The Republic of Uganda

Ministry of Health

The Family Planning Research and Learning Agenda for Uganda 2021–2025

PROMOTING SCALE, QUALITY, AND EQUITY

MINISTRY OF HEALTH
DECEMBER 2020

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This document was developed by Makerere University School of Public Health, in consultation with the Ministry of Health's Reproductive and Infant Health Division. The Ministry of Health would like to acknowledge the contributions of the various institutions and persons involved in the development of this Family Planning Research and Learning Agenda (FP RLA).

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Dr Charles Olaro
Director Clinical Services, Curative Services, Ministry of Health

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Foreword

Uganda has just concluded its family planning (FP) 2015-2020 mission to achieve universal access to family planning to help Uganda attain middle-income status by 2020. Strides have been made towards the goal of reducing unmet need for FP among married women to 10 percent by 2020 and increasing the modern contraceptive prevalence rate (mCPR) amongst married women and those in union to 50% by 2020.

Uganda is currently developing its 2nd Costed Implementation Plan (CIP)-2020-2025 for FP, which aims to increase the mCPR for all women from current levels of 30.4% in 2020 to 39.6% by 2025 (based on the ambitious scenario from the FP Goals Model application), reduce unmet need for contraception from 17% in 2020 to 10% for all women and reduce teenage pregnancy from 25% to 14% by 2025. In pursuit of these aims, the Ministry of Health is invested in maximizing partnerships and enhancing the use of evidence to roll out strategic high impact practices to mitigate persisting barriers to FP across the country. It is crucial to address persisting bottlenecks in demand creation, service delivery, and access by developing communication strategies and community outreach strategies that reach youths and other hard-to-reach sub-populations while removing barriers to their successful and continued uptake of modern FP methods. Boosting health workforce numbers and capacities, as well as ensuring contraceptive security, are also key aspects of the agenda. Clearly these goals cannot be achieved without an enabling policy and environment, adequate financing, and robust stewardship, management, and accountability.

This FP Research and Learning Agenda presents a great opportunity for the country to tailor future research to respond to key FP evidence gaps; synthesize, package, and promote the use of existing evidence to ensure future investments are evidence-based; harmonize stakeholder efforts; and strengthen monitoring of progress towards making FP programs more equitable, cost-effective, and client-centered.

To meet national FP objectives, the country needs to enhance demand while guaranteeing product security and service quality. Family planning programs must not only aim to broadly increase uptake of modern FP, but also understand and prioritize the FP needs of youth and other hard-to-reach populations. The FP RLA will be instrumental in guiding the Ministry of Health's approach to investing in FP services and addressing evidence gaps and critical for informing relevant FP stakeholders on how to implement more effective and accessible service delivery strategies.

The FP RLA is directly in line with the objectives of the National Sexual and Reproductive Health and Rights (SRHR) Policy (2017–2022) and promotes research into achieving the national targets for the Sustainable Development Goals (SDGs). The FP RLA also complements other existing FP-supportive government documents, including the FP CIP II (2020/21–2024/25), the National Development Plan III, the Health Sector Development Plan goals, and the Reproductive, Maternal Newborn, Child and Adolescent Health (RMNCAH) Sharpened Plan.

In Uganda, FP stakeholders are diverse, each with different but collective responsibilities and perspectives. These stakeholders include policy makers, public and private sector partners, community- and faith-based implementers, external donors, researchers, and women and their partners. This RLA, which represents a synthesis of stakeholders' collective views, will promote knowledge-sharing and collaboration across all the FP stakeholders. Uganda's FP RLA will also act as a basis for directing research plans and monitoring evidence uptake in order to strengthen the utilization of FP evidence to inform FP programs and national decision-making.

I therefore wish to present the Uganda Family Planning Research and Learning Agenda as one of the steps towards improving FP services, support from partners, harmonization, coordination, and the overall general health of the people of Uganda.

Dr. Mugahi Richard
Assistant Commissioner Reproductive and Infant Health, MOH

List of Abbreviations

CIP	Costed Implementation Plan
DHS	Demographic Health Surveys
FP	Family Planning
HIP	High Impact Practice
IEC	Information, Education, and Communication
KII	Key Informant Interview
MakSPH	Makerere University School of Public Health
mCPR	Modern Contraceptive Prevalence Rate
MOH	Ministry of Health
PMA	Performance Monitoring for Action
R4S	Research for Scalable Solutions
RLA	Research and Learning Agenda
SRH	Sexual and Reproductive Health
TWG	Technical Working Group
UDHS	Uganda Demographic and Health Surveys

Executive Summary

Uganda has made significant progress in improving FP outcomes. However, a number of challenges and evidence gaps still exist. As Uganda moves toward setting the next targets for its Family Planning Costed Implementation Plan (CIP) for 2020–2025, there is a need to elucidate evidence gaps and generate, synthesize, and apply new evidence to achieve FP objectives.

The primary objective of this Family Planning Research and Learning Agenda (FP RLA) is to support the Ministry of Health, researchers, and implementing partners to develop and prioritize FP implementation science questions that will contribute to achieving Uganda's FP policy and program goals for 2021–2025.

To develop this FP RLA, researchers at Makerere University School of Public Health, in partnership with the Ministry of Health Uganda, used a country-wide consultative, consensus-driven approach augmented by a broad review of literature and secondary analysis of Uganda Demographic and Health Surveys (UDHS) data.

The FP RLA highlights a number of **evidence gaps** focused on:

- **SELF-CARE:** These gaps include a lack of common understanding of, and perceptions about, self-care among potential users and providers. There is a need for evidence on the most feasible, cost-effective approaches to introducing and scaling up self-care services and on equitable approaches to generating demand. There is limited evidence on health system capacity to promote self-care with adequate linkages, including to support clients and manage side effects. The most effective training approaches for health workers are not well documented.
- **EQUITY:** There is no consensus on the definition and indicators for measurement of equity, with most FP programs not considering all dimensions of equity in design and limited disaggregated data to identify inequities and track progress in addressing the equity gaps. Additionally, there is limited evidence on the contribution of the private sector in bridging inequities in FP. Evidence is also needed on suitable financing mechanisms and implementation approaches to ensure equitable FP care. There is a need to explore the reasons for variations, within and between regions, in the demand satisfied by modern FP in Uganda.
- **HIGH IMPACT PRACTICES (HIPS):** Evidence on the cost and cost-effectiveness of HIPs, such as postpartum FP, quality of FP care through outreach, and health workers' attitudes on post-abortion care, remains to be documented. The community health worker sustainable motivation packages, the community-based strategy for socio-behavior change, and an appropriate implementation model for provision of FP through drug shops remain to be tested.
- **YOUNG PEOPLE:** There is limited evidence on the best approaches for reaching young people with FP care, the perceptions on peer-to-peer FP care, and what is considered appropriate information for young people. Research on the determinants and motivation of young people to seek FP care and how to decrease the rates of teenage pregnancy is also limited. Evidence-based interventions are needed to support young people to delay sex debut and to empower parents to guide young people on matters of sexuality.

This FP RLA will be disseminated and used by the FP Technical Working Group (TWG), the Ministry of Health (MOH), FP implementing partners, and researchers in the country. The FP RLA will complement the 2020–2025 CIP and will contribute to the goal of strategic Shift 2, which aims at shifting from a predominantly public to a Total Market Approach for universal health coverage and sustainability.

The FP RLA will also serve as a guiding document to harness stakeholder partnerships towards better knowledge management for FP by highlighting what evidence exists, how it can be applied, and with what effect. It is anticipated that with robust evidence and targeted programming, the Ugandan government and its partners will be positioned to achieve its FP goals.

Introduction

Despite progress in improving FP outcomes in Uganda, the country still faces challenges within certain pockets of the population. For instance, there has been a significant decline in the unmet need for FP for married women in Uganda, from 34% to 26% from 2016 to 2020 [1]. However, this unmet need is far higher than the FP 2020 target of 10% [2]. Furthermore, the teenage pregnancy rate has stagnated at 25% since 2016, and is even higher among rural, less privileged populations [1] despite information, education, and communication (IEC) campaigns and strategic programming efforts over the past decade. A lot of evidence has been generated through research and programs, but the bulk of it remains un-synthesized or untested. Although the effective uptake of research into policy or practice needs to be built upon a foundation of active knowledge exchange and stakeholder engagement [4], the achievement of this for FP in Uganda has been less than satisfactory. In addition, specific strategies for adapting and implementing evidence-based high impact practices within Uganda are not well documented and assessed.

As Uganda implements the Costed Implementation Plan 2020/21-2024/25 for FP, there is a need to not only elucidate evidence gaps, generate new evidence, and apply existing evidence, but also to promote stakeholder collaboration and consensus on how to scale-up access to voluntary FP and method choice to women of reproductive age (15-49 years) while maintaining quality and equity. It is envisioned that this RLA will guide future studies and investments in research and will contribute to the development of the next CIP, as well as informing advocacy for policy and program strengthening.

OBJECTIVE: The primary objective of the FP RLA is to support the Ministry of Health to develop and prioritize FP implementation science questions that will contribute to achieving Uganda's FP policy and program goals.

The Uganda FP Research and Learning Agenda:

1. Highlights the critical role of evidence, partnerships, and stewardship in improving coverage, efficiency, cost-effectiveness, and quality of FP services in Uganda.
2. Prioritizes the current evidence gaps in FP programming and research that need to be bridged to create demand and to reduce barriers to the continued uptake of modern FP methods in key populations.
3. Maps the current gaps and contradictions in policy which constrain the creation of an enabling environment for FP programming, advocacy, and stewardship.
4. Outlines approaches to implementing the Research and Learning Agenda.

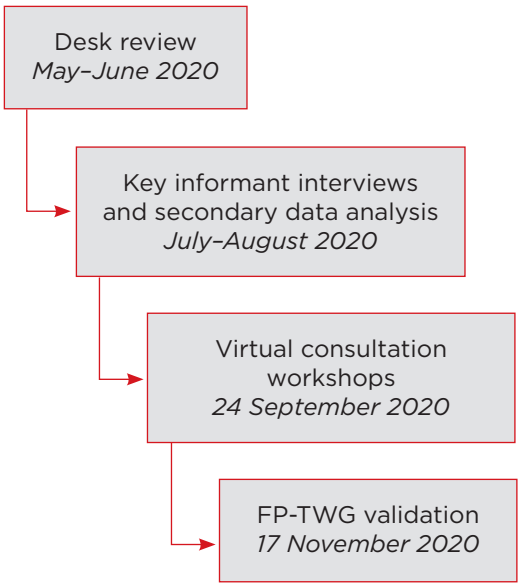
Methodology

The Ministry of Health, in partnership with Makerere University School of Public Health, seeks to generate evidence to support more scalable, equitable, efficient, and effective FP programs in Uganda and globally. This work is supported by Research for Scalable Solutions, a five-year USAID-funded project that aims to strengthen the utilization of evidence to increase access to voluntary FP and improve healthy timing and spacing of births.[1] In order to develop this RLA, researchers at Makerere University School of Public Health, an R4S partner, in partnership with the Ministry of Health Uganda, conducted the following activities:

- **A desk review** of 113 Uganda FP documents, including 42 program documents, 18 research articles, 11 policy documents, 15 issue briefs and fact sheets, and 27 webinar reports, blogs, newsletters, press briefs, and book chapters published from 2010 to 2020. These were categorized around equity in FP programs, self-care, and young people.
- **Secondary data analyses** of de-identified population-level datasets from the Uganda Demography and Health Surveys in 2006, 2011, and 2016 were conducted to examine equity across selected wealth, social, and environmental dimensions over time.
- **Key informant interviews** were conducted virtually with 25 stakeholders, including policymakers, donors, and program implementers, to explore opinions about priority FP research topics and perspectives related to self-care, HIPs, and equity for family planning and reproductive health.
- **A virtual consultation** workshop was conducted with 60 stakeholders from the MOH and several development partners and implementing partners in Uganda on 24 September 2020 to share and discuss findings from the desk reviews and key informant interviews (KIIs) and develop/review priority questions for the FP RLA. Prior to the consultation, 54 participants responded to an online survey to prioritize the evidence gaps. The list of evidence gaps was further prioritized during the workshop (see prioritized questions, tables 1–4).
- **An FP|RHCS-WG virtual meeting** was held with 54 stakeholders on 17 November 2020 to validate the evidence gaps.

FIGURE 1

Summary of the processes and timelines for development of the FP RLA



1. The R4S project developed the methodology that has been used to develop FP Research and Learning Agendas in 6 countries (Cote d'Ivoire, Malawi, Mozambique, Nepal, Niger, and Uganda) with adaptations by local stakeholders to reflect their needs and priorities.

Synthesis of Findings

In this RLA, priorities are further categorized into topics that highlight research evidence that needs to be: i) generated and tested in order to bridge FP demand gaps and reduce barriers to the continued uptake of modern FP methods in key populations, and ii) collated, synthesized, and adapted to address the current gaps and contradictions in FP policy and programming in Uganda.

Below is the refined set of research topics categorized along these lines.

Photo credit: Marie Stopes Uganda

A health worker conducts an FP outreach in Northern Uganda

FP RLA Priority Areas

Self-care Implementation in Uganda

Self-care represents the ability of individuals to promote and manage their health with or without the support of a health worker [5]. It has the potential to drive progress towards FP goals and increase equity in Uganda, where there are diverse inequalities. People have practiced self-care for many years — for example, the use of traditional FP methods. However, new products, information, and technologies and their delivery evolve. Today's interventions build on those that have existed for ages, as well as innovations based on evidence.

The country consultation key informant interviews and desk reviews revealed varied understanding of the concept of self-care in Uganda, which needs harmonising. With the momentum from the MOH and partners towards expanding self-care, a harmonised understanding will be achieved. Indeed, the Uganda national self-care guidelines, currently under development, have drawn from this RLA and the findings from the desk review, secondary data analysis, and key informant interviews.

EVIDENCE GAPS IN SELF-CARE

Broadening the understanding of self-care: There is a need to deepen the current knowledge of how individuals and communities understand, perceive, experience and/or would like to experience self-care for FP, as well as what factors influence individual needs and preferences, including the role of social, community, and gender norms. While there is evidence on how to implement selected self-care interventions, including DMPA-SC, there are gaps in understanding how to implement a range of self-care strategies and how to support linkages with the broader health system to ensure continuity of care with quality.

Policy on self-care to inform strategic direction: It is not clear how self-care interventions can be better coordinated at the national and sub-national levels to avoid fragmented efforts. No evidence is available on how to guide and regulate the use of FP self-care services and products in Uganda, including traditional self-care products. There is also no clear link between other FP HIPs and self-care, such as supporting self-care for young people, sexual education for self-awareness to promote self-care, the regulation of digital platform use, and where self-care is promoted. Clear guidance is needed on how to relate self-care to other HIPs, including for underserved groups such as youth, and how self-care can be harnessed to address equity issues.

Training on self-care: Both clients' and health workers' training on self-care are lacking at scale. As self-care is expanded, there is a need to provide evidence on the training needs of health workers, as well as understanding of their perspectives. The most effective training approaches for health workers have not been documented for self-care, and a clear plan to support clients who experience adverse drug reactions while on self-care options is still lacking.

Private-sector engagement: Documented evidence is needed on mechanisms for engaging the private-sector to boost the distribution of a range of methods, including injectables and emergency contraception (EC), in addition to evidence on the effectiveness and safety of these approaches, including evidence from pilot studies in drug shops.

Demand generation and scale-up of services: There is a need for evidence on what equitable approaches can be utilized to generate demand for FP self-care. The scale- up of self-care services needs to be informed by research on the most feasible, cost-effective approaches. Different models for self-care options (such as DMPA-SC) need to be tested at scale. Demand generation will reinforce the need to address limited health system capacity to promote self-care with adequate linkage to manage side effects.

Use of traditional FP methods and herbal medicines: Data have revealed an increasing trend towards the use of traditional family planning methods, coupled with increasing use of herbal medicine. Given the increased prominence of the use of traditional methods in this context, there is a need to elucidate patterns of uptake and the drivers of their use in order to inform behavior change and program strategies for enhancing the use of more effective modern FP methods. There is a need to map the segments of populations who are not reached with messages on modern FP and to understand and emulate the marketing strategies used by herbalists. There is also a need to strengthen the regulation of herbal medicines for FP.

Young woman receives guidance on insertion of injectable FP method under guidance of CHW

TABLE 1

FP Research and Learning Agenda — Priority Questions for Self-care

Research evidence gaps	Gaps for evidence synthesis and research utilization
1. What are the social norms and practices that influence/ affect self-care uptake in the general population, and among population sub-groups? 2. What are the community attitudes and perceptions towards self-care? 3. How best can males be involved in FP self-care interventions, both as partners of eventual users and users of male controlled self-care methods? 4. What approaches create demand for FP self-care equitably for all groups and regions? 5. What are the most effective training approaches on self-care for health workers and clients? What are the current training needs/gaps? 6. What feasible and cost-effective approaches exist to foster the rollout, scale-up and follow-up self-care clients? 7. What mechanisms can be used to establish post market safety and address side-effects from self-care methods?	1. How best can health facilities and end users dispose of the waste from self-care? Lessons from the DMPA-SC self-injection pilot need to be synthesized, scaled up, and transferred to other products. 2. How effective and safe is private-sector provision of a range of self-care FP methods? A clear understanding is needed on how to regulate counterfeit products like EC, expired drugs/ products. 3. How can private sector providers be harnessed and adequately incentivized to provide FP services, especially given their proximity to communities?

Equity in FP Programs in Uganda

The Ministry of Health recognizes equity as a very important element in FP policy and programing and is currently addressing equity through drug shops, Voluntary Health Teams at the community level, subsidies, and interventions selected based on need. The Total Market Approach and National Health Insurance are also anticipated to reduce inequities for FP [6]. Nevertheless, Uganda still has gaps in mainstreaming Equity in FP programing that need to be addressed.

EQUITY EVIDENCE GAPS

Definition of equity: In Uganda, there is presently no consensus on the clear definition and dimensions of equity for FP to be measured, and equity and equality are often used interchangeably. In policy documents, the equity definition focuses on universal access to FP [7], while in programing, equity is mainly defined using the wealth dimension, with access to and utilization of FP as main outcomes without factoring in the aspect of need [8].

Measurement of equity: There is also no consensus on the appropriate indicators to assess equity for FP. The modern contraceptive prevalence rate has commonly been used as the main indicator, and use of the demand satisfied — which would address the need — is rare. Access to FP, unmet need for FP, total fertility rate, teenage pregnancies, and unintended pregnancies have also occasionally been considered as indicators of equity for FP.

The specific settings and areas of concern with inequity in FP include:

POPULATIONS

- Inadequate focus on people with disabilities, peasant farmers, rural residents, informal settlements (urban), young people, and the less educated. There is also a need to monitor humanitarian efforts, including the effect of migrant populations on the achievement of FP goals.

- Geographical variation in the number of FP programs and implementing partners, where some regions have multiple FP programs and others have none, although their need is high.

PROGRAM AND POLICY

- Current FP programs are not considering equity in intervention design and packaging.
- The current policies have no clear or well-defined strategies to address inequities in FP.

DATA

- Limited or complete lack of data for people with disabilities and the very young (10–14 years) in almost all data sources, including the DHS, DHIS2, and research settings.
- Data quality challenges (inconsistent data capture, missing data, incomplete data) in key data sources, such as health facilities, the entry level for DHIS2.
- Timeliness of data: The census occurs only every 10 years and major surveys (DHS) are five years apart, while routine administrative data (HMIS) is collated and reported monthly, and no source provides real-time data to inform real-time decision-making for equity in FP programming.
- Poor access to data or lack of information on how to access data, especially from non-health sectors, remains a challenge.

TABLE 2

FP Research and Learning Agenda-Priority Questions for Equity

Research evidence gaps	Gaps for evidence synthesis and research utilization
1. What is the contribution of the private sector towards reducing the inequities in FP care? 2. What are the underlying reasons for and lessons learned from the declining inequities in teenage childbearing and demand satisfied by modern FP in some regions? 3. Why are there regional inequities in demand satisfied by modern FP in Uganda? (Explore the reasons for within and between regional variations in demand satisfied by modern FP). 4. How do socio-cultural factors and sub-groups (e.g., people with disabilities, young people) lead to inequities in FP care? 5. How effective are financing mechanisms at reducing inequities? (E.g., Total market Approach and National Health Insurance) 6. What strategies/approaches can be used to reduce inequities in demand satisfied by modern FP in Uganda? (E.g., dimensions to focus on and feasible indicators for monitoring and evaluation and learning inequities, setting-specific FP interventions) 7. What approaches/strategies can enhance equitable access to FP care and messages across the dimensions of equity? (Education, Region, Age, Wealth and Residence) 8. What are the patterns and trends of family planning uptake among special populations such as refugees, disabled persons, etc.? 9. Why has there been persistently high and inequitable risk of teenage childbearing in Uganda? How can this be mitigated? (identifying dimensions to prioritize [geographies, age groups, educational status] and appropriate innovative interventions)	1. How best can implementers and partners provide equitable FP care? a. What criteria should IPs use to choose settings for FP interventions? b. What criteria can be used to target populations? c. How can interventions/ approaches be tailored to settings and to specific populations? d. How can coordination of IPs and synergies across implementers be enhanced? 2. Why are some regions still lagging despite past investments?

KNOWLEDGE TRANSLATION

- Limited capacity for advanced analyses, interpretation, visualization, and presentation at the varying levels of the FP program.
- Limited utilization of data because of inappropriate synthesis and packaging of research findings for decision-makers, along with poor knowledge translation skills, prevents proper decision-making for equity in FP programming. There is also a need to monitor actions resulting from the evidence engagements and to explore innovative ways research findings can be used to influence practice at service delivery points.

Implementation of High Impact Practices in Uganda

High impact practices are a set of evidence-based FP practices vetted by experts against specific criteria and documented in an easy-to-use format [9]. The FP CIP (2015–2020) for Uganda prioritized implementation of a number of HIPs to advance FP, including community-based distribution of injectable contraception by community health workers, voucher schemes, immediate postpartum FP, outreaches, social franchising, and integration of FP into other services. However, these practices have been implemented on a pilot basis [6]. The next CIP 2020-2025 aims to adopt and scale up a number of HIPs based on learning and evaluation to improve FP indicators in Uganda. However, a number of evidence gaps around HIPs still exist.

HIP evidence gaps

EVIDENCE GAPS RELATED TO SERVICE DELIVERY HIPs

Health workers' attitudes on post-abortion care: In Uganda, abortion remains illegal. However [10], due to high teenage pregnancies, many young people end up having unsafe abortions. Implementing partners have promoted post-abortion FP. However, there is still limited evidence on health workers' attitudes towards providing post-abortion FP given that abortion is illegal in Uganda.

Quality of FP care during outreaches: Several partners have implemented FP through outreaches. The MOH also supports health facilities to conduct routine outreaches. However, few mothers take up FP during outreaches. The quality of care during outreaches also remains unexplored in Uganda.

Uptake of postpartum FP: A number of implementing partners have invested in postpartum FP. However, the uptake is still low [13]. There is limited synthesized evidence on the barriers to and facilitators of postpartum FP uptake in Uganda. Additionally, with some mothers still delivering at home and with traditional birth attendants, there is still an evidence gap on innovative strategies to effectively reach them with postpartum FP.

Motivation of community health workers: Uganda has used community health workers to educate communities about FP and to distribute FP injectables, as well as pills and condoms. However, these community health workers face a number of challenges, including poor motivation and limited skills [15]. A fundamental question remains on how community health workers can best be incentivized to effectively and sustainably deliver FP services to communities.

Provision FP through drug shops: Provision of FP through drug shops has been piloted by several partners, including FHI 360, PATH, and Population Services International (PSI). The National Drug Authority approved the delivery of FP through drug shops. There is a need to understand the best sustainable implementation models and their implications — whether FP should be provided at subsidized cost or free of charge. Furthermore, challenges include some private facilities exploiting clients, selling counterfeit products, and not adhering to guidelines. It is important to explore how these outlets can be effectively supervised to ensure guidelines are adhered to and clients receive quality services.

EVIDENCE GAPS RELATED TO SOCIAL AND BEHAVIOUR CHANGE HIPs

Misconceptions and myths about FP in communities: There is a lot of evidence on misconceptions and myths about FP in communities in Uganda. However, implementing partners still grapple with community-based strategies to change strong cultural norms, myths, and misconceptions about FP.

Male involvement in FP: Male involvement has been encouraged and promoted by MOH and FP programs as a critical component to achieving FP targets in Uganda [6], However, male involvement in FP still remains low. It is important to explore the best approaches for engaging men in FP.

EVIDENCE GAPS RELATED TO ENABLING ENVIRONMENT HIPs

Domestic public financing: The Government of Uganda pledged in its FP2020 commitments [11] and in the CIP 2015-2020 [6] to increase the budget allocation to FP to advance the FP agenda. However, this commitment has not been fully realized. Furthermore, the FP programs are predominantly donor funded. There is a need for innovative engagement and financing to prioritize and increase budget allocations to FP programs for sustainability.

Stagnation of policies: Several policies have been drafted to advance FP, especially among young people. However, policy implementation has stagnated due to resistance from sections of some stakeholders. Evidence on innovative engagement strategies to harmonize and address the competing stakeholder perspectives remains to be explored.

Supply chain: Management of stock levels is a priority, to ensure equitable access to FP commodities. However, some health facilities — especially those in remote areas — continue to suffer stock outs of FP commodities, and yet stocks are expiring in stores and some health facilities [12]. While evidence on the barriers for stock to reach the last mile exists, innovative methods of distribution and redistribution of commodities within districts and among different health facilities are still limited.

OTHER CONSIDERATIONS FOR IMPLEMENTING HIPS

HIP cost-effectiveness: Uganda has prioritized the scale-up of HIPs in the FP CIP 2020–2025, including those related to postpartum FP, drug shops, and community health workers, among others. However, there is still limited evidence on the cost of the scale-up [14].

Regulation of Implementing partners: Uganda is working with several implementing partners to implement FP programs. However, some regions have many implementing partners, while others have few or none. This uneven distribution of implementing partners contributes to inequities in FP programs. There is a need to explore frameworks to ensure equitable distribution of implementing partners and FP services in the country.

Monitoring and evaluation of FP2020 commitments: Uganda committed to achieving the FP2020 commitments [11]. However, evaluation of achievements and barriers and facilitators remains limited.

TABLE 3

FP Research and Learning Agenda-Priority Questions for HIPs

Research evidence gaps	Gaps for evidence synthesis and research utilization
1. What is the quality of FP care offered during outreaches? 2. What are the attitudes of providers towards post-abortion FP in the Ugandan context? 3. How can community health workers be effectively harnessed (capacity building and incentives) to support FP care in a sustainable manner? 4. What is the appropriate model for the sustainable provision of a broad FP method mix in drug shops: free of charge or at a cost, and what are the implications? 5. How can the supervision of drug shops be improved to ensure adherence to policies and guidelines (e.g., licensing, monitoring counterfeit drugs, tracking, and regulation of fees to enhance equity)? 6. How can male involvement be harnessed to improve FP uptake? 7. What appropriate community-based strategies can be deployed for effective social and behaviour change? 8. What is the cost-effectiveness of High Impact Practices such as drug shops, postpartum FP?	1. What framework can government use to ensure even distribution of implementing partners in the country? 2. How did Uganda perform on the FP 2020 commitments? What were the facilitators and barriers? 3. How can the different stakeholders be engaged to harmonise and address resistance to policy formulation and implementation of relevant FP policies? 4. What are the barriers and facilitators of post-partum FP uptake? 5. How can FP be targeted to women delivering from home? 6. What are the innovative approaches to increasing budget allocation to FP programs and reduce the over-reliance on donors? 7. How can FP commodities be redistributed within districts to reduce stock outs in facilities and drug shops?

Young People

Uganda has one of the youngest populations (68.5%) and the highest fertility rates globally. About 1.2% of girls aged 15 to 19 and 4.5% of the young women aged 20 to 24 had their first birth by the age of 15 years. Modern contraceptive use among young people in Uganda remains very low, and over 40% of pregnancies among women below age 20 are unintended [16]. Consequently, there are high levels of unplanned births, unsafe abortions, maternal morbidity/mortality, and school drop-outs. Extending voluntary FP care to the young people is critical to harnessing the demographic dividend in Uganda. However, most young people face challenges in accessing FP services. Also, there are several evidence gaps on the delivery of FP services to young people.

Evidence gaps for young people

Models of delivering FP to young people: Although Uganda has a liberal FP policy that allows access to contraceptive services for every sexually active individual and couple regardless of age, a huge number of sexually active young people have never used contraceptives [17]. Efforts to improve access to FP and reproductive health services for young people have been mainly through youth-friendly corners. However, these youth corners have not addressed the challenge, and unmet need for FP among youth is still high, ranging from 30.4% to 31.3% [16]. The service delivery models that are effective in delivering voluntary FP and reproductive health care to young people remain undocumented. Besides, evidence gaps exist on the attributes of service delivery models that young people prefer.

TABLE 4

FP Research and Learning Agenda-Priority Questions for Young People

Research evidence gaps	Gaps for evidence synthesis and research utilization
1. What are the stakeholders' (parents, teachers, health workers, political, cultural and religious leaders, etc.) perceptions on the use of young people to reach fellow young people with FP and reproductive health care information and services? 2. What FP and reproductive health information do key stakeholders perceive to be appropriate for young people aged 10–14 years? Who should provide this information to them? 3. What motivates young people to seek FP and reproductive health services from the private sector as opposed to the public sector? 4. What is the acceptability and suitability of self-care interventions to support young people's access to voluntary FP and reproductive health care services? 5. What interventions can support young people to delay sexual debut? 6. What interventions can parents be empowered to guide young people on matters of sexuality? 7. What are the strategies to decrease the teenage pregnancies generally and during the COVID-19 period? How can these efforts be sustained post-COVID-19? 8. What service delivery models are effective in delivering voluntary FP and reproductive health care to young people and what attributes do young people prefer? 9. How can sexually active young people be empowered to access and use voluntary FP and reproductive health care services (including contraceptives)? 10. How can the underserved young people be effectively reached (those living with disabilities, out of school, those living in rural areas, urban poor youth, refugees, and others) with FP and reproductive health care? 11. How can young people be engaged in the design and implementation of voluntary FP and reproductive health care programs that target them?	1. What are the stakeholders' (parents, teachers, health workers, political, cultural and religious leaders, etc.) perceptions on the provision of voluntary FP and reproductive health care information and services to the young people? 2. What are the determinants of young people's sexual behaviour and FP access? What are the young people's fears regarding FP?

Engaging young people in the design and implementation of voluntary FP and reproductive health care programs: A recent United Nations Population Fund global strategy calls for urgent involvement of youth in their own affairs [18]. Despite this, most FP programs have been designed by adults for youth, without involving the youth. Engaging young people in designing and implementing voluntary FP and reproductive health care programs has been articulated but not yet realized.

Empowering sexually active young people to access and use voluntary FP and reproductive health care services: Although some youth are using contraception, many are not able to meet their reproductive desires. An analysis of national and regional DHS data indicates that there is demand for contraception among married youth aged 15-19, but this demand is often unfulfilled [19]. Despite this, the strategies of empowering sexually active young people to access and use voluntary FP and reproductive health care services (including contraceptives) are not well documented. Besides, there is a need to empower parents and care givers to guide young people on matters of sexuality.

Decreasing teenage pregnancies: Teenage pregnancy rates have stagnated at 25% among youth aged 15-19 years since 2006 [16, 20, 21]. Moreover, COVID-19 has resulted in an increased rate of teenage pregnancy [22]. There is a need to determine strategies to decrease the occurrence of teenage pregnancies, generally and during the COVID-19 period, and ways of sustaining these efforts post-COVID-19.

Supporting young people to delay sexual debut: According to the UDHS (2016), 17% of young men and 12% of young women aged 15–24 reported having sex before age 15, while 56% of women and 52% of men aged 18 to 24 reported having sex before age 18 [16]. This early sexual debut is associated with detrimental physical, emotional, and social outcomes [23]. Interventions to delay sexual debut among young people are needed.

Increasing uptake of FP and reproductive health care by underserved youth: Disparities in contraceptive use exist by age, marital status, education, socio-economic status, and rural-urban geographic location [6]. Despite this, strategies to increase uptake of FP and reproductive health care to underserved young people are not fully explored.

Self-care interventions to support access to voluntary FP and reproductive health care services by young people: Although there is evidence that promoting self-care has the potential to increase access to and use of FP for youth [24], there is an evidence gap regarding FP self-care approaches among young people.

How will this FP RLA be used?

This FP RLA will be disseminated to the FP TWG, MOH, and other sectors, FP implementing partners, and researchers in the country. The MOH will conduct regional dissemination meetings with regional actors (implementing partners, district health officers, communities of practices, technical directors) and map out actors to identify those who could take on specific priority questions.

The FP RLA will also be published on the MOH and MakSPH websites.

MOH will initiate a community of practice composed of providers of FP services which could be used as a platform to share and disseminate evidence for enhancing FP service delivery.

MOH will collaborate with Makerere University to identify research questions that could be addressed by students.

The FP RLA will be discussed at least three times in a year during the FP TWG meetings. This FP RLA is aligned with Uganda's 2021–2025 CIP, housed by the Ministry of Health.

Under the goal of strategic Shift 2, moving from a predominantly public to a Total Market Approach for universal health coverage and sustainability, information will be generated and used for evidence-based prioritization and FP programming in Uganda.

How will this FP RLA be monitored?

This FP RLA will be monitored through the:

- Number of research priorities funded/ implemented
- Evidence products generated and shared to address existing evidence gaps
- Policy and program changes and harmonization made as a result of uptake of evidence from the RLA
- Changes in implementation practices at the provider level
- Citations of FP-RLA by policy makers, program implementers, funders, and researchers.

This FP RLA will therefore be instrumental in:

- Driving the generation of primary evidence and the synthesis of existing evidence and its uptake to inform the selection of targeted HIPs to be tested or scaled up towards better FP policy and programming in Uganda.
- Enhancing stakeholder collaboration, consensus building, shared learning, and evidence-informed advocacy for FP in Uganda. Collaborative quality improvement initiatives will be used to generate evidence for implementation science questions at the grassroots.
- Highlighting policy and program gaps and contradictions that need to be bridged and harmonized in order to create an enabling environment for FP in Uganda.

It is anticipated that this FP RLA will form the basis for the synchronized generation and uptake of evidence for policy and programming across the country to reduce duplication in research and programming and ultimately enhance progress towards achieving Uganda's FP targets as per the FP CIP 2020–2025.

Strategic Shift 2 of Uganda's FP CIP 2020–2025 includes strategic outcome 7that targets to ensure "strategic information is generated and used for evidence-based prioritization and FP programing."

The aims include:

- Support generation, access, and use of FP information to identify and better target vulnerable groups
- Set up mechanisms for access and utilization of FP data by stakeholders
- Strengthen monitoring of the private sector market channels on FP service provision and data management
- Strengthen data quality and data management systems for FP data

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Appendices

APPENDIX 1
List of Participants for the Virtual Workshop

https://drive.google.com/file/d/1n9iOtfaTz36cMetMZvK272_UT5KGgKNG/view?usp=sharing

APPENDIX 2
Agenda for the Country Consultation Workshop

UGANDA MINISTRY OF HEALTH-RESEARCH for SCALABLE SOLUTIONS (R4S) STAKEHOLDERS CONSULTATION, 24TH SEPTEMBER 2020, KAMPALA UGANDA

Agenda for the online stakeholder consultation, 24th September 2020

TIME	Activity	Responsible person	Session Objective(s)
8:45–9:00am	Registration	Hadija Omar	Record attendance
9:00–9:10am	Introduction of organizations present and group photo (online)	All participants type their names and organization in chat box	Record individual and institutional stakeholder representation
9:10–9:15am	Welcome/Opening Remarks	Dr. Charles Olaro, Director of Curative Services, MOH	Establish meeting purpose and locate it within MOH FP strategic direction Provide overview of R4S objectives and strategy for FP
9:15–9:20am	Remarks on R4S, FHI 360	Mr. Fred Mubiru, FHI 360 Country Office	
9:20–9:25am	Remarks on R4S, USAID	Mrs. Rhobbinah Ssempebwa, USAID Mission Uganda	
9:25–9:35am	Progress on the FP Costed Implementation Plan and linkage with FP research agenda setting	Dr. Makanga, Assistant Commissioner, Reproductive and Infant Health Services, MOH	Reorient meeting on Country's strategy and progress towards implementing CIP — highlight gaps Harmonize country and R4S strategies for FP

TIME	Activity	Responsible person	Session Objective(s)
9:35–10:50am	Overview of meeting objectives and landscape methods	Dr Suzanne Kiwanuka	• Reiterate meeting objectives and expected outcomes • Present and validate findings from desk review, KIIs, secondary data analysis • Solicit stakeholder inputs on landscape analysis
	Finding on HIPs	Dr. Dinah Amongin	
	Findings on Equity in FP	Dr. Fredrick Makumbi	
	Finding on Self-care	Dr. Simon Kibira	
	Findings on youth and young people	Dr. Joseph Matovu	
10:50–11:00am	Questions reactions		
11:00–11:40	Break away sessions for Priority setting exercise for evidence gaps across HIPs, Equity, Self-care, Youth and Young people for the FP research agenda	Facilitators Delphi Panel Survey using zoom screen share	Prioritize evidence gaps across HIPs, Equity, Self-care, Adolescents and Young people for the FP research agenda
		Mr. Frederick Mubiru (FHI360)/**Equity**	
		Dr. Betty Kyaddondo (Director Family Health, NPC)/**Youth and young people**	
		Dr. Walugembe, Fiona (PATH)/**Self-care**	
		Dr. Lillian Sekabembe (PSI)/**HIPs**	
11:40–11:55am	Summary of issues on agreed gaps, priorities and next steps	Chief Rapporteur	Provide an overview of emerging priorities and next steps for research agenda development
11:55–12:10pm	Closing Remarks	Prof. Rhoda Wanyenze	Wrap up meeting and provide a way forward for R4S Uganda

APPENDIX 3

Country Consultation Presentation Slide Deck

https://drive.google.com/file/d/1D23qJaV6IlVMtC_eko5iY_qMju7IG-2c/view?usp=sharing

The Republic of Uganda

Ministry of Health