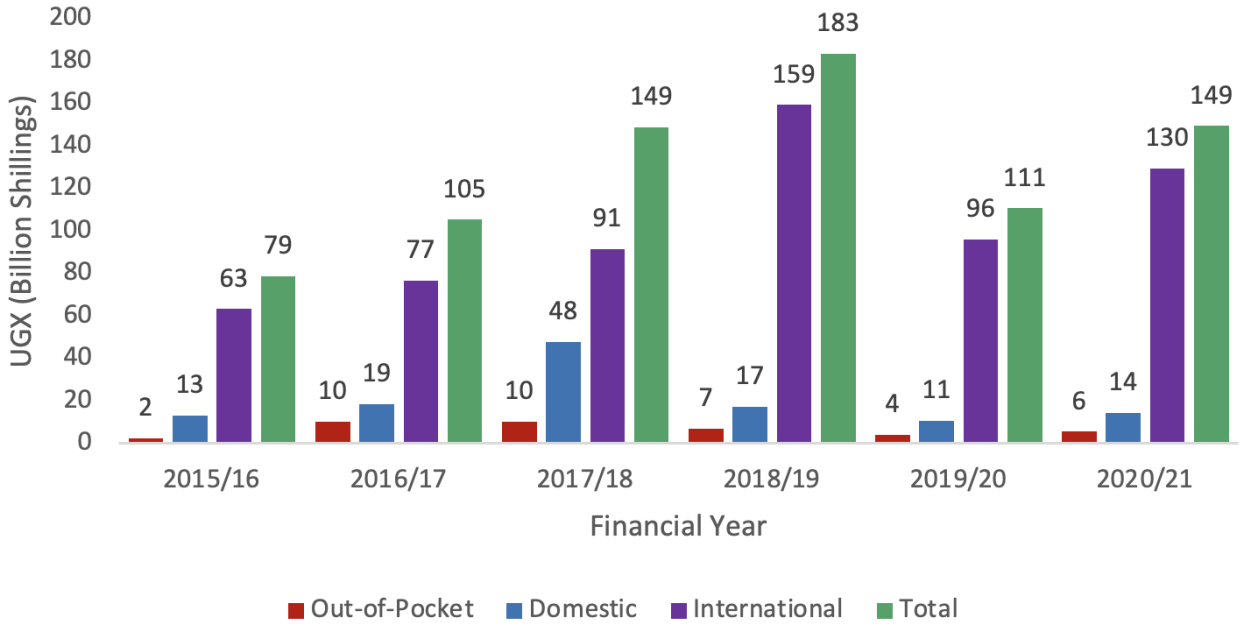
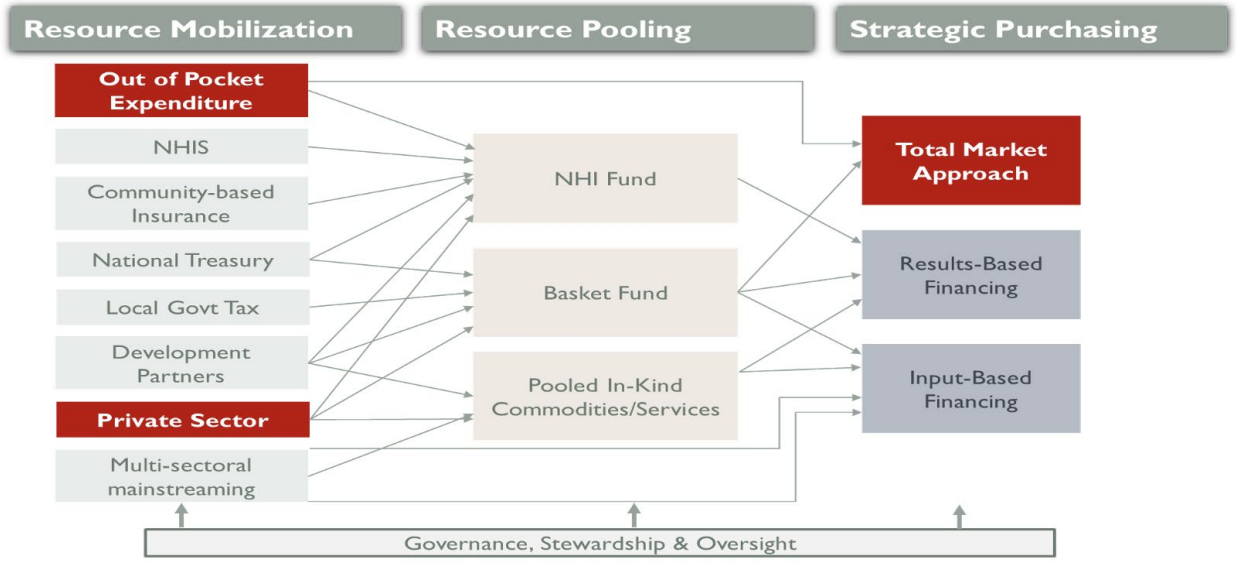


Figure 9: Family Planning Financing Frame Work



Source: Financing Strategy for Family Planning Services in Uganda 2020/2025 (draft)

2.4 Current Private Sector Financing Strategies

Pooling of Health funds (Insurance schemes) → The mechanism of pooling resources to cover health expenditures is one approach that can contribute to equity and access, and create efficiencies in health markets by increasing competition, containing costs, and enhancing adherence to quality standards. Currently, the main pooling mechanism in Uganda is government funds raised by taxes and on-budget donor support. There are a few individuals accessing prepaid health services through private health insurance and a few existing voluntary and community-based health insurance (CBHI) schemes. Uganda has an undeveloped, though, growing insurance market. The health insurance coverage among people aged 15 years and above is still low at 4%, far below the NDP III target of 25 percent and Vision 2040 target of 70 percent.[5] The regions with the highest health insurance coverage are Kampala (7%), Buganda North (6%), and urban areas generally at six percent. The regions with high unmet need for health insurance because they have a high percentage of persons with knowledge about health insurance and low coverage, yet with a high percentage of persons that are willing to join a scheme are Elgon, Acholi, West Nile, and Bunyoro. Of all persons under health insurance coverage, 62% are under private commercial schemes for the formal sector while 23% are under a household arrangement.[6]

The market is highly fragmented among a few players who are competing for small market shares.[7] The major obstacles facing the growth of private health insurance are: i) limited market, ii) overutilization of services, and iii) inaccurate recording practices by the health providers. The benefits covered are largely curative. The existing health insurance schemes don't cover family planning products and services.[8]

National health insurance bill status →The debate around the introduction of the national health insurance fund has been on over the last two decades. The efforts were fast-tracked in 2006 with the establishment of the National Task Force on Health Insurance to draft a Bill, which was first tabled in 2009. The bill was passed by Parliament in March 2021. Currently, the bill is with MoH awaiting presentation and approval by Cabinet, then re-tabling on the floor of Parliament. The bill has a pre-set benefits package that includes a range of essential health services including family planning counseling and services. Given the delays that have taken decades and the ongoing debate among policymakers, health finance experts, and the public, it is highly unlikely that the National Health Insurance Bill will be implemented anytime soon.

Despite the low health insurance coverage, inadequate benefit packages, and minimal market penetration; the National Health Financing Strategy, the draft Family Planning Financing Strategy, and the draft NHIS Bill acknowledge the importance of private health insurance. Continued and sustained efforts are required to ensure the integration of family planning products and services in the benefits packages.

Government financial support to Private Not for Profit health facilities → For over two decades, the Government of Uganda has been extending PHC conditional grants to PNFP sector (including all PNFP hospitals and lower-level health centers) in recognition of their contribution to health. Since 2003, the support includes government payment of salaries to seconded medical officers; and a medicines credit line allowing PNFP hospitals and health centers to purchase medicines and supplies using credit. The allocation of PHC conditional grants per facility has been declining over the years due to stagnated total grant contributions combined with an increasing number of PNFP facilities. The PHC conditional grant covers approximately 9% of a PNFP health facility's costs. Therefore, the PNFP facilities are increasingly reliant on user fees, which contribute 44% of PNFP financing.[9]

Results-Based Financing (RBF) → Over the past two decades, Uganda has implemented several RBF programs with support from development partners. The MoH together with partners piloted the Results-Based Financing as a core intervention to transform health purchasing from traditional input-based budgeting to performance-based. The MoH further developed the National RBF Framework to guide the scale-up and institutionalization of RBF. The national scale-up efforts are supported by the World Bank, the Global Financing Facility (GFF) under the Uganda Reproductive, Maternal, and Child Health Services Improvement Project, and other partner-funded projects. To streamline RBF into the Uganda Intergovernmental Fiscal Transfers for Results Program (UgIFT) for public financing, the MoH developed the Results-Based Financing Mainstreaming Strategy FYs 2022/23 – 2026/27. This strategy is expected to promote public-private partnerships through co-financing service delivery. However, only PNFPs are eligible to participate in the RBF initiative if they meet the eligibility criteria in the Health Sub-Programme Grant and Budget Guidelines. The private for-profit facilities are excluded.

RMNCAH/FP Voucher schemes → In pursuit of UHC and to improve FP and MNCH outcomes, the MOH embraced results-based financing (RBF) reforms that include vouchers as a demand-side purchasing mechanism. The RBF and Voucher schemes are also articulated in the second MOH Health Financing Strategy as part of health finance reforms to support the achievement of UHC by 2025. The MOH RBF Framework for the Health Sector (Uganda Ministry of Health 2016b) outlines a path to institutionalize RBF initiatives that include supply-side performance-based financing (PBF) and demand-side voucher schemes, as part of the national system. These financing mechanisms are meant to complement the input-based financing for priority services such as FP and MNCH and increase access by engaging PNFP and PHP providers.

It is recommended that the Government of Uganda continues with efforts to establish a government-financed demand-side purchasing mechanism to purchasing services from providers of all types (public, PNFP, and private) and better coordinate service delivery across the health sector and expand access to services.[10]

[5] *Uganda Bureau of Statistics (UBOS), 2021. Uganda National Household Survey 2019/2020. Kampala, Uganda; UBOS*

[6] *Uganda Bureau of Statistics (UBOS), 2021. Uganda National Household Survey 2019/2020. Kampala, Uganda; UBOS*

[7] *PSA Report 2016*

[8] *PSA Report 2016*

2.5 Existing Enablers and Barriers to the Private Sector Investment in Family Planning

2.5.1 Barriers to Private Sector Investment in Family Planning

Policy environment limiting contraceptive access by adolescents → Uganda has no explicit policy on contraceptive access by adolescents. Many related strategic documents including the School Health Policy, and Sexuality Education Guidelines for the Out of School have not been approved. There is also growing opposition from political and religious leaders. This affects and limits the contraceptive demand among adolescents. This is coupled with persistent opposition from some stakeholders especially the religious, political, and cultural leaders further limiting the continued growth of the family planning market. Increasing contraceptive use among these groups would require addressing entrenched sociocultural norms, and opposition from the stakeholders and creating a favourable policy environment.

Competition from the public sector → Overall, 58.5% of the women of reproductive age who use contraceptives access them through the public sector, while 38.8% of women obtain them from the private sector.[11] At times the relationship between the public and private sector is more competitive than complementary. The Government of Uganda has a policy on the indiscriminate provision of free health services including family planning through the public health system regardless of the socio-economic status of its citizens. People with the ability and willingness to pay for family planning services still have the option to access FP products and services from the public or subsidized market. Permanent (Female sterilization-85.6%) and long-acting reversible contraceptives (IUD-70.3% and Implants-82.6%) are largely accessed in the public health facilities with the required logistics and technical capacity, further limiting the private sector.[12]

Investing in an area essentially dominated by the public sector; with broad access to free family planning services, may create disincentives to private sector investment. It may be seen as crowding out the private health sector and reducing the number of service outlets and the options for potential clients. The availability of free and subsidized products and services may undermine the private sector's growth in the provision of contraceptives.

Barriers related to demand and uptake of family planning services →

Uganda still experiences barriers to family planning. The demand is affected at three levels:[13]

- ***Personal/ individual:*** The key factors include lack of comprehensive and correct information about family planning, fear of side effects, negative influence by peers, myths, and misconceptions. Only 47.6% of the women of reproductive age who are current users of contraceptives are given comprehensive information about contraceptives (Method information Index Plus-MII+). The adolescents, 15-49 years are more disadvantaged with the method information index plus (Percent of current users told about side effects, what to do about side effects, of other methods, and the possibility of switching methods) of 35.9%.[14]
- ***Socio-cultural: Socio-cultural impediments to contraceptive uptake still exist including;*** the influence of social norms, social stigma, culture, and religion coupled with the role of the extended family. Broad sociocultural factors underlie the ability and willingness of the most influential actors to drive the Total Market Approach for FP. The culture and politics surrounding free health services, larger families, and increased population growth are some factors that may constrain the effective implementation of the National TMA Strategy for family planning.
- ***Institutional/ systemic:*** Existence of systemic challenges with limited availability of preferred options coupled with inadequate capacity to deliver some contraceptive methods at some service outlets especially at the community level and in the private sector.

[10] *Jordanwood, Tapley, Angellah Nakyanzi, Espilidon Tumukurate, Eric Tabusibwa, James Mwaka, Anooj Pattnaik, Sarah Straubinger, Flavia Moi, and Sarah Byakika. 2021. Reproductive Health Voucher Schemes in Uganda: How They Worked and Key Lessons for the Future. Kampala: ThinkWell and Ministry of Health.*

[11] *Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.*

[12] *Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.*

[13] *Asingwire, N, Muhangi, D, Kyomuhendo, D and Leight, J, 2019. Impact evaluation of youth-friendly family planning services in Uganda, 3ie Grantee Final Report. New Delhi: International Initiative for Impact Evaluation (3ie)*

[14] *Performance Monitoring for Action Survey Report 2022*

Limited access to in-service capacity building in the commercial sector → The private sector providers have limited in-service training opportunities to build the clinical skills required to deliver the contraceptive method mix, especially LARCs. Many private providers lack access to in-service training that enables them to offer the full range of modern family planning methods (SHOPS 2014). This gap limits providers' scope of clinical practice and encourages bias against LARCs in favor of the short-acting methods with which the providers are familiar. Many private providers lack access to in-service training that enables them to offer the full range of modern family planning methods. Government stakeholders indicated that this gap limits providers' scope of clinical practice, and encourages bias against LARCs in favor of the short-term methods with which the providers are familiar. District Local Governments and Implementing Partners hardly include the commercial sector in their respective capacity-building and scale-up plans. Many of the donor-funded projects focus on the public and the PNFP sectors, to the exclusion of private for-profit providers.

Limited donor support to the commercial sector → Though many donors agree to increasing domestic financing to family planning as an approach to sustainable financing, they contribute significantly to funding family planning programme under the public and PNFP sectors, often supporting the distribution of free and subsidized FP products and services. They have made limited investments in supporting the implementation of the commercial sector component of the TMA Strategy, tracking market growth, or incentivizing the commercial sector entry and sustainability of the contraceptive market. More investments in the private sector, sustained influence of the policy environment by the Development Partners, and better donor coordination could ease some of the steep competition facing the commercial sector. This will further contribute to the diversification of financial and programmatic contributions to family planning as a core element to smooth financing transition and sustainable financing.

Summary of barriers as per Private Sector Assessment (PSA) Report 2016

According to the Uganda Private Sector Assessment in Health Report 2016, a number of factors hindering private sector engagement were highlighted including the following:

Policy Barriers

- National Policy on Public Private Partnership in Health (PPPH Policy) is not widely disseminated with limited awareness at the decentralized level.
- Reluctance in implementing PPPH Policy at the district level that it conflicts with development partners' regulations.
- No common understanding of PPPHs.
- Political commitment to PPPHs varies in the public sector
- Commitment to work with the private health sector also varies among development partners
- Multiple agencies are involved in regulating private sector quality with similar functions that overlap.

Relationship Barriers

- Suspicion and misunderstanding of the profit motive in health. Lack of trust persists between sectors.
- MOH is not aware of nor does it acknowledge private sector contribution to health due to limited information on non-state actors' health activities and partnerships.
- Long-standing philosophy that all health services should be free. Believe quality is poor among PHPs without data to back up the claim.
- MOH does not actively and systematically engage and/or include the private health sector in policy and planning.
- The private sector resists sharing information with MOH.

Market Barriers

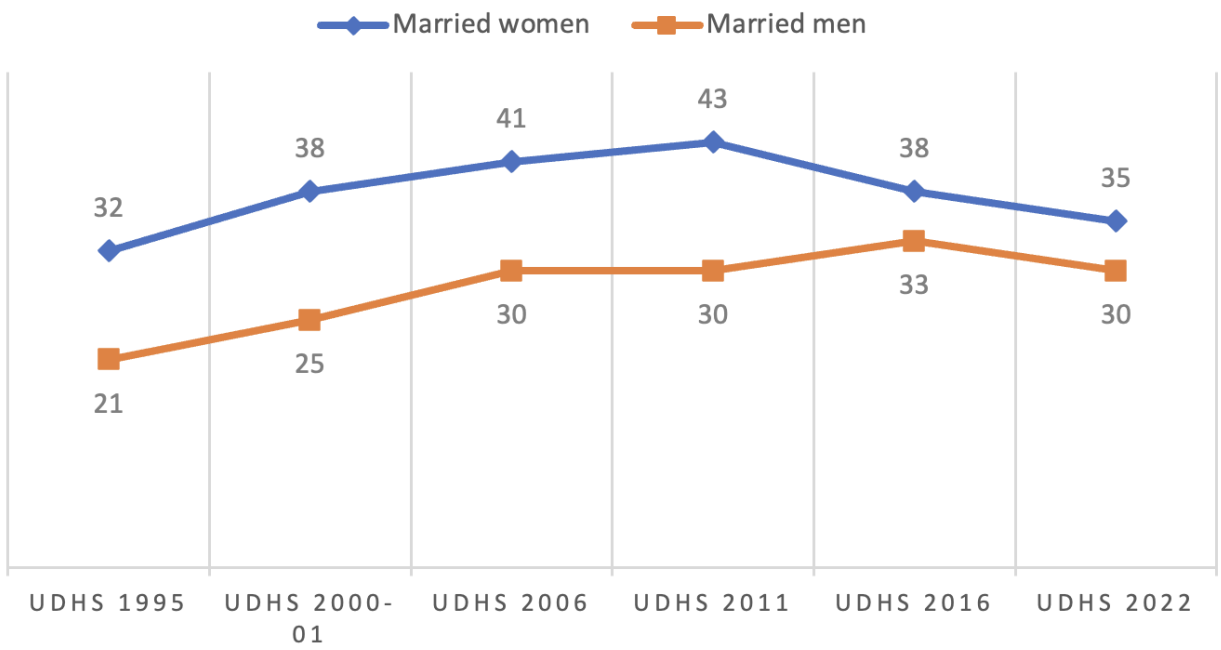
- Market conditions are difficult not only for commercial sector health providers
- MOH does not have accurate information on the size and scope of the private sector.
- Although the health sector is growing rapidly, there is limited access to finance for health businesses including PNFPs.
- Both PHPs and PNFPs experience high costs of inputs (e.g. land, power, water, and infrastructure) PHPs have the double burden of income and other taxes (e.g. V.A.T. and import tax).
- Both PNFPs and PHPs need access to capital so they can improve their facilities, and purchase needed equipment and supplies, which ultimately produces benefits for the health sector.
- With the high cost of inputs and lack of access to credit, PNFPs face financial uncertainty under current government financing mechanisms.
- Donor funds crowd out PHPs in certain markets e.g. FP.
- Lack of government financing mechanisms, such as national and/or social health insurance, service contracting, and demand side subsidies, that are widely accessible to eligible PNFPs and PHPs

2.5.2 Enablers to Private Sector Engagement in Family Planning

There are a number of factors and facilitators combined to incentivize increased private sector actions and engagement in family planning in Uganda, including the following:

Changing fertility preferences: Trends in desire to limit childbearing → Much as the ideal family size in Uganda increased over the last two decades from 4.8 children (UDHS 2000-01) to 5.8 children (UDHS 2022) among women, the proportion of currently married women who want no more children increased from 32% in 1995 to 35% in 2022. The proportions among currently married men have followed a similar trend, increasing from 21% in 1995 to 30% in 2022. This creates an opportunity for more women and men to use modern family planning methods to space or limit births (Figure 12).

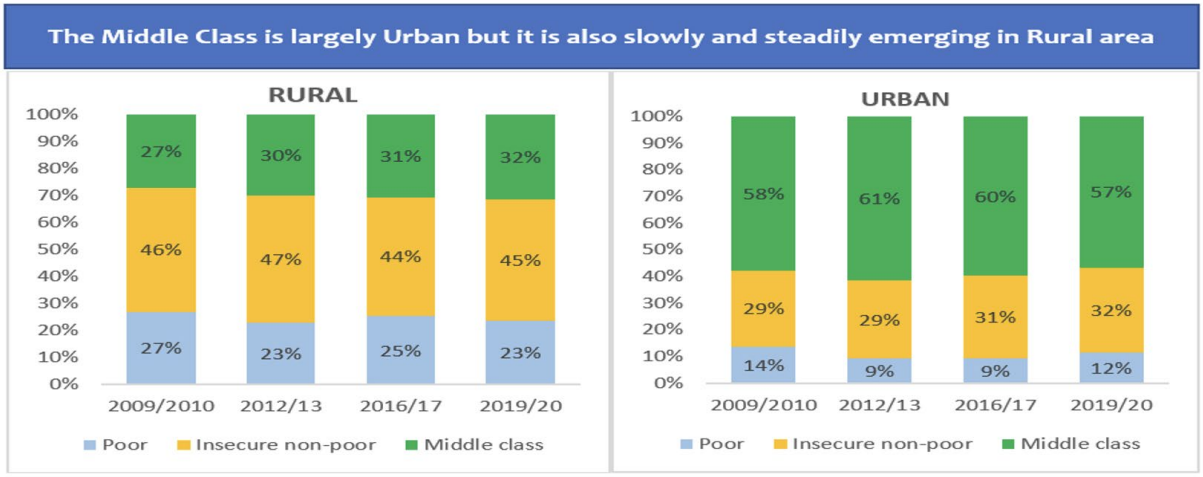
Figure 10: Percentage of currently married women and currently married men aged 15-49 who want no more children



Poverty dynamics and poverty levels → The 2021 Poverty Status Report on Uganda's poverty dynamics over the last five years indicates an overall decrease in the national poverty rate from 21.4 percent in 2016/17 to 20.3 percent in 2019/20. The incidence of poverty is higher in rural areas than in urban areas. Between 2016/17 and 2019/20, the proportion of the middle class increased from 37.65 percent to 38.2 percent. Although the increment is small, it is a good sign that the proportion of the population with high consumption per adult equivalent (CPAE) is increasing, which is vital for building a middle-class society.

The increase in the income-secure population is important for socio-economic transformation. This is because the middle class tends to have stable incomes and savings, which can be channeled towards investments and paying for their health care. More than half of the population in urban areas is in the middle class compared to a third in rural areas. This has been consistent over the last decade. This would probably mean that the population in the urban areas may be more likely to spend more with possibly higher out-of-pocket expenditure. The middle is slowly but steadily emerging in the rural areas as demonstrated in Figure 13.

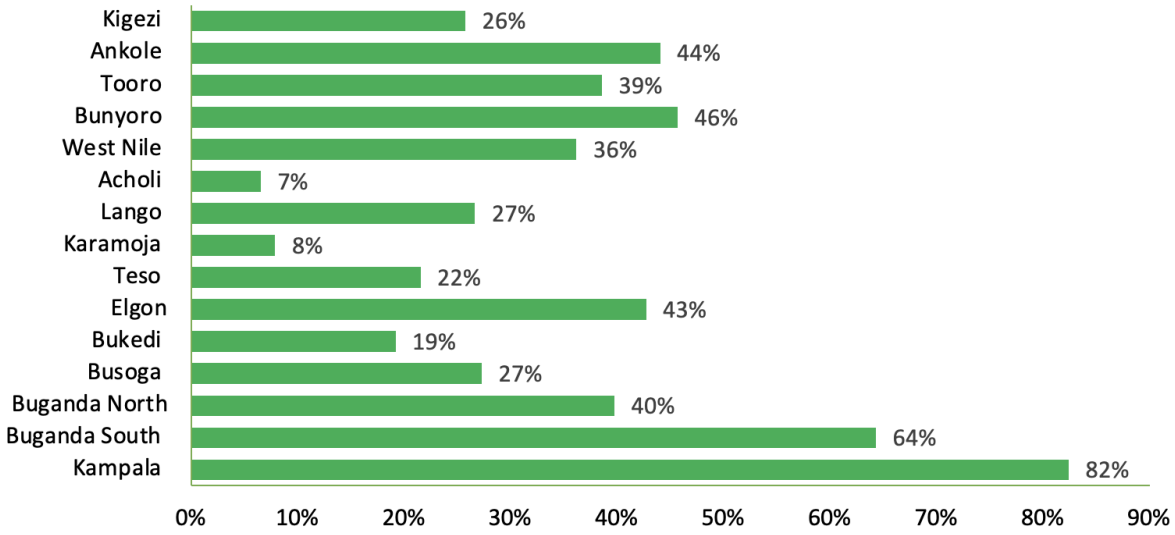
Figure 11: Population in poverty, insecure non-poor, and middle-class



The distribution of the middle-income class across the country is not homogenous. Kampala has the highest proportion (82%) of its population in middle-class status. The regions with a proportion of middle-class status higher than the national average of 38.2 percent in 2019/20 are Kampala, Buganda South, Bunyoro, Ankole, Elgon, and Buganda North. The average percentage change in the proportion of the population in the middle-class status over 3 years (2016/17 – 2019/20) was 9.96%. The regions with a percentage change higher than the national average are Buganda North, Kigezi, Ankole, Elgon, and Teso.

A middle-class society is associated with growth in real income commensurate with a middle-income economy. Based on these statistics and projects, 9.65 percent of the population would be moving towards the middle-income status if the movement can be sustained over time. This represents a population of 3.9 million, of which 61.6 percent are in urban areas. These can be targeted by the private sector for family planning since they are more likely to have a higher purchasing power and a higher out-of-pocket expenditure towards accessing family planning products and services.

Figure 12: Proportion of middle class in 2019/20 across the 15 sub-regions



Higher purchasing power → Uganda's Gross National Income (GNI) per capita increased from $270 in 2000 to $930 in 2022. This economic growth also fueled increases in the number and quality of private sector channels.[15] This is due to various economic channels and investments the country has identified under the Uganda Vision 2040 and National Development Plans that are being harnessed for socio-economic transformation. This economic growth is expected to increase the contraceptive market with the potential to fuel the increases in the number and quality of private sector channels.

Ability and willingness to pay (AWTP) for family planning services → The ability and willingness to pay for contraceptives, and associated factors study in Uganda established that the ability to pay was generally high in the general population (85% among men and 52% among women). A high proportion of women (96%) and men (82%) were able to pay at least Ug Shs 1000 ($0.27) for FP services while 93% of women and 83% of men who had never used FP services will in future be able to pay for FP services cost at least Shs 2000 ($0.55). From the same study, 19% of men and 14% of women will afford to pay at least Shs 20,000 (USD 5.48) for FP services. Higher proportions of women can afford to pay compared to men when the cost of FP services is less than Shs 5000 while it's the reverse with higher cost. The factors independently associated with ability and willingness to pay were lower age group (<25 years), residence in urban areas, attainment of higher education level, and higher wealth quintiles.[16] Levels of Willingness to pay

The levels of willingness to pay are generally high in the population. Overall, two-thirds of the men (66%) and women (67%) were willing to pay for the same FP services in the future. The factors independently associated with willingness to pay among men were being resident in urban areas and from regions of Buganda North, Eastern, and Western regions while among women it's being younger (15–24), attainment of primary/secondary education level, being in higher wealth index and being from Eastern region. Appropriate pricing of subsidized and full-cost services targeting those with the ability and willingness to pay will create a robust and healthy market that maximizes demand for FP services and products.[17]

In another survey on willingness to pay for socially marketed products by USAID Communication for Health Communities (CHC), both men and women were willing to pay for the three USAID socially marketed products – Protector condoms, Injectaplan, and Pilplanplus, provided by the private retail outlets.

However, the price range they were willing to pay for the three products significantly varied. The survey findings highlight that acceptable price range for a package of Protector condoms (UGX750 -1800), Injectaplan (UGX1500 – 5000), and Pilplanplus (UGX1300 -4550). Thus, the results of this survey should be used to inform the recommended consumer price and market pricing strategy for the three products.

Conducive policy environment to spur private sector investments in FP → Uganda has developed, launched, and continues to implement a number of private sector-friendly policies and strategic documents that have the potential to facilitate private investment in family planning. The different policies and strategies are enumerated in section one of this investment case.

Multi-pronged investments in demand creation → Over the years, there have been significant investments in behavior change campaigns promoting condom use, though primarily aimed at HIV prevention, had a halo effect on condom use for family planning. Most of these investments have been driven by development partners including USAID through its Social Behavioral Change Communication Activities including Communication for Health Communities (CHC), Mass media condom promotion through the Obulamu campaign, and USAID's Social and Behavior Change Activity (SBCA). These campaigns also had a dedicated focus on promoting the demand and uptake of family planning guided by the various national strategies including the National Family Planning Social Behavior Change Communication Strategy (2016-2021) and National Comprehensive Condom Programming Strategy & Implementation Plan 2020 – 2025. The demand creation activities for family planning have been largely supported by Implementing Partners, operating at regional district and community levels.

[15] *https://www.macrotrends.net/countries/UGA/uganda/gni-per-capita'>Uganda GNI Per Capita 1984-2023. www.macrotrends.net. Retrieved 2023-11-13.*

[16] *Tumwesigye NM, Makumbi F, Mukose A, Atuyambe L, Namanda C, Ssali S, Tweheyo R, Gidudu A, Sekimpi C, Hashim CV, Nicholson M, Waddimba RN, Ddungu P. Ability and willingness to pay for family planning services in low resource settings: evidence from an operational research. Afr Health Sci. 2022 Mar;22(1):28-40. doi: 10.4314/ahs.v22i1.5. PMID: 36032478; PMCID: PMC9382500.*

[17] *Tumwesigye NM, Makumbi F, Mukose A, Atuyambe L, Namanda C, Ssali S, Tweheyo R, Gidudu A, Sekimpi C, Hashim CV, Nicholson M, Waddimba RN, Ddungu P. Ability and willingness to pay for family planning services in low resource settings: evidence from an operational research. Afr Health Sci. 2022 Mar;22(1):28-40. doi: 10.4314/ahs.v22i1.5. PMID: 36032478; PMCID: PMC9382500.*

Demand creation is one of the focused areas under National Family Planning Costed Implementation Plan (FP CIP) II, and it is one of the strategic and priority interventions under the Technical Strategy 3: Sub-Regional Focus to Address Inequities; and Strategic Outcome 11: Reducing inequities in FP service provision and greater equitable access to FP services to underserved groups. The FP CIP II targets to increase to 15% the percentage of women reached by Interpersonal interventions in every region, and increase the proportion of women reached through FP Mass media to 80%. Sustaining demand creation for family planning, maintaining significant investment in behavior change campaigns, and building on existing SBC government and partner interventions will further expand the contraceptive market critical for private sector engagement in family planning.

Expanding Private sector infrastructure → The private health sector in Uganda has diverse categories of outlets including Private for-profit facilities (2,794), Private Not-for-Profit facilities (1,004), Wholesale Pharmacies (786), Retail Pharmacies (1,557), and Drug shops (11,371) distributed across the country.[18] The private health facilities (clinics, medical centers, and hospitals) and pharmacies are heavily concentrated in Kampala Extra and Central regions while the drug shops are close to even distribution across the country. This widespread private sector footprint will facilitate the private sector to rapidly scale up supply and meet the growing demand for family planning.

Figure 13: Number & Percentage Categories of Private Health Sector Outlets

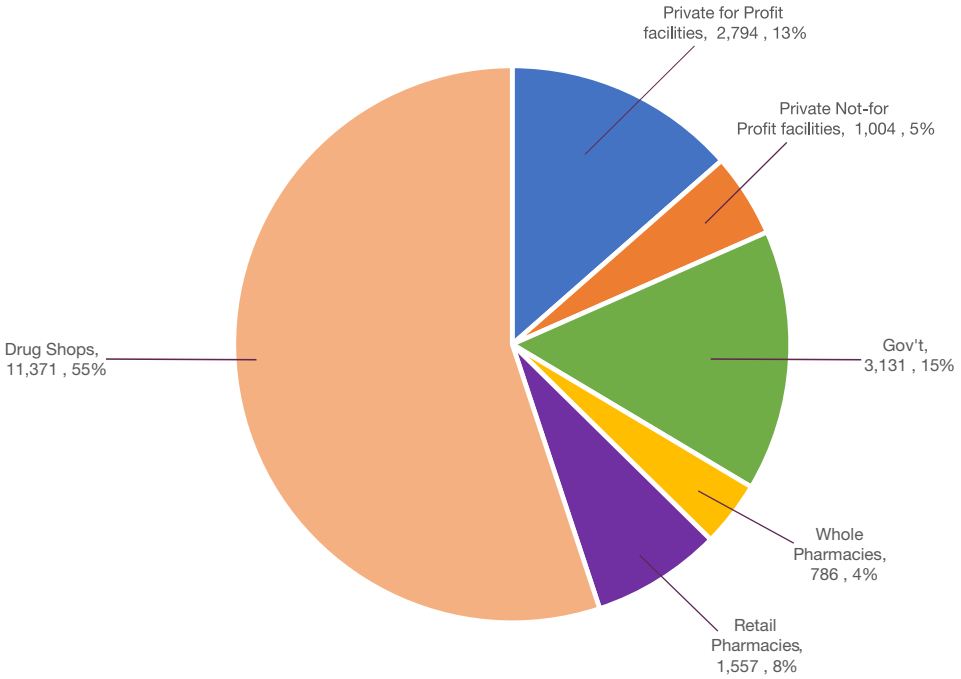
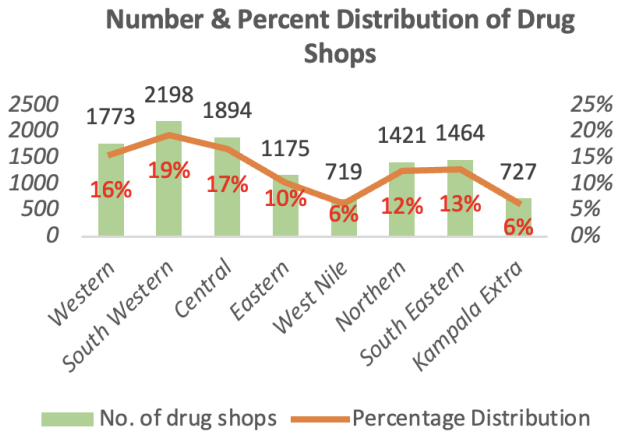
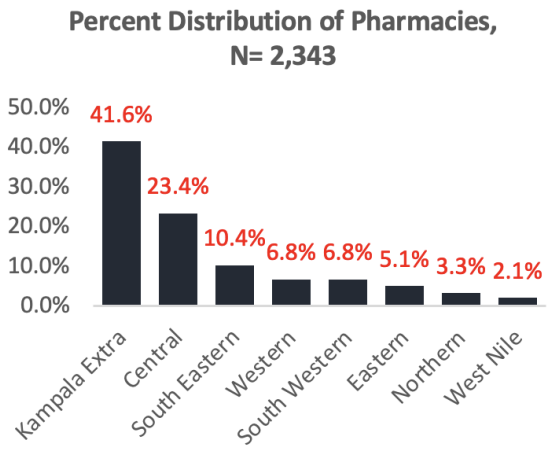


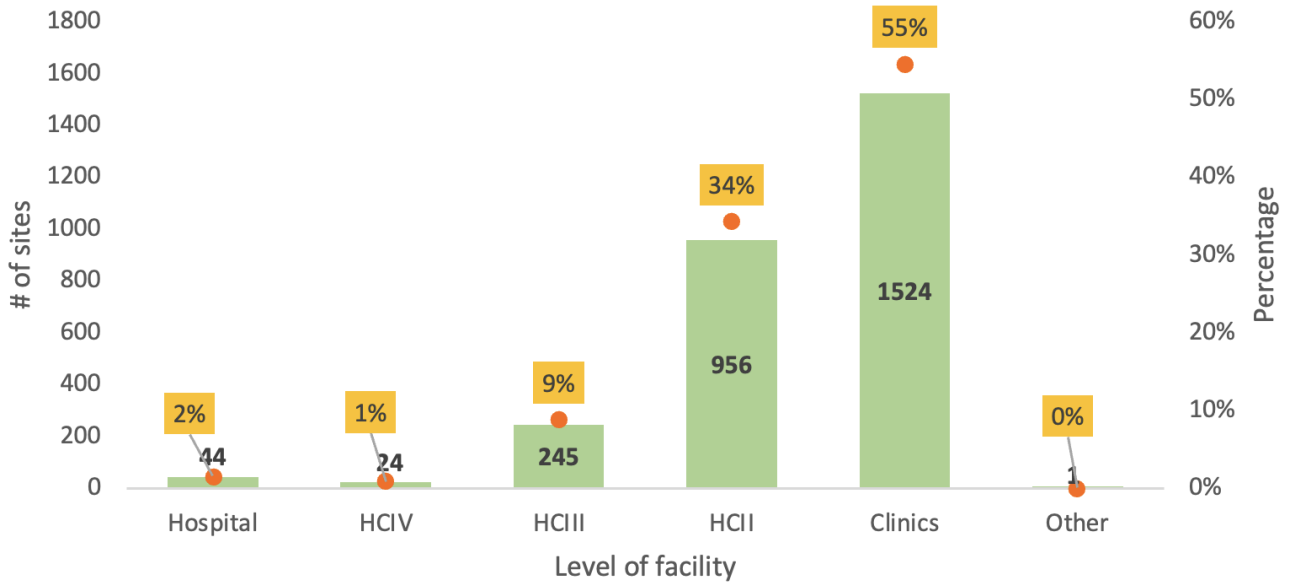
Figure 14: Number and Percentage Distribution of Drug Shops and Pharmacies





[18] *National Drug Authority Website and Ministry of Health Master list of sites.*

Figure 15: Number & Percentage Private For Profit Faciities by Level of Care



Summary of private sector enablers as per PSA Report 2016 → According to the Uganda Private Sector Assessment in Health Report 2016, a number of factors enabling private sector engagement were highlighted including the following:

Policy enablers

- An important change in government mindset was observed. No longer has a question "if we should" but "how can we" work with the private sector, including PHPs.
- A Policy framework is in place as well as a few of the necessary institutions.
- Political will in certain pockets of the Ugandan government and MOH departments.
- PPPH Node is in place and serves as an entry point for private sector engagement with MOH.

Relationship enablers

- Health Policy Advisory Committee (HPAC) is a logical forum for public-private dialogue with strategic modifications to its membership and scope.
- PHPs still believe partnerships are important, want to be more involved in policy and planning, and are looking for quick and feasible strategies to build their relationship with the MOH.

Market Enablers

- The health market growing at an accelerated rate.
- Positive experience in commercial lending to build on in Uganda's health sector.
- Both PNFPs and PHPs want to strengthen business and financial skills to better manage costs, improve operations, and become financially sustainable.
- Many PHPs deliver key services to the poor.

Section Three: **Objectives, Guiding Principles, Risks and Mitigation of the Investment Case**

3.1 Objectives of the Investment Case

- To document country-level data related to current financing and commitments within the private sector to achieve National family planning outcomes.
- To define investments needed within the country's development framework(s) to enable increased private sector investment in family planning.
- To present a compelling case, including return on investment, for a prioritized set of investments needed to achieve the family planning targets within the private sector.

3.2 Guiding principles for investing in the FP program

1. Know your market before you invest. Do not invest in any intervention until it is clear what the impact will be across all market players and market functions, and on users. Support market assessments in all regions of Uganda.
2. Do no harm to the market (beware of unintended consequences). Use market assessments and other guidance to determine possible market distortions due to funding, including decreased sustainability.
3. Invest in systemic corrections to failing condom market functions. Rather than funding one sector or partner over another, or investing in what is 'easy' (e.g. more condoms in warehouses), donors/ Investors should fund fixes that will help the entire market to grow and become more equitable and sustainable.
4. Consumer choice is key to increasing contraceptive use. Consumers need more choices of contraceptive brands, where they get them, and at what price.

3.3 Risks/Challenges and mitigation measures

Risk/challenge 1: Delays in effecting the required policy and legislative shifts/modifications including allowing adolescents to access contraceptives, policy to allow pharmacies to dispense injectable contraceptives, integrating private sector in RBF strategy, provision of tax relief and access to loan capital, National Health Insurance Bill etc.

Mitigation measure: Sustained advocacy by the private sector, Civil Society, Development Partners, and Implementing Partners with the Government to develop/approve and effect the relevant policy reforms to facilitate private sector investment in family planning.

Conduct routine business analysis to provide evidence on savings the Government makes through effecting these policy shifts that can be re-invested in boosting the entire health sector, and its contribution to socio-economic transformation.

Risk/challenge 2: Emerging health markets may be affected by economic volatility and, stagnant or declining middle class with reduced ability and willingness to pay.

Mitigation measure: Establish a loan fund and effective method of operation targeting the private health sector. These risks can be further migrated through guarantee schemes, including the Results-Based Financing that involves the private health sector.

Risk/challenge 3: Vulnerability to market failures. There may be obstacles, for example, to market entry for pharmaceutical importers and a limited number of suppliers can lead to inflated pricing and supply failures.

Mitigation Measure: Provide access to loan capital. Establish loan fund and effective methods of operation. Provide tax relief to providers of contraceptive services and products. The incentives to private providers include reducing tariffs on contraceptives.

Risk/Challenge 4:

Low profitability of family planning services and supplies, due to small markets, competition from free public sector services, barriers to entry, and uncertain income streams

Mitigation Measure: Re-establish the social marketing programs and free health services (FP) eligibility for subsidies, which forces those able to pay to access them from the private health sector. MOH should conduct regular market segmentation assessments to inform the subsidies and eligibility revisions. Integrate private for-profit facilities into the Results-Based Financing Mainstreaming Strategy FYs 2022/23 – 2026/27; and support its rollout as part of Government incentives to encourage private provision of family planning.

Conduct routine business analysis to determine how Insurance Companies would save more money through reduced maternity and pediatric claims to trigger a shift to significant private sector involvement. This would incentivize insurance companies to expand insurance coverage and include family planning in the insurance benefits packages.

Scale up social behavioral change and advocacy interventions for family planning using multimedia platforms. This also requires sustained engagement of the Health Development Partners to invest more resources in creating demand for family planning.

Risk/challenge 5: Private investment in health can be concentrated in higher-level hospitals and high-quality clinics for those with the capacity to pay, and these are often in urban areas.

Mitigation Measure: Provide access to loans to private players especially in rural areas who can invest in family planning.

Risk/challenge 6: Market interventions by donors that affect the competitiveness of supplies (e.g. increased volume of free and subsidized contraceptives for the public sector.

Mitigation Measure: Donor funding for family planning commodities has grown steadily since the early 2000s, but is unlikely to increase substantially beyond current levels in coming years. Funding cuts over the last four years have been effected by some development partners.

Sustain engagement with Development Partners to invest in the private sector to promote sustainable financing for FP

Risk/challenge 7: Social and cultural attitudes to family planning (e.g. Services for adolescents, fertility preferences etc.)

Mitigation Measure: Implement and scale up interventions that address social norms to support an individual's or couple's decision-making power to meet their reproductive intentions.

Interventions that have successfully addressed social norms and increased the use of voluntary contraception include community group engagement, mass media, couples' communication, digital health for SBC, multiple channels of communication, mass media, and interpersonal communication.

Risk/challenge 8: Governments' interest in seeking private sector involvement in FP may also be affected by: 1) inequity in geographical access as most qualified private service providers are located in urban areas where they are more financially sustainable; 2) limited access to long-acting contraceptives in the private sector as more participation by private service providers can be expected to skew method mix towards short-acting contraceptives

Mitigation Measure: The government should target implementing risk sharing and mitigation through guarantee schemes; including extending loans to private health sector providers that offer family planning services in rural areas to increase access to private healthcare.

Section Four: **Making a Business Case for Private Sector Investment in Family Planning**

Uganda is not the first: There are documented successful private-sector investments in family planning Workplace family Planning services in Indonesia.

In Indonesia, the provision of family planning services in the workplace has been a crucial tool for sustaining contraceptive use and promoting long-acting and permanent methods. The Asia Foundation Partnership (AFP) facilitated an agreement at the district level between local government and businesses. This model was inspired by a national memorandum of understanding that supports family planning programs in workplaces throughout Indonesia.[19]

Social Marketing and social franchising

Among private sector service options, social marketing and social franchising play a significant role in creating sustainable markets for contraceptive services. These approaches help introduce a greater variety of contraceptive methods at various price points, making them accessible to a wider population.[20]

Pharmacies and drug shops

Private sector pharmacies and drug shops contribute to sustainable contraceptive markets. By ensuring availability and accessibility, they enhance the reach of FP services.[21]

Corporate workplace programs

Workplace programs within the corporate sector show promise of reaching millions of women. These programs can integrate FP services into employee health and wellness initiatives, making it convenient for working individuals to access information and services.

Return on Investment[22]

Cost-effectiveness analysis places a value on a health investment in terms of the cost to achieve a health outcome. In the health field, a standard way to gauge the cost-effectiveness of an intervention is to use the incremental cost-effectiveness ratio (ICER). The ICER is determined by dividing the additional cost of an interven¬tion by its additional effectiveness. For this investment case,the main measure of effec¬tiveness is the DALY averted, one of the effectiveness measures traditionally used to compare a wide range of health interventions. To calculate DALYs averted in the analysis shown in this section, we convert additional family planning users using country- and method-spe¬cific coefficients from FP2020 Core Indicators and Marie Stopes International's (MSI) Impact 2 model.[23]

Table 1:Additional number of women using contraceptives through private sector and couple years of protection (CYPs)

Description	Number of women using commercial sector	Couple Years of Protection (CYPs)
Implants	426,589	1,066,473
Injectables	112,280	112,280
Condoms	129,340	129,288
Contraceptive pills	75,452	94,277
IUDS	16,454	75,688
Total Number of women reached in commercial sector	**760,115**	**1,478,006**

[19] *https://gatesinstitute.org/project/case-study-private -sector-invests -in -family-planning*

[20] *https://apps.who.int/iris/rest/bitstreams/1086511*

[21] *Shopsplusproject.org*

[22] *Corby N, Boler T and Hoving D. The MSI IMPACT CALCULATOR: Methodology and assumptions. London: Marie Stopes International, 2009.*

[23] *For more on MSI's Impact 2 model, see: https://mariestopes.org/media/3321/methodology_paper_june_2018-1.pdf and http://impact¬calculator.psi.org/.*

Table 2: Return on Investment in private sector

Demographic and health impact of family planning services (as measured per CYP)		
1	Number of pregnancies averted	844,575
2	Number of maternal mortalities averted	3,175
3	Number of abortions averted	209,385
Overall health impact of family planning services as measured per CYP		
1	Disability-adjusted life years (DALYs) averted	364,499
Economic impact of family planning services as measured per CYP		
1	Total cost savings	**(GBP) 85 Million ;** USD 107 Million; UGX 417 Billion

The Impact 2 model measures DALYs averted from both maternal and child health gains associated with family planning use. For purposes of this investment case analysis, however, we take a more conservative approach and use only the DALYs averted produced by maternal health gains, in line with current guidance discouraging inclusion of child health impacts in calculating DALYs averted from family planning use (Askew et al. 2017). This is important to note when comparing the ICERs generated by this analysis with other, previous calculations of family planning effectiveness and cost-effectiveness.

Market Size and Health Impact → The universe of need for family planning refers to the total number of products and services that must be distributed to meet the total demand for family planning. Using the UBOS 2023 Population projects, the latest UDHS 2022 and PMA 2022 statistics, the total need for modern contraception is 8,351,129, while the total modern contraceptive use is 4,394,550. The country still has a high use/need gap of 3,956,579, which implies that 47.4% of the total need for contraception is not fulfilled. Uganda has one of the highest annual population growth rates in the world, at 3% per annum, and the highest Total Fertility Rate (TFR) of 5.2 children per woman in East Africa.[24] The modern contraceptive prevalence rate is only 38% among married women and 43% among sexually active unmarried women. The total demand for family planning among married women is 64% and only 60% of it is satisfied by modern contraceptive methods. Among the married women 22% have an unmet need for FP. [25]

Increased commercial market value → With the TMA strategy target of increasing private sector share of the market from 30% to 50% by 2025. However, this investment case has considered 2023-2030 in order to be in harmony with other health sector invesmtment cases. For the period 2023/24-2029/30 the commercial sector will realize an average annual growth in the number of family planning customers of 411,804 women, an increase from the current 3.9%% market share to 15.9% commercial market share. This will translate into a commercial market value of 125 billion Uganda shillings (USD 32 million) by 2030. This will translate into UGX 28.6 Billion (USD 7.3 Million) of public and donor subsidies saved and an additional 232,593 number of of rural/poorer women additionaly reached with any FP method.

Table 3: Individual commercial value of different contraceptives

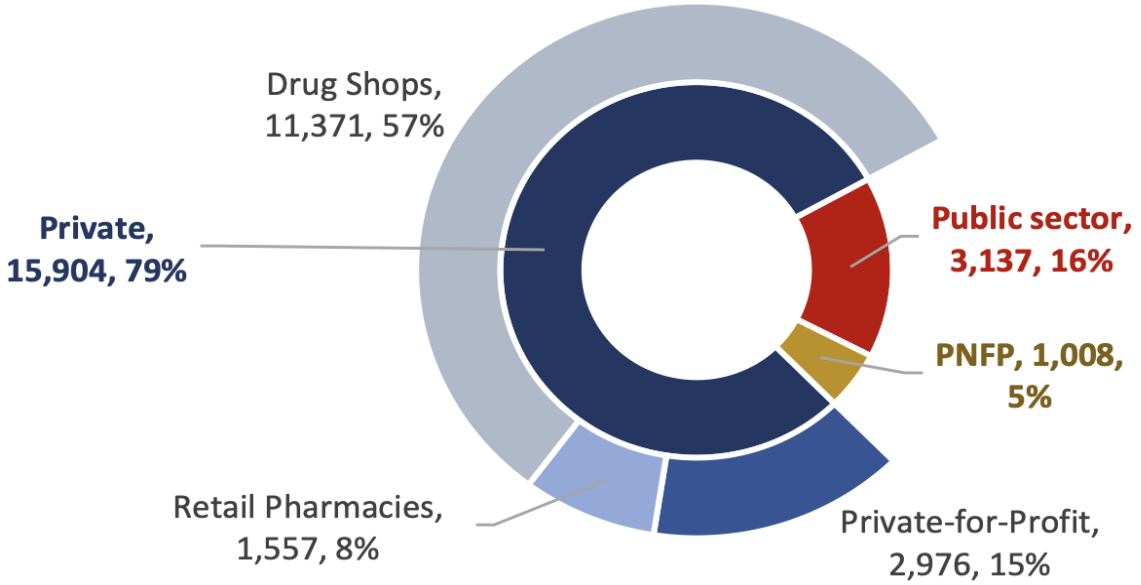
Contraceptive method	Condoms	Oral Pills	Injectable	Implants	IUDS
Number of women served by the commercial sector by 2030	129,340	75,452	112,280	426,589	16,454
Commercial value	UGX 112 Billion (USD 29 Million)	7.2 Billion (USD 1.8 Million)	UGX 3.4 Billion (USD 0.87 Million)	UGX 2.3 Billion (USD 0.59 Million)	UGX 265 million (USD 0.067 Milion
Public and Donor subsidies saved by 2030	UGX 5.7 Billion (USD1.5 million)	UGX 2.6 Billion (USD 0.68 Million	UGX 8.6 Billion (USD 2.2 Million)	UGX 11.4Billion(2.9 million)	UGX 131 Million (USD 0.034 Million)

[24] *Uganda Bureau of Statistics (UBOS) 2022. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS.*

[25] *Uganda Bureau of Statistics (UBOS) 2022. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS.*

Growing and predominant Private sector health infrastructure[26] → Over 50% of the population access their health services through the private sector, in rural and urban settings. Approximately, 79% of facilities belong to the private sector (Drug shops -57%; Retail pharmacies- 8%; Private for-profit health facilities -15%. The public sector health facilities account for 16% and yet they consume 90% of donor-funded FP commodities distributed through NMS and Alternative distribution systems.

Figure 16: Market share of the health infrastructure

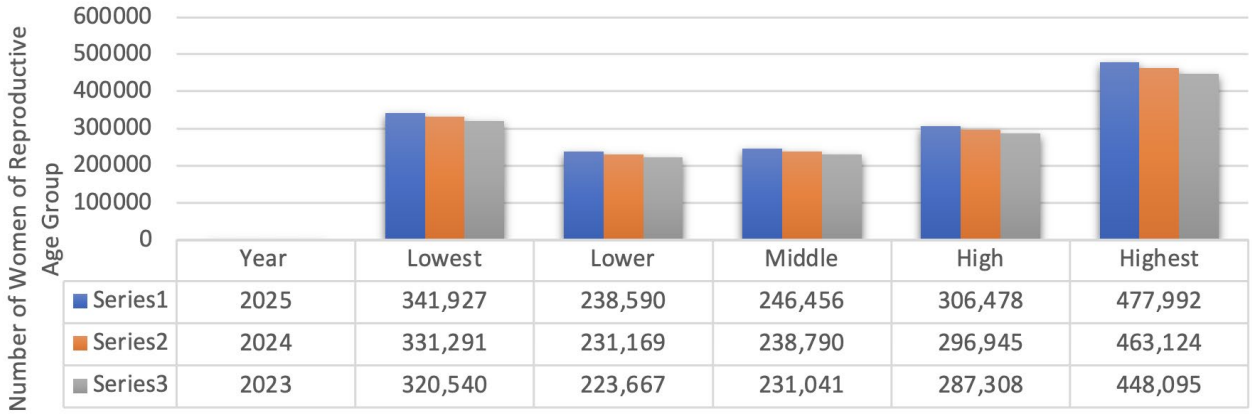


Source: *NDA list of drug shops licensed as of 12th August 2022(https://www.nda.or.ug/drug-shops-licensed-in-2020/); NDA List of currently licensed outlets as of 5th February 2024 (https://www.nda.or.ug/licensed-outlets/)*

Increasing buying power for contraceptive commodities[27] → The population of women of the Reproductive Age Group (15-49) grew to 11.3 million out of which 4.3 million were on contraceptives. Most important 40% (1.5 million) of women on contraception were paying for their contraceptives. The number of women paying for contraception is forecast to increase from 1,5 million (2023) to 1.6 million in 2025. Interesting to note is that more women in the lowest wealth quintile (poorest) continue to buy contraceptives than the Lower, middle, and high-wealth quintiles women, and the trend is expected to increase through 2025.

Figure 17: Increasing purchasing power for the lower wealth quintile.

Number of Women of Reproductive age group forecast to procure contraeptive 2024-2025



	Year	Lowest	Lower	Middle	High	Highest
Series1	2025	341,927	238,590	246,456	306,478	477,992
Series2	2024	331,291	231,169	238,790	296,945	463,124
Series3	2023	320,540	223,667	231,041	287,308	448,095

Source: *Uganda Demographic Health Survey 2016 for the baseline historical data used to forecast*

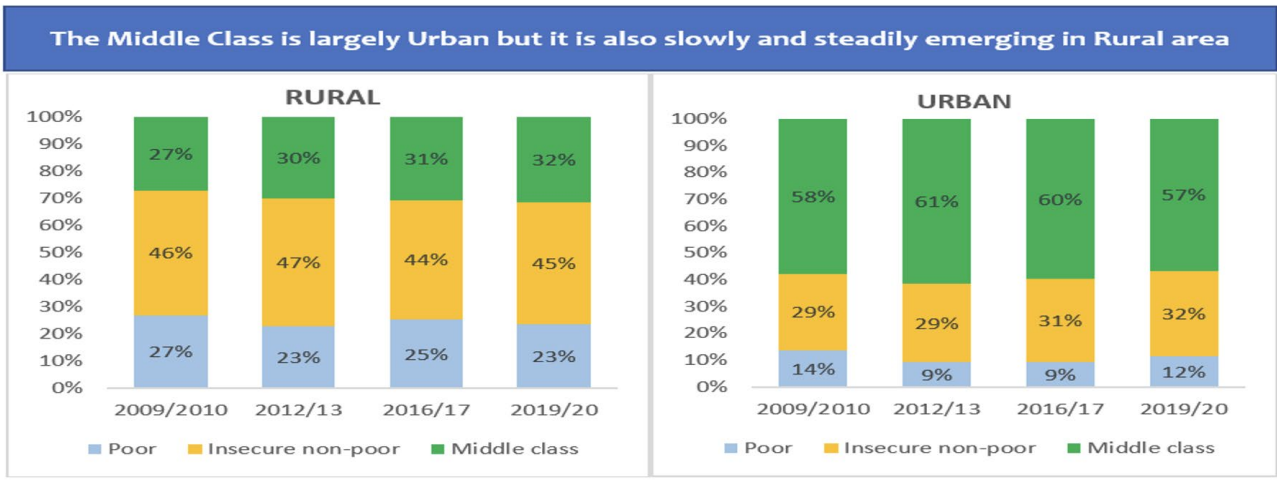
Growing Middle Class in Rural Areas[28] → The middle class is largely urban, however, data from the Uganda Bureau of Statistics shows a steadily emerging middle class in the rural areas. The middle class increased from 27% (2009/2010) to 32% (2019/20) and the number of poor in urban areas reduced from 14% (20019/2010) to 12% (2019/20).

[26] *NDA list of drug shops licensed as of 12th August 2022(https://www.nda.or.ug/drug-shops-licensed-in-2020/); NDA List of currently licensed outlets as at 5th February 2024 (https://www.nda.or.ug/licensed-outlets/)*

[27] *UDHS 2016*

[28] *UBOS poverty status report 2021*

Figure 18: Poverty status of rural vs urban areas



Source: *UBOS Poverty Status Report 2021*

Observed increased demand for contraceptive commodities → It is forecast that the contraceptive commodities needs will increase by 14% with emergency contraceptives taking the biggest growth in demand at 1,073%. Overall, the total number of all women using modern contraceptive methods has more than doubled over the last decade from 1,680,000 in 2012 to 3,630,000 in 2022.[29] The demand for family planning among married women increased from 64.3% in 2011 to 66% in 2022. The demand satisfied with modern contraceptive methods for all women has increased from 45% in 2012 to 59% in 2022. Similarly, the demand satisfied among married women increased from 41.9% to 57.2% over the same period. The unmet need for family planning among all women reduced from 27% in 2012 to 22% in 2022.[30] Over 40% of the total demand for FP is not satisfied.

Table 4: Number of estimated women on different contraceptive methods

Description	2023	2025	Percentage
Male condoms	328,541	373,037	14%
Female condoms	19,792	22,472	14%
Pills (COCs)	206,625	234,609	14%
Pills (POP)	22,958	26,067	14%
Implants 5years	493,603	560,455	14%
Implant 3 years	654,311	742,928	14%
Injectable DMPA IM	623,832	708,821	14%
Injectable DMPA SC	935,748	1,062,482	14%
Emergency Contraceptives	142,500	1,671,799	1,073%
Cycle Beads	19,792	22,472	14%

Source: *Uganda RMNCAH quantification workbook 2022-2027 updated on 23rd February 2023.*[31]

[29] *Uganda FP2030 Indicator Summary Sheet: 2022 Measurement Report*

[30] *Uganda FP2030 Indicator Summary Sheet: 2022 Measurement Report*

[31] *Uganda RMNCAH quantification workbook 2022-2027 updated on 23rd February 2023.*

Table 5: Quantities of contraceptives needed by Sector

		All sector		Public sector		Private Not for Profit (PNFP)		Private for Profit (PFP)	
Commodities Needs		2023	2025	2023	2025	2023	2025	2023	2025
Male Condoms	Pieces	422,162,856	545,041,377	140,865,142	190,000,000	211,297,714	271,041,377	70,000,000	84,000,000
Female condoms	Pieces	2,374,996	2,696,655	0	0	2,374,996	2,696,655	0	0
Pills (COCs)	Cycles	3,099,370	3,519,135	1,394,716	1,583,611	1,549,685	1,759,567	154,969	175,957
Pills (POPs)	Cycles	344,374.40	391,014	154,968	175,957	172,187	195,507	17,219	19,550
Injectables (DMPA-IM)	Vials	3,181,544	3,612,439	1,431,695	1,625,598	1,431,695	1,625,598	318,154	361,243
Injectables (DMPA-SC)	Units	3,056,778	3,470,775	1,375,550	1,561,849	1,375,550	1,561,849	305,678	347,077
IUDs	Units	41,304	46,898	12,804	14,538	28,087	31,891	413	469
Implants (5-year)	Units	123,854	140,628	61,927	70,314	61,927	70,314	0	0
Implants (3-year)	Units	270,908	307,598	127,327	144,571	143,581	163,027	0	0
Emergency Contraceptives	packs	2,849,995	3,235,986	427,499	485,398	1,282,498	1,456,194	1,139,998	1,294,394
Cycle beads	Units	19,792	22,472	-		19,396	22,023	0	449

Source: *Uganda RMNCAH quantification workbook 2022-2027 updated on 23rd February 2023.*[32]

Within the RMNCAH commodities product range, it is the contraceptive commodities that are forecast to post the highest market growth based on the MOH RMNCAH quantification workbook 2022-2027. The anticipated increase in demand for contraceptive products is forecast to lead to market growth in monetary terms as shown in the table below.

Table 6: Comparison of growth of RMNCAH commodities market in value terms

Component	FY2020/21(USD)	FY2024/25 (USD)	Market Growth
Contraceptives	$96,308,370	$195,920,502	103%
Contraceptive equipment	$213,496,877	$330,144,450	55%
Maternal Health	$6,124,343	$6,616,816	8%
Newborn Health	$700,317	$755,372	8%
Child Health	$278,536	$319,993	15%
Nutrition	$3,630,030	$3,976,661	10%
Total	**$320,538,473**	**$537,733,794**	**68%**

[32] *Uganda RMNCAH quantification workbook 2022-2027 updated on 23rd February 2023.*

Section Five: **Making A Business Case for Government Investment in Private Sector Family Planning Market**

A strong private does not increase inequality but reduces inequity and increases access to FP → a research study on the effect of expansion in private sector provision of contraceptive supplies on horizontal inequity in modern contraceptive use (Evidence from Africa and Asia) came to a conclusion that expansion of private sector does lead to equitable access to contraceptives, on the centrally, it increases access to the poor and marginalized.[33]

It's the responsibility of the government to plan for a sustainable FP program[34] → Over the last decade, the demand for FP services has increased dramatically as evidenced by the increase in modern Contraceptive Prevalence Rates (mCPR) and growing numbers of women entering child-bearing ages. However, during the same period, donor financing for FP programs has diminished and is more pronounced with social marketing. Taken together, both trends can potentially threaten the continuation of current levels of mCPR as well as progress toward the long-term sustainability of FP programs. In response, many countries have turned to the private sector for the provision of contraceptive supplies and services, a lesson that Uganda could learn from.

Targeted Government investment in the private sector leads to large subsidies saved[35] → The highest subsidies saved on investment in the private sector will be realized from implants (3.8 billion UGX), injectables (2.4 billion UGX), and condoms (1.6 billion UGX) by 2023.

Table 7: Subsidies saved through intentional growth of the private sector

Contraceptive Method	Subsidies saved (Billion UGX)
Implants	3.8
Injectables	2.4
Condoms	1.6
Oral Pills	0.83
IUDS	0.44

Investment in the commercial sector will lead to an increased number of women reached and served[36] → Government investment in the Total Market approach with increased focus on commercial will lead to increased uptake of contraceptive commodities from 3.9% (2023) to 16.7% (2025). This will result in a commercial value of 36 billion Uganda shilling and a saving of 8.7 billion in subsidy reaching an additional 77,150 women in commercial sector.

The majority of the impact from the commercial sector will be due to the contribution of Implants (44%), Injectables (28%) and condoms (19%). This implies that the government could focus on ensuring deepening commercial sector focus on implants, injectables, and condoms to have maximum impact.

[33] *Hotchkiss et al. International Journal for Equity in Health 2011, 10:33 http://www.equityhealthj.com/content/10/1/33*

[34] *Peters DH, Mirchandani GG, Hansen PM: Strategies for engaging the private sector in sexual and reproductive health: How effective are they? Health Policy Plan 2004, 19(Suppl 1):i5-i21.*

[35] *Total Market Approach (TMA) Projection Tool: Klein, K., K. Ward, and S. Koseki. 2019. "Model for TMA Projection Tool." Washington, DC: Palladium, Health Policy Plus. USAID DEC: PA-00W-BM6*

[36] *Total Market Approach (TMA) Projection Tool: Klein, K., K. Ward, and S. Koseki. 2019. "Model for TMA Projection Tool." Washington, DC: Palladium, Health Policy Plus. USAID DEC: PA-00W-BM6*

Table 8: Commercial Sector Profile

Description	2023	Maintain Status Quo	TMA Scenario
#Women served by the commercial sector	208,502	370,380	760,114
%Women served by the Commercial Sector	5.0%	5.3%	10.8%
#Products sold by the commercial sector in USD	2,201,815	2,478,101	10,767,489
%Products sold by the commercial sector	3.9%	3.8%	16.7%

Description	UGX	USD
Increased commercial market value (Commercial Impact)	125,408,638,923	32,156,061
Subsidies saved (Government and donor financial impact)	28,622,100,091	7,339.000

Table 9: Family Planning Program Impact

Description	Number of women
Number of rural /poorer women additionally reached with any family planning method	232,593

Table 10: Impact of contribution of private sector to the method mix

Description	Additional number of women through commercial sector
Implants	92,852
Injectables	70,356
Condoms	46,764
Contraceptive pills	21,553
IUDS	1,067
Total Additional women reached in the commercial sector	**232,593**

Section Six: **Government Investments Required to Spur Growth of Private Family Planning Market**

The government and family planning stakeholders should maintain momentum after the launch of the TMA strategy, and donors should support implementation and ensure focus on achieving the strategy objectives.

The government should prioritize working with donors and implementing partners to track and ensure that free and subsidized products and services remain exclusively in areas with lower wealth profiles.

Donors should collaborate with the Ministry of Health and ensure that their program indicators and goals align with the government's stated objective to expand commercial sector investments in the family planning sector.

Ministry staff with TMA knowledge must advocate to others within the government for the sustainability of family planning by linking it to the country's health goals and broader environmental and economic development. Without their support, enabling policies that open up the family planning market to the commercial sector and make the program more sustainable in the long-term will not be possible.

Renewed social and behavior change communication efforts will be necessary to keep demand in line with supply. Social and behavior change efforts will not only increase demand for paid products among the wealthy; they will also ensure that poor and marginalized populations seek out family planning products made available through the public sector and donor resources that are freed up over time through commercial sector growth.

Recommended Smart investments by Government to spur Private sector growth

The do-nothing option/Maintain the status quo[37] → In this scenario, the government continues to operate as usual. The method mix and source mix stay the same, but the population and mCPR increase at the current rate. In this case, the public sector will remain at 59% source mix while the private sector stagnates at 40% until 2025. This translates to an increase in visits from 5,242,000 in 2022 to 6,268,000 in the public sector while the private sector will post an increase from 5,022,000 visits in 2022 to 5,991,000 in 2025.

Table 11: Modelling impact of do nothing to grow private sector

Contraceptive Method	Maintain Status Quo			Change in number of visits with No TMA Implementation			
	FP client Visits 2022	FP client Visits 2025	Change (2022 to 2025) with No TMA	FP client Visits 2022	FP Visits 2025 with No TMA	Change 2022 to 2025	Difference between status quo and new
Public	5,242,000	6,268,000	1,026,000	5,242,000	6,268,000	1,026,000	0
Private	5,022,000	5,991,000	968,000	5,022,000	5,991,000	968,000	0
Other	145,000	173,000	28,000	145,000	173,000	28,000	0
Total Visits	10,409,000	12,432,000	2,022,000	10,409,000	12,432,000	2,022,000	0

Government Implementation of task sharing in the private sector (policy shift and capacity building) is a smart investment that will result in 40% increase in the number of FP visits and 49% decrease in visits to the public sector[38] → Implementation of task sharing for injectables in private sector will increase source mix for private sector from 40% (2022) to 56% (2025) leading to a reduction in public sector source mix from 59% (2022) to 43% (2025). This will translate into decreased visits to the public sector from 5,242,000 (2022) to 3,509,000 (2025) while posting a significant increase in visits to the private sector from 4,151,000 (2022) to 6,911,000 (2025). There is enough capacity in the private sector to absorb the numbers bearing in mind that more than 50% of health sector facilities including pharmacies, clinics, and drug shops are in the private sector.

[37] *https://fpmarketanalyzer.org*

[38] *https://fpmarketanalyzer.org*

Table 12: Modelling impact of the implementation of task sharing in the private sector

	Maintain Status Quo			Change in FP visits with TMA Implementation			
	FP Visits 2022	FP Visits 2025	Change (2022 to 2025)	FP Visits 2022	FP Visits 2025	Change 2022 to 2025	Difference between status quo and TMA
Public	5,242,000	6,268,000	1,026,000	5,242,000	3,509,000	-1,733,000	-2,759,000
Private	5,022,000	5,991,000	968,000	5,022,000	8,750,000	3,728,000	2,759,000
Other	145,000	173,000	28,000	145,000	173,000	28,000	0
Total Visits	**10,409,000**	**12,432,000**	**2,022,000**	**10,409,000**	**12,432,000**	**2,022,000**	**0**

This table shows the number of visits in 2022, and the changes in FP from 2022 to 2025 based on the status quo (no source or method mix change), and the new method and source mix in the scenario selected above. In some cases, visits may decline even if users increase. This happens when users shift to methods that require fewer visits per year.

Promotion of implants in the private sector is a smart investment that will result in a decrease in the number of FP visits both in the public and private sector relative to the current status quo.

The promotion of implants will significantly change the source mix by increasing implants from 17% (2022) to 39% (2025) and impacting on injectable source mix from 51% (2022) to 38% (2025). The shift in source mix will translate into an increase in the public sector share of the source mix from 59% (2022) to 64% (2025) while reducing private sector source mix share from 40% (2022) to 34% (2025). This will result in reduced visits from 5,242,000(2022) in the public sector to 4,948,000 (2022) while the private sector visits reduce from 5,022,000 (2022) to 4,525,000 (2025).

For the above scenario to be achieved, the government must balance the availability of skilled providers (in both the Public and private sectors) to be able to meet the increased demand for both implant insertions and removals, determine the type of training and supervision plans that would be needed and put in place.

Table 13: Modelling Impact of Implants in the Private Sector

	Maintain Status Quo			TMA Implementation scenario			
	FP Visits 2022	FP Visits 2025	Change (2022 to 2025)	FP Visits 2022	FP Visits 2025	Change 2022 to 2025	Difference between status quo and new
Public	5,242,000	6,268,000	1,026,000	5,242,000	4,948,000	-294,000	-1,320,000
Private	5,022,000	5,991,000	968,000	5,022,000	4,525,000	-497,000	-1,465,000
Other	145,000	173,000	28,000	145,000	129,000	-16,000	-44,000
Total Visits	**10,409,000**	**12,432,000**	**2,022,000**	**10,409,000**	**9,602,000**	**-807,000**	**-2,829,000**

Removal of policy barriers to allow growth of the private sector in LARC provision is a Smart Government Investment[39] → In this scenario, implant use increases, and the share of IUDS and implants in the private sector increases. By implication, the share of implants in the method mix will double, up from a minimum of 5% to a maximum of 40%, and the share of IUDS and implants in the private sector will both increase by 20 percentage points.

[39] *https://fpmarketanalyzer.org*

The impact on the number of users is more pronounced with implants increasing from 17% (2022) to 37% (2025) while the other methods in the method mix don't change significantly. This scenario leads to a decrease in visits in both the public and private sectors relative to the status quo because implant users do not need to return as frequently to replace their method. To achieve this scenario there should be the right type of facilities or providers within the private sector to deliver LARC. In addition, there should be enough providers to be able to meet the increased demand for both insertions and removals. In Countries where the private sector is mostly pharmacies/ shops, the private sector's share of LARC provision may be limited which is not the case for Uganda.

Table 14: Modelling impact of LARCs in the private sector

	Maintain Status Quo			TMA Implementation scenario			
	FP Visits 2022	**FP Visits 2025**	**Change (2022 to 2025)**	**FP Visits 2022**	**FP Visits 2025**	**Change 2022 to 2025**	**Difference between status quo and new**
Public	5,242,000	6,268,000	1,026,000	5,242,000	4,833,000	-409,000	-1,435,000
Private	5,022,000	5,991,000	968,000	5,022,000	4,640,000	-382,000	-1,350,000
Other	145,000	173,000	28,000	145,000	129,000	-16,000	-44,000
Total Visits	**10,409,000**	**12,432,000**	**2,022,000**	**10,409,000**	**9,602,000**	**-807,000**	**-2,829,000**

This table shows the number of visits in 2022, and the changes in FP from 2022 to 2025 based on the status quo (no source or method mix change), and the new method and source mix in the scenario selected above. In some cases, visits may decline even if users increase. This happens when users shift to methods that require fewer visits per year.

Recommended Government strategic interventions

Focus Area: Policy environment

Strategy: Enhance the enabling policy environment for private sector engagement in FP: Address market and policy barriers to private sector products and services.

Interventions:

- Review and approve existing policies that affect the operation and engagement of the private sector in family planning
  - Approve the policy supporting private pharmacies to deliver a wide range of modern FP methods, including injectable
  - Establish an accreditation mechanism for eligible private pharmacies and drug shops to offer a full range of FP methods including injectables.
  - Streamline the issue of contraceptive access by adolescents in the National Health Policy, and approve other related strategic guidelines including the Sexuality Education Guidelines for the Out-of-School
- Facilitate the private health insurance market growth.
  - Implementing the new Health Insurance Act which will create the necessary institutional arrangements to not only regulate the health insurance sector but also create the NHIS
  - Creating a level playing field in the insurance marketplace by ensuring private insurance companies and private healthcare providers are part of the NHIS
  - Promoting greater efficiency in the private health insurance industry by encouraging larger risk pools, incentives for better contracting, etc.
  - Creating opportunities for private health insurance companies to introduce micro-insurance schemes and/or to compete for contracts to become the insurers for the informal sector under the NHIS.

Area of focus: Government Capacity for Private Sector Stewardship

Strategy: Build MoH capacity to assure quality in a mixed health delivery system

Interventions

- Integrate the private sector into the existing HMIS & DHIS2 reporting mechanisms to routinely collect standardized data on the private sector to inform dialogue and regulatory reform.
- MoH reviews all current data collection efforts, analyze the accuracy of data collected and identify gaps in reporting by the private sector.
- Strengthen private sector reporting to MoH.
- MoH collects, analyses, and share data regularly with the private sector
- MoH uses data to understand private sector trends and issues, to inform dialogue with the private sector and to provide evidence for regulatory reforms
- Streamline and Institutionalize the QA System Governing the Private Sector
- Build capacity and institutionalize the Self-Regulatory Quality Improvement System (SQIS) in all four Councils and DHMTs as a mechanism to assess quality in private facilities
- Build capacity among private sector representative organizations - UPMB, UCMB, UMMB, UHF, and UHMG – to apply SQIS among its member facilities
- Centralize data on SQIS, use data to inform policy and PPP/Hs, and share data with private sector entities as sector-wide tool describing the quality of private facilities.
- Strengthen the supportive supervisory capacity of government stewards at all levels.
- An investment in advocacy and communication that shifts the mind-set of policymakers and society about free health and family size is needed to boost contraceptive prevalence in the long term.

Area of focus: Private Health Sector Capacity

Strategy: Build the capacity of Private sector networks, and private sector providers to advocate for private sector engagement in FP, removing financial barriers and provision of contraceptive method mix

Interventions

- Use financial mechanisms to structure key health markets
  - Empower networks to co-regulate with MoH quality of private providers' MCH services)
  - Empower associations and bureaus to become formal network administrators to facilitate the development of sustainable private-sector healthcare businesses and chains.
  - Strengthen linkages among private sector providers through the existing platforms like UHF and bureaus and ensure registration of all members within the respective networks. These platforms will facilitate strengthening their capacity, improving the quality of services, and ensuring the referral of clients within the networks.
- Build the capacity of private sector providers in the provision of new contraceptive technologies and contraceptive method mix
- Build capacity of private sector providers and network in advocacy and creation of awareness on benefits of private sector contribution in FP.
- Build private capacity to dialogue with MoH and to participate in policy and implementation.
- Integrate capacity development activities into a domestic resource mobilization decision-making process by developing the capacity of civil society organizations to conduct budget advocacy or and developing the capacity of parliamentarians to understand the return on investment in family planning

Area of focus: Finance

Strategy: Create financial incentives to attract the private sector to invest in FP

Intervention

- Roll out Health Financing Strategy
- Finalize and scale the FP Financing Strategy
- Incentivize the private sector to participate in PPP/Hs.
- Reduce the risk of investing in the family planning market (e.g., increase access to and uptake of loans for healthcare providers as part of the sustainable strategy to invest in FP.
- Whole market approach: Conduct market segmentation every 3-5 years to identify supply gaps and monitor ability to pay, changes in the method mix, and changes in sourcing patterns.
- Leverage financing mechanisms to influence health markets. Structure the health markets by engaging both PNFPs and PFPs to participate in RBF and Voucher mainstreaming efforts.
    - Integrate PHPs in the Strategy for Mainstreaming RBF into the Uganda Intergovernmental
    - Fiscal Transfer Program for Results in the Health Sub-Programme and scale it up
    - Assist PPP/H to create institutional arrangements for contracting under RBF
    - Provide training to PPP/H Node and potential private provider networks in contracting skills
- Integrate FP in the voucher program and facilitate its scale-up
- Engage the Government of Uganda to approve the NHIS: Promote understanding of the benefits of a NHIS; Bring together private health insurance companies and other supporters to advocate for NHIS and pressure the GoU to approve the NHIS
- Roll out the TMA strategy: Segment those who can afford to pay and steer them to the private sector

Area of focus: Demand creation

Strategy: Strengthen investments in demand creation

Intervention

- Continued investments in demand generation aimed at changing socio-norms regarding ideal family size are critical in sustaining mCPR growth and growth in private sector contributions.
    - Conduct SBC and demand creation assessments and analysis to understand barriers to use and attitudinal differences between various FP market segments. This analysis will guide the design of campaigns, services, and products for the various market segments.
    - Demand creation activities should target those in wealth quintiles, urban areas, and young couples.
    - Invest heavily in stimulating demand for LARCs and innovative products while monitoring the market shift.
    - Link supply-side financing (PBF) with demand-side initiatives (such as voucher mechanisms and awareness-raising campaigns).
    - Explore and adopt innovative communication channels such as social media and mobile technology.

Area of focus: Service delivery

Strategy: Strengthen the capacity of the private sector to provide the contraceptive method mix and increase access to contraceptives.

Intervention

- Build clinical skills of providers within the private facilities, pharmacies, and drug shops in FP methods provision and counselling
- Expand the range of FP methods, including injectables, through private provider networks.
- Contract out family planning services to extend the reach and contraceptive method mix through a partnership with private providers (as part of RBF framework and Voucher programmes, NHIS benefits package).

Area of focus: Supply chain

Strategy: Streamline and simplify regulatory systems and the overall supply chain for contraceptives in the private sector

Interventions

- Streamline and modernize the regulatory system governing FP commodities. Areas to pursue include: i) modernizing oversight systems and tools to make the regulatory agencies more management-oriented and "user-friendly" to the private sector; and, ii) collecting better data on all supply chain activities including the private sector.
- Simplify registration and importation procedures to ensure method availability and expand method choice.
- Strengthen the private sector supply chain for short-acting methods to mitigate supply chain disruptions but also ensure the availability LARCs as the market shifts to provider-dependent methods.
- Strengthen monitoring contraceptive availability, quality, and prices; looking at multiple distribution channels (public, private, and NGO); and analyzing funding needs and shortfalls. This aimed at addressing sustainability and supply gaps in FP commodities.
- Stop dumping free contraceptives in the private sector through a review of the guidelines for alternative distribution strategy in line with the market segmentation assessment.

Area of focus: Health information system

Strategy: Strengthen data management of health services in the private sector using the existing MoH HMIS & DHIS2 system

Interventions

- Integrate the private health providers (facilities, clinics, pharmacies, and drug shops) that provide FP services and products in DHIS2 to provide visibility for the private sector.
- Build capacity of private providers in data collection, reporting, analysis, and use.
- Integrate private health sector stakeholders in implementing the M&E frameworks for the National FP CIP II and TMA Strategy
- The proposed investments are aligned to strategies under the PPP/H Strategic Framework focusing on establishing and/or strengthening the public and private institutions and build their capacity.

Table 15: Summary table of recommended Smart government investments required to spur FP commercial sector Market

Investment area	Strategy
Policy environment	Enhance the enabling policy environment for private sector engagement in FP: Address market and policy barriers to private sector products and services.
Government Capacity	Build MoH capacity to assure quality in a mixed health delivery system
Private Health Sector Capacity	Build the capacity of private sector networks, and private sector providers to advocate for private sector engagement in FP, removing financial barriers and provision of contraceptive method mix
Finance	Create financial incentives to attract the private sector to invest in FP
Demand creation	Strengthen investments in demand creation
Service delivery	Strengthen the capacity of the private sector to provide the contraceptive method mix and increase access to contraceptives.
Supply chain	Streamline and simplify regulatory systems and the overall supply chain for contraceptives in the private sector.
Health Information Management	Strengthen data management of health services in the private sector using the existing MoH HMIS & DHIS2 system

Recommended Stakeholder for Intentional and focused Government targetting for FP TMA stewardship

- Private health insurance providers
- Importers and distributors of RMNCAH supplies
- Financial institutions like banks, foundations among others
- Private for-profit healthcare institutions including health facilities, pharmacies, and drug shops.
- Private not-for-profit health care institutions
- Organizations with a niche in community distribution of healthcare supplies
- E-commerce platforms
- Reproductive Health Organizations dealing with cost recovery.
- Professional Councils

Section Seven: **Commercial Sector Smart Investments to Grow the FP Market**

The private sector can play a crucial role in advancing family planning efforts in Uganda. Here are several ways in which private sector contributions can make a significant impact:

Service Delivery and Accessibility → Private health facilities, including clinics, pharmacies, drug shops and hospitals, can provide family planning services. By expanding access to contraceptive methods, the private sector ensures that women and couples have convenient options for family planning.

Product Distribution and Marketing → The private sector can distribute contraceptive products efficiently. Social marketing campaigns promote awareness and encourage product adoption, making contraceptives more accessible to underserved populations.

Innovative Financing Models → Private sector entities can develop innovative financing models. For instance, they can collaborate with insurance companies or microfinance institutions to offer affordable family planning services.

Workplace Programs → Many private companies implement workplace programs that include family planning services. Integrating family planning into employee health benefits contributes to reproductive health and well-being.

Research and Development → Private sector investments in research and development lead to improved contraceptive methods. Innovations such as long-acting reversible contraceptives (LARCs) benefit from private sector expertise.

Public-Private Partnerships (PPPs) → Collaborations between governments, NGOs, and private sector organizations enhance family planning programs. PPPs leverage resources, expertise, and infrastructure to reach more individuals.

Supply Chain Management → The private sector excels in supply chain logistics. Efficient distribution ensures a steady supply of contraceptives, reducing stockouts and improving availability.

Training and Capacity Building → Private providers receive training to deliver quality family planning services. Strengthening their capacity enhances service provision.

Data Collection and Monitoring → Private sector involvement improves data collection and monitoring. Accurate data informs program adjustments and resource allocation.

Community Engagement → Private sector actors engage with communities to raise awareness. They participate in community-based events, workshops, and outreach programs.

In summary, the private sector's commitment to family planning contributes to healthier families, gender equality, and sustainable development. By collaborating with governments and NGOs, private entities can amplify their impact and create positive change for millions of lives.

Strategic interventions by the Private sector

Reduce contraceptive markup to increase sales[40] through a consolidated distribution system → Currently the mark-ups on contraceptives range between 70% -270%.

[40] *HEPS Uganda, Samasha Medical Foundation Cost and pricing report 2014: An assessment of private health facilities in Uganda*

Table 16: Summary of supply chain mark-ups

Stage in supply chain	Add-on	Imported Product	Local Manufactured
Stage I: Manufacturer	Insurance and freight	7-15%	N/A
Stage II: Importation	NDA Verification fees Clearing and Forwarding Importers mark up	2% 2-5% 7-20%	N/A
Stage III: Wholesale	Wholesale mark up (Kampala) Wholesaler mark up (Upcountry)	6-25% 25%	15-25% 25%
Stage IV: Retail	Retailer's mark-up	50-600%	50-600%

The Uganda private sector supply chains can be described as complex networks of importers, wholesalers, distributors, sub-distributors, and amass of retail outlets, where there is little visibility on what is being purchased and when. This results in stock-outs and enables substandard medicines to enter the supply chain. In countries where supply chains do operate efficiently, private sector investment in pharmaceutical distribution and retailing can yield additional benefits to the consumer, such as improved availability of medicines and assurance of quality, along with the potential for lower mark-ups along the supply chain as the number of intermediaries decreases. Technological innovation could be one of the fastest and most impactful ways of increasing supply chain efficiency, particularly in markets with profound transport infrastructure deficiencies. Digital innovations range in sophistication from text messaging systems that update stock levels, to "smart" vaccine fridges that automatically send stocking and temperature control reports.

Reduce the cost of contraceptive registration at NDA through expiedited registration process → commercial sector to prioritize the WHO pre-qualified contraceptives including condoms. This will reduce the time for registration from more than 1 year to 6 months. This is because registration of contraceptives not pre-qualified will require NDA to inspect the manufacturing plant for asses GMP will increase the cost for registration that is transferred to the end user in the form of a high mark-up.

The commercial sector to organize into a strong advocacy group for market segmentation → commercial sector should actively get engaged with the government to implement market segmentation. The commercial sector should be on the decision-making table. This could be done through a loose commercial sector group that meets regularly and representation.

Section Eight: **Stakeholders Roles and Contributions**

The realization of effective engagement of the private sector in family planning will require mapping, active involvement, and execution of the roles of key stakeholders. These will significantly contribute to advocating for, developing, and/or implementing the private sector engagement in family planning strategies and ensure the attainment of the National FP CIP & NDP III targets and SDG.

The stakeholder categories to be engaged will include the following:

- Ministry of Health and Ministry of Finance, Planning and Economic Development
- Health or social committees in parliament
- National Drug Authority
- Private health sector networks and associations
- Professional associations that bring together private healthcare providers
- Private Health Insurance Providers
- Importers and Distributors of contraceptives
- International nongovernmental organizations and implementing partners dealing with cost recovery

Details of roles and contributions are summarized in table 2.

Table 17: Actors in private sector engagement in family planning; roles and contributions

Stakeholder	Responsibility	Contribution to private sector engagement in FP
Ministry of Health	Ensure effective governance and regulatory framework to ensure universal access to FP. Strengthen advocacy for diversification of funding for FP. Gathers evidence on the value of investing in family planning program and coordinates with other stakeholders within and outside of the government.	Articulates family planning budget needs to departments and ministries within the government as well as to development partners.
Ministry of Finance, Planning, and Economic Development	Sets and maintains the health sector budget. Explores avenues and feasibility of implementing	Approves and disburses health budget including allocation to family planning, particularly the budget line for contraceptives. Provides financial incentives for private sector investment in family planning (tax exemptions, affordable loans etc.)
Health or social committees in parliament	Leads the development and consideration of legislation related to the health sector, including approval of the health sector budget.	Approves and can advocate for the health budget, including allocation to family planning (particularly the budget line for contraceptives) and health financing reforms that could include family planning.
National Drug Authority (NDA)	Creating the regulatory environment that will facilitate the importation and provision of FP services and products within the private sector. Deal with the development and regulation of the pharmacies and drugs in the country.	Simplify the importation modalities/ procedures of contraceptives. Authorizing the private pharmacies to provide injectable contraceptives (self-injection). Regular provision of data on contraceptive imports to inform quantification and monitor uptake

Private sector associations (Umbrella organizations and networks including Uganda Health Federation, Uganda Private Midwives Association)	Bring together private health providers to ensure awareness of standards and guidelines for high-quality care; coordinate continuing medical education and professional development opportunities; and represent private healthcare providers, bringing their concerns to the government	Advocate for engaging private providers in the provision of FP services including opportunities for social contracting of services directly with the government and empanelment with health insurance agencies and payers. May also advance to receive free or subsidized FP commodities if they are serving vulnerable and hard-to-reach populations.
Health Professional Associations/Councils (UMDPC, Pharmaceutical Society of Uganda & UNMC, Allied Professional Council)	Certification and accreditation, quality assurance of private facilities, licensing of professionals, and Continuous Professional Development of health providers	Accreditation of private health providers to increase access to contraceptives. Capacity building of private health sector providers on contraceptive mix, support supervision that integrates FP
Civil society organizations	Promotes accountability and transparency; advocates for support for family planning generally and for specific populations (e.g., adolescents).	Holds the government accountable to follow through on commitments and act with transparency; advocates for family planning contributions from the government and development partners.
Health Insurance Agencies	Determines services that are covered in benefits packages and determines providers that can offer them.	Considers integration of family planning services and commodities in benefits packages and contracts diverse cadres of providers in the public and private sectors for service delivery, thereby increasing access and financial risk protection.
Private service delivery providers	Provides the full range of family planning services and commodities permitted for their cadre according to national policies and regulations. These include providers operating at health facilities, pharmacies, and drug shops.	Increases access to and uptake of family planning among women of reproductive age, which contribute to a country's modern contraceptive prevalence rate.
Commercial supply chain, retail, and other market vendors (Importers and Distributors)	Import and supply family planning commodities to health facilities, pharmacies, drug shops and other retail outlets.	Share challenges and concerns to help create a conducive policy and regulatory environment to grow and finance the FP commodity and service delivery market. Also, invest in and support demand creation as well as foster and share innovations in contraceptive technology and supply chain solutions.
Subnational and local government leaders in the health sector	Develops and allocates the health sector budget at regional/district/county levels, especially in decentralized contexts.	Allocates the health budget across health programs, including family planning. Facilitate accreditation of private health facilities by MoH to provide family planning products and services. Facilitate access to HMIS and DHIS2 by private health facilities/providers to ensure effective data management and use. Provide HMIS tools and conduct support supervision and ongoing capacity building for provision of FP services and products
Non traditional outlets	Targetted stewatdship for condom distribution	

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