

REPUBLIC OF UGANDA

THE SECOND NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2020/21- 2024/25 (FP-CIP II)

Reproductive and Infant Health Division

Ministry of Health
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Foreword

The recently concluded general elections have brought to bear the impact of high fertility on a bulging youth constituency facing unemployment, poverty and poor skilling. Further, the youth are experiencing high fertility leading to increased dependency ratios that, if not addressed could potentially result into a security risk and regression in the country's socio-economic development.

Currently, more than 3.8 million women of reproductive age are using contraceptives in Uganda. The country has witnessed an increase in mCPR of 1.2% points for married women annually. This remarkable achievement is a clear testimony that the partnership between the public sector, development partners, civil society and the private sector in the previous five years, has been focused and results-oriented.

The Government of Uganda has prioritised the promotion and practice of family planning as part of a strategy to achieve the national goal of **increasing household incomes and improved quality of life of Ugandans**. Family Planning is one of the pillars for harnessing the Demographic Dividend in Uganda.

At a global level, Uganda made commitments at FP2030, the Sustainable Development Goals (SDGs) and at **every woman and every child partnership**. This FP-CIP II will contribute to the attainment of global targets, and the fulfilment of the commitments.

The FP-CIP II, has been developed to provide a strategic direction for family planning programming and elaborates how the multi-sectoral approach will play a role in not only addressing the fertility concerns, but also ensure quality family planning services and information for women and men of reproductive age.

Successful implementation will lead to increased socio-economic development and contribute to the attainment of the country's vision 2040 - **a transformed Uganda society from a peasant to a modern and prosperous country within thirt years**. The FP-CIP II comprehensively captures and costs evidence-based, high-impact family planning interventions relevant to the Uganda context.

In order to achieve the above, there's need to strengthen mutual accountability fostered between the public sector, development partners, civil society and private sector for the FP-CIP II and the FP2030 commitments.

I, therefore, wish to present the Second National Family Planning Costed Implementation Plan 2020/21-2024/25.



Hon. Dr. Jane Ruth Aceng Otero
Minister of Health

Preface

In July 2012, at the London Summit on Family Planning, Uganda committed to attaining universal access to Family Planning (FP). In 2017, it further renewed its commitment, extending it to cover adolescents and young people as a commitment to the present and future mothers and children. Further, Uganda made commitments at the FP2030 re-affirming Family Planning as a priority intervention.

The FP-CIP II is a detailed roadmap for achieving the national goals and emanates from her responsibility for and the necessity to improve maternal and child health survival in Uganda. It details our progress, what we are committed to doing, and how we will collaborate with partners to achieve these laudable goals.

Although, based on current efforts, we have achieved commendable increase in the modern Contraceptive Prevalence Rate (mCPR), we need to significantly accelerate our progress to meet our targets and contribute to national and global aspirations while maintaining a commitment to support the rights of women, girls and couples to decide freely, and for themselves, whether when, and how many children they want to have.

The FP-CIP II aligns with the broad principles of government policy on reducing fertility through expanding contraceptive use. Based on the evidence, we see opportunities for growth in modern contraceptive use among all women from current levels of 30.4% in 2020 to 46.6% by 2025. This growth will contribute to achievement of the HSDP II goal of accelerating movement towards universal health coverage with focus on primary healthcare of population health, nutrition, wellbeing, safety and management by 2025.

We need multi-sectoral collaboration with precise mutual accountability mechanisms to ensure we deliver on our commitments to FP-CIP II and FP2030. For Government to achieve this, we must collaborate with bi-lateral and multi-lateral agencies, civil society, community and private sector.

The Government is fully committed to this effort, and I want to thank all those who have contributed to our success so far and to the success of developing this FP-CIP II (2020/21-2024/25). I know that with sustained commitment, we can achieve these targets for the current generation and posterity.

I would also like to thank the stewardship provided by Dr. Charles Olaro who chaired the FP-CIP II Development task force.

For God and My Country.



Dr. Mwebesa Henry
Director General Health Services

Acknowledgement

I would like to recognise the various teams, stakeholders and consultants who have endeavoured to ensure that the development of this FP-CIP II is completed. In addition, we recognise the role played by the FP-CIP II taskforce that provided an oversight role.

On behalf of the Ministry of Health, we would like to express our sincere gratitude to UNFPA for funding the development of the FP-CIP II, Marie Stopes Uganda for sourcing and facilitating the consultants, Avenir Health through the Track20 project, for the technical support they provided in modelling the results and Samasha Medical Foundation that put together the FP-CIP II report.

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The Ministry of Health wishes to acknowledge Development Partners for the continued collaboration and their technical guidance that they conferred at all stages of the development.

The development process of the FP-CIP II has been a culmination of partnership, engagement, cooperation and collaboration of numerous individuals and stakeholder organisations.

The Ministry of Health wishes to acknowledge Development Partners for the continued cooperation and the technical guidance they conferred at all stages of the development.

It is impossible to mention all the people involved in the stakeholder consultation. However, we are very thankful for the technical contributions that originated from a cross-section of the family planning stakeholders, encompassing implementing partners and District Local Governments, for making sure that the sub-regional-specific priorities are taken care of.

The main networks that are especially thanked for their advice, guidance and additional technical inputs consist of the Family Planning/ Reproductive Health Commodity Security working group, the Maternal Child Health Technical Working Group and NASMEC-Safe Motherhood.

I call upon my technical team and all stakeholders to implement the plan as we aim to accelerate universal access to family planning services, information and commodities in the country through a well-coordinated multi-sectoral approach.



Dr. Olaro Charles

**Director Health Services (Curative Services) and
Chair of the FP-CIP Development task force**

Ministry of Health

Acronyms

ADS	Alternative Distribution System	MDAs	Ministries, Departments and Agencies
AGYW	Adolescent Girls and Young Women	MEC	Medical Eligibility Criteria for Family Planning
AW	All women of reproductive age (15-49 years)	MISP	Minimum Service Package
MW	Married women/ in union age (15-49 years)	MoES	Ministry of Education and Sports
BCC	Behavioral Change Communication	MoFPED	Ministry of Finance Planning and Economic Development
BFP	Budget Framework Paper	MoGLSD	Ministry of Gender, Labour and Social Development
CHW	Community Health Worker	MoH	Ministry of Health
CIP	Costed Implementation Plan	MoLG	Ministry of Local Government
CPR	Contraceptive prevalence rate	MoWE	Ministry of Water and Environment
CSO	Civil society organization	NDP	National Development Plan
mCPR	Contraceptive prevalence rate for modern methods	NMS	National Medical Stores
DDP	District Development Plan	NPA	National Planning Authority
DFP-CIP	District Family Planning Costed Implementation Plan	NPC	National Population Council
DMPA-IM	Depot Medroxyprogesterone Acetate (Depo-provera)	OPM	Office of the Prime Minister
DMPA-SC	Depot Medroxyprogesterone Acetate subcutaneous (Sayana press)	PAFP	Post-abortion Family Planning
FAM	Fertility Awareness Methods	PBCC	Provider Behavioral Change Communication
FP	Family Planning	PFP	Private-for-profit health facility
FPET	Family Planning Estimation Tool	PMA	Performance Monitoring for Action
HCD	Human Capital Development	PNFP	Private-not-for-profit health facility
HIPs	High impact practices	PPFP	Post-partum Family Planning
HIV	Human Immune-deficiency Virus	PPP	Public private partnerships
HSDP	Health Sector Development Plan	SDP	Service delivery point
IP	Implementing Partner	SI	Self-Injection
ICWEA	International Community of Women living with HIV in Eastern Africa	SOPs	Standard Operating Procedures
IPC	Inter-personal communication	TFR	Total Fertility Rate
IRCU	Inter-Religious Council of Uganda	VHT	Village Health Team
JMS	Joint Medical Stores		
MAAIF	Ministry of Agriculture Animal Industry and Fisheries		

Definition of terms

TERM	DEFINITION
Adolescent	Persons aged 10 to 19 years.
Adolescent-responsive	An evolution from traditional stand-alone models of adolescent-friendly services towards a systems-approach to making existing family planning services adolescent-responsive.
Community Link Facilitators (CLF)	Persons identified as “Expert clients” who look for loss to follow-up of FP clients.
Ethnic Minority	A group within a community which has different national or cultural traditions from the main population.
Gender	Social and cultural construct of roles, responsibilities, attributes, opportunities, leverages, status, access to and control over resources and benefits between women and men, boys and girls, in a given society.
Method Information Index Plus	Serves as a proxy for quality of counselling and reflects the extent to which women are informed about side-effects and alternate methods.
Missed Opportunities	Situations during which potential FP clients have a chance to be counselled and provided with FP services.
Poorest	Persons in first quintile.
Postpartum Family Planning	Provision of FP counselling and methods during the 12 months period following child birth.
Religious Minority	A religion held by a minority of the population of a country or region.
Safe Spaces	An abstract form of environment that is socially constructed by how people interact within their physical environment, which is the place. These spaces are open and welcoming environments that are available and can be accessible in form of physical or virtual spaces.
Sub-region	Refers to the UBOS grouping of districts.
Youngest	Persons aged 10 to 14 years
Young Person	Persons aged 10 to 24 years
Youth	Persons aged 18 to 30 years

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Executive summary

The 2015-2020 FP-CIP implementation phase registered modest improvement in the modern contraceptive rate for married women increasing from 31.4% in 2015 to 38.7% in 2020, while for all women -mCPR increased from 23.5% in 2015 to 30.4% in 2020.

The FP-CIP I (2015-2020) provided an overarching framework for addressing FP services in the country. It focused on mobilising and investing government and partner resources that resulted in a scale-up of Family Planning service provision. This is evidenced by the improved performance of the FP and fertility indicators above.

Development Partners have progressively increased their financing of family planning services and commodities over the FP-CIP I implementation period. In 2018, international organisations contributed about Shs 91 Billion, representing 61 percent of the total income received (UGX 149 Billion)⁴. There was a rise in the financial resources put aside for family planning commodities throughout the planned period from USD 3.6M in 2015 to 10.1 M in 2020.

Innovative Financing Mechanisms were implemented that included, results-based financing (RBF) in some facilities to incentivise some delivery of more and better quality RMNCAH services, including family planning. Further, RBF was used to address critical constraints such as quality of care, low staff productivity (especially absenteeism), mal-distribution of staffing and retention challenges, and insufficient coverage of essential interventions.

The FP-CIP I review findings further revealed several successes³, among which was the establishment of a National Coalition of champions and advocates that supported the scaling up of best practices, focus on FP advocacy by stakeholders, launch and implementation of the Family Planning Social Behavioral Communication Strategy (2016 - 2021) and review and adoption of the National Strategy for Male involvement/participation in Reproductive health, Maternal, Child, Adolescent Health and Rights - Nutrition, including HIV/TB.

Several implementing partners (IPs) were able to design and roll out male involvement initiatives in some districts to address the related challenges affecting contraceptive uptake. Additionally, the Ministry of Education and Sports approved the National Sexuality Education Framework 2018 even though it is yet to be disseminated. Peer educators' training guidelines were reviewed, and training was carried out, resulting in increased education of young people on FP. Deliberate efforts were made to increase access to FP information using social media by young people.



Several implementing partners were also able to design and roll out male involvement initiatives in some districts to address the related challenges affecting contraceptive uptake.

10.1M

There was a rise in the financial resources for procurement of family planning commodities from USD 3.6M in 2015 to 10.1M in 2020.



Other successes included training national trainers and tutors in Uganda on Post-partum Family Planning (PPFP) and post-abortion Family Planning (PAFP). Regarding FP commodity security, Depot Medroxyprogesterone Acetate subcutaneous (DMPA-SC), referred to as Sayana press, has been registered for home use and self-injection with several self-injection pilots conducted in drug shops leading to good results for scaling up FP uptake. Community-based distribution through Village Health Teams (VHTs) has played a significant role in increasing access to Depot Medroxyprogesterone Acetate (DMPA), referred to as Depo-Provera and Sayana Press.

The Quantification, Procurement and Planning Unit (QPPU) developed several strategies and plans to ensure a reliable supply of FP commodities in the public and private sector (Alternative Distribution System) in the country. All in all, commodities have increased availability in rural and hard-to-reach areas owing to an active Alternative Distribution System.

Overall coordination of FP through the technical working groups has remained strong due to the active Family Planning Reproductive Health Commodity Security Working Group (FP/RHCS WG), the FP Budget Advocacy Group, the Adolescent and School Health working group, and the Maternal and Child Health Technical Working Group (MCH TWG). Implementing partners have played an essential role in supporting the MoH to develop and implement the FP-CIP I performance, monitoring and evaluation plan with a national and sub-national FP-CIP database.

Despite of the above achievements, implementation of the FP-CIP faced design and programmatic challenges that limited its overall performance (refer to findings in Table 14). There were limited interlinkages across the six thematic areas, hence difficulty in assessing the overall outcome and impact of the interventions.

Furthermore, there was inadequate financing; narrow targeting of adolescents, young people and first-time parents; limited use of data to drive FP-related decisions and programming; weaknesses in the multi-sectoral engagement for FP service delivery, as well as uneven sub-regional partner support that contributed to inequitable access to FP information and services. The more significant chunk of FP financial resources for Uganda was from international organisations⁵. The total FP market potential, especially in the private sector, was underutilised, leading to over-reliance on the public sector to provide FP services partially supported by donors and implementing partners.

The FP-CIP II will address the above-unfinished business (2020/21-2024/25) and will adopt a programmatic rather than thematic focus through a technical and strategic approach. This will galvanise stakeholders to view FP as a sectoral issue, ensuring focus on regional variations and inequities while reducing program dependency on the public health service delivery platform for sustainability and universal coverage. It recognises the importance of prioritisation of high-impact practices, domestic resource mobilisation, efficient use of available resources, reduction of heavy reliance on external financing and active resource mobilisation and evidence-based programming to reduce the likelihood of an unfunded FP-CIP.

The FP-CIP II (2020/21-2024/25) is explicitly aligned to the NDP III (2020/21 - 2024/25), HSDP (2015/16 - 2019/2020) goals, and RMNCAAH Sharpened Plan (2016/17 - 2019/20).

The priority issues identified include weak health systems (poor staffing, failure to use data in streamlining the supply chain and procurement, poorly equipped facilities, weakness in harnessing synergies from integrated service delivery), sub-regional specific inequitable access, especially among the marginalised groups (the young, the poor, rural residents, the ethnic minorities, the religious minorities, the least educated, the disabled) and due to geographical challenges and urbanisation,

lack of male involvement; missed opportunities were due to low implementation of High Impact Practices and lack of appropriate equipment, commodities and insufficient skills; minimal engagement of the multi-sectoral approach and unsustainable financing at national and sub-regional levels.

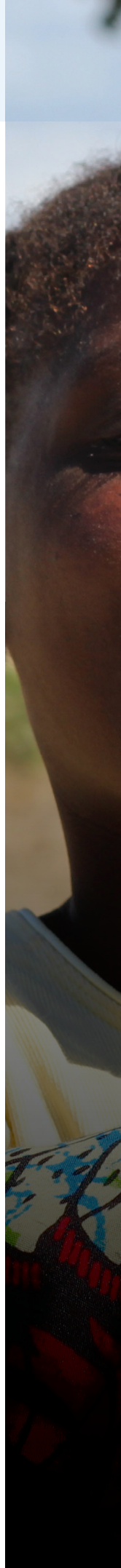
To address the above issues and accelerate the annual increase in mCPR, the implementation of the FP program in the next five years will be based on three technical strategies - a multi-sectoral approach for socio-economic development, universal coverage and sustainability; and a sub-regional focus to address sub-regional inequities. A range of interventions have been proposed to achieve the afore-mentioned technical strategies:

1. A functional National FP multi-sectoral committee.
2. Multi-sectoral policies impacting FP adopted and implemented.
3. Strengthened health care system to ensure delivery of a minimum package of FP through integrated service delivery approaches.
4. Supply chain strengthened to ensure a reliable supply of full method mix through all FP market channels.
5. Current nascent FP market transformed into a mature commercial sector.
6. Increased and sustainable Government financing and harmonized partner support to enhance FP program delivery at national and sub-national levels.
7. Strategic information generated and used for evidence-based prioritization and FP programming.
8. Improved quality of FP services.
9. Decreased proportion of adolescent girls who have given birth before 18 years.
10. High impact practices scaled up.
11. Reduced inequalities in service provision and greater equitable access to FP services to underserved groups.

The goal of the above interventions is to increase the modern Contraceptive Prevalence Rate (mCPR) for all women from current levels of 30.4% in 2020 to 39.6% by 2025 (or for married women from 38.7% in 2020 to 46.6% in 2024); reduce unmet need for contraception from 17%⁶ (in 2020) to 15% for all women with the ultimate goal of achieving below 10% by 2025, and reduce teenage pregnancy from 25% in 2020 to 14% by 2024⁷.

The FP-CIP II (2020/21-2024/25) has been developed through a consultative process with leadership from the Ministry of Health and coordinated through the FP-CIP development and review national taskforce. A situational analysis was concurrently conducted to evaluate the FP-CIP I (2015-2020) and FP2030 commitments. The results of which informed the formulation of the priority areas and approaches. The FP-CIP II (2020/21-2024/25) goals and interventions were modelled using the FP goals model to determine the contribution of high-impact interventions to regional mCPR.

The total cost of the FP-CIP II in the next five years is projected to be \$295 million (1,089 billion UGX). This translates into a financial increase of approximately 24% from the previous 2014/2020 FP-CIP I. These funds will enable the country to increase the current 4.9 million women (in 2020) using modern contraceptives to about 7.4 million women by 2024.





Introduction

01

1.1 BACKGROUND AND RATIONALE

At the 2012 London Summit on Family Planning, the Government of Uganda, represented by His Excellency YK Museveni, made commitments to improve FP information, services and commodities. In 2017, a follow-up summit reaffirmed the country's commitment to increasing access to FP information, services and commodities to the Ugandan population⁸.

The FP-CIP I, outlined strategies to reduce the unmet need for FP to 10% and increase mCPR amongst married women and those in union to 50% by 2020. The FP-CIP I emphasised increased access to FP for young people, a multi-sectoral approach, optimising the existing health workforce and commodity security. By the end of 2020, using data from the FP2020 consensus meeting, Uganda registered a modern unmet need for FP among married women of 30.5% and mCPR (married/ in the union) of 38.7% and an average annual increase in mCPR of 1.4 percentage points for married/in union women⁹ over the eight years of the FP2020 partnership.

The FP-CIP II (2020/21-2024/25) will complete the unfinished business considering the experiences learned from the FP-CIP I¹⁰ and the emerging global evidence to accelerate increase in mCPR and reduce unmet needs. The post FP2020 era has renewed international and Uganda government commitment to improve health, reduce inequities and promote human rights.

Increasing access and utilisation of FP services will contribute to reduced fertility, which is central to the achievement of Sustainable Development Goals (SDGs), Uganda Vision 2040, the National Development Plan III (2020/24 - 2024/25NDP III); and National Health Sector Development Plan II (NHSD II), the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Sharpened Plan II and National HIV/AIDS Strategic Plan (2020 - 2025).

1.2 PROCESS OF FORMULATING THE FP-CIP II (2020/21-2024/25)

The Ministry of Health constituted and coordinated a national task force comprising of development partners, implementing partners and civil society drawn from the Maternal Child Health Technical Working Group, Family Planning/Reproductive Health Commodity Security Working Group, Medicines, Procurement and Management Technical Working Group and Division of Health Information.

10%

The FP-CIP I, 2015-2020 outlined strategies to reduce unmet need for FP to 10% and increase mCPR amongst married women and those in union to 50% by 2020.



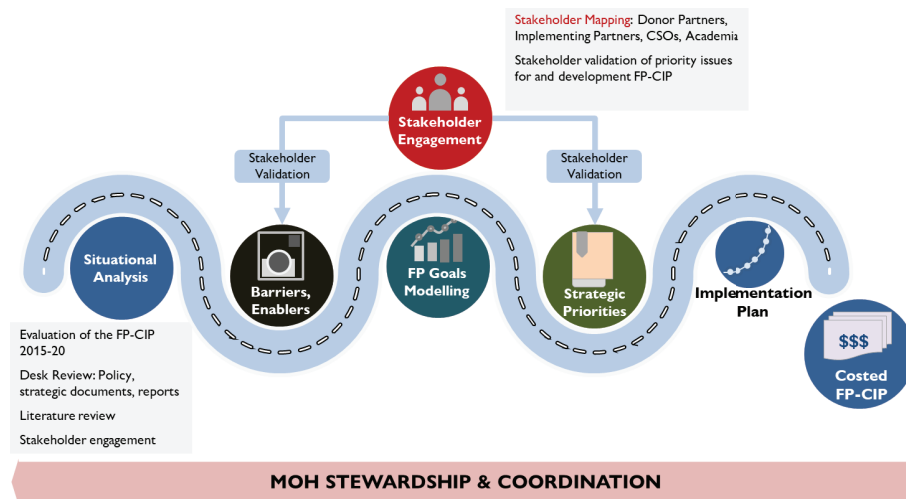
The FP-CIP II (2020/21-2024/25) will complete the unfinished business, in consideration of the experiences learned from the FP-CIP I and the emerging global evidence, so as to accelerate increase in mCPR and reduce unmet need.

A situation analysis was conducted in order to inform the country context. This included reviewing the performance of the FP-CIP I; desk review of policy, strategic documents, programmatic reports and research, interpretation of available data (from surveys and routine DHIS2 data, including the Family Planning Atlas); national and subnational stakeholder consultations.

This was done to identify demand and supply-side constraints limiting access and use of FP; document best practices, lessons learned, and opportunities to overcome the challenges. Further stakeholder consultations and FP goals modelling were conducted to define technical strategies and priority interventions for the next FP-CIP.

The development was guided by the conceptual framework model illustrated in Figure 1 below.

Figure 1: Conceptual Model used to develop the FP-CIP II (2020/21-2024/25)





Situation Analysis

02

Mother and child, Embu
© CIMMYT

2.1 GLOBAL CONTEXT

Before 2015, the FP agenda was anchored in the International Conference on Population and Development, Cairo (ICPD, 1994) and the Millennium Development Goals (2000). Through the ICPD, countries committed to emphasising couples' rights to decide if, when and how often to have children. The MDG (5b) prioritised universal access to reproductive health, including FP. These initiatives catalysed the development of the UN Global Strategy for improving Women and Children's Health (2010), the UN Commission on Life Saving Commodities and the Family Planning 2020 partnership (FP2020). The UN Strategy focused on reducing child mortality and improving maternal health, while the FP2020 sought to empower women and girls to access modern contraception. The UN Commission on Life Saving Commodities was about reducing barriers to 13 priority under-utilised commodities, including implants, emergency contraceptives and female condoms.

In the post-2015 era, investments in FP are supported in the SDGs (SDG) 3, specifically, Target 3.7 on ensuring universal access to sexual and reproductive health care services, including Family Planning, information and education and the integration of reproductive health into national strategies and programs by 2030; Updated Global Strategy for improving Women's, Children's and Adolescents Health (2016), renewed FP2030 commitments and the ICPD25 (2019). The SDGs sought to ensure universal sexual and reproductive health care access, including FP (SDG 3.7). At the same time, the Updated Global Strategy (2016-2030) aims to ensure that every newborn, mother and child not only survives but thrives. The renewed FP2030 commitments aim to increase the number of women reached with contraceptives and reduce unmet needs. ICPD25 focuses on collective investment in universal access to sexual and reproductive health and rights (SRHR) to address the urgent needs of adolescents and youth.

At least half of the world's population still lacks access to essential health services due to a shortage of health services and health workers, further stretched by the COVID 19 pandemic. Every year, 100 million people are pushed into poverty due to unaffordable care¹¹. Innovative strategies beyond traditional health sector responses are urgently needed to contribute to universal health care. Self-care interventions are among the most promising and exciting new approaches to improving health and well-being, both from a health system perspective and for people who use these interventions. Self-care builds on existing movements such as task-sharing and task-shifting and has the potential to contribute to all aspects of WHO strategic priorities and 'triple-billion goals',¹² on this basis; WHO developed the consolidated guidelines on self-care interventions for health for SRHR that were launched in 2019.

Throughout all these initiatives, Uganda has shown support at the highest level through making commitments to FP2020, SDGs, and Global Strategy for Women, Children and Adolescents health. In addition, the evidence-based High Impact Practices for FP have also been identified to guide country programs¹³. With the renewal of the FP2020 partnership towards 2030, Uganda needs to reaffirm its commitment to FP by aligning to the post-2030 agenda.

Based on the lessons learned from countries implementing FP-CIPs and have had varying experiences in attaining the FP2020 global goal, successful FP programs need to observe the following:¹⁴

- Government ownership of the family planning program at national and sub-regional levels.
- Strong Implementing Partner (IP) coordination at national and sub-national levels, with Government-driven stewardship.
- Sustainable financing for all components of the family planning program including capacity building, service delivery, commodity security, data management and demand creation.

- High Impact Interventions/practices (HIIs/Ps) with public-private partnerships (PPP).
- Data to guide decision making including monitoring progress and report annually.
- Equity focus through community empowerment and engagement to access family planning services.
- Prioritization of FP interventions as a key to a successfully implemented CIP.

2.2 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

A body of evidence has emerged on ASRH progress, lessons, and implications for action.¹⁵ Global and regional trends suggest substantial – albeit – uneven strides in reducing levels of adolescent childbearing over the last 25 years. In many FP2030 contexts, there is less need for a technical “hammer” and a greater need for engaging politically on sensitive issues constraining women’s and adolescent empowerment and rights and access to FP. Progress has also been made in improving contraceptive uptake in adolescents; however, many sexually active adolescents aged 15-19 years who want to avoid an unintended pregnancy are not using an effective method of contraception. This is both a supply and demand-side issue, as in Table 1.



Table 1: Barriers, underlying causes and required strategies for ASRH

Barriers	Underlying causes	Required strategies
Lack of desire to avoid, delay, space and limit childbearing	<p>Early childbearing within or outside marriage/union</p> <ul style="list-style-type: none"> • Is socially acceptable or even encouraged. • Is the only real-life option available. 	<ul style="list-style-type: none"> • Improve access to education and employment opportunities targeting those who are disadvantaged. • Reduce child marriage.
Lack of desire to use contraception	<ul style="list-style-type: none"> • Fear of side-effects of contraception. • Fear that contraceptive use can prevent one from getting pregnant in the future. • (Perception that) traditions and religious doctrine forbid contraceptive use 	<ul style="list-style-type: none"> • Address knowledge gaps, myths and misconceptions on contraception.
Poor quality - including disrespectful - contraceptive service provision	<p>Health workers</p> <ul style="list-style-type: none"> • Have knowledge gaps and misconceptions about contraceptive service provision. • Do not have the competencies to deal with the specific needs of adolescents. • Are judgmental and disrespectful with them. 	<ul style="list-style-type: none"> • Using a package of evidence-based approaches to improve and sustain improvements in competencies, attitudes, motivation and hence the performance of health workers.
Lack of self-assurance and independence to use contraception	<ul style="list-style-type: none"> • Being reluctant to say that one is sexually active. • Being embarrassed to seek contraception. • Facing opposition from partners and other influential family members, including emotional/physical violence. 	<ul style="list-style-type: none"> • Building adolescent girls' abilities to make/negotiate decisions about childbearing and contraceptive use. • Engaging/supporting their male partners in shared decision making. • Building support for contraceptive use from family and community members. • Increasing awareness and availability of self-care options as a discreet, private means of accessing contraception.
Limited access to contraception	<ul style="list-style-type: none"> • Laws and policies prevent the provision of contraception by age or marital status. • Adolescents are unaware about where, when and how to obtain contraceptive services. • Adolescents are unable to reach a service location. • Adolescents are unable to pay for contraceptives. 	<ul style="list-style-type: none"> • Enabling adolescents and their partners to access contraceptives/ contraceptive services.

Source: Chandra-Mouli, V. and E. Akwara, 2020



There is a need to work differently to address the quality of contraceptive service provision to adolescents by:

- moving from a one-size-fits-all approach to one that recognises that (i) adolescents are a diverse group with differing needs and preferences and (ii) several service-delivery models, each with its strengths and weaknesses;
- moving away from separate health services for adolescents, and instead, make existing health services more adolescent-friendly, e.g., antenatal clinics & HIV testing;
- working more actively with pharmacies and shops to expand contraceptive access;
- implementing a package of proven approaches to build the abilities of service providers and motivate and enable them to do their best;
- moving away from using training as the only approach to improve and sustain improvements in service providers' performance;
- holding service providers accountable to adolescents and their communities;
- ensuring adolescent sexual and reproductive health is part and parcel of existing quality assurance mechanisms, e.g. supportive supervision;
- promoting meaningful youth involvement and participation in SRHR program design and implementation addresses young people's felt needs;

Global learnings have informed the development of FP-CIP II (2020/21-2024/25).

2.2 REGIONAL CONTEXT

The FP situation in East Africa presents a mixed picture. Despite rising age at birth and progress in contraceptive prevalence, there is persistent low uptake of long-acting family planning methods and high levels of teenage pregnancy, unmet need for family planning, and unintended pregnancy. Marked disparities based on a woman's age, residence, wealth status, and literacy status also characterise access to and use of family planning services. Additionally, high contraceptive discontinuation rates and poor knowledge of conception and fertile period persist among the sub-region's women. Like other sub-Saharan countries, the population structure in Uganda is ripe for harnessing the Demographic Dividend. Addressing these issues would require:

- investing in approaches that increase family planning accessibility and availability for poor, young, rural, less educated, and other special needs women;
- addressing community and household-related oppositions to family planning as well as the myths and misconceptions that surround the use of modern contraceptives;
- ensuring adequate counselling of the FP clients generally and specifically on side effects, what to do about side effects, other methods, and the possibility of switching modes;
- availing a wide range of FP methods to ensure method mix;
- advocating for keeping girls in school to promote maternal education and economically empower women to reinforce individual and contextual attitudes towards the benefits of contraception;
- promoting awareness, accessibility, and affordability of long-acting reversible contraceptives; continuous research on the dynamics of FP, including what works to improve access, use, and quality of services in different contexts.

- addressing inequalities is key - which calls for targeted programming;
- implementing PFP as a high-impact practise offers an excellent opportunity for couple counselling.

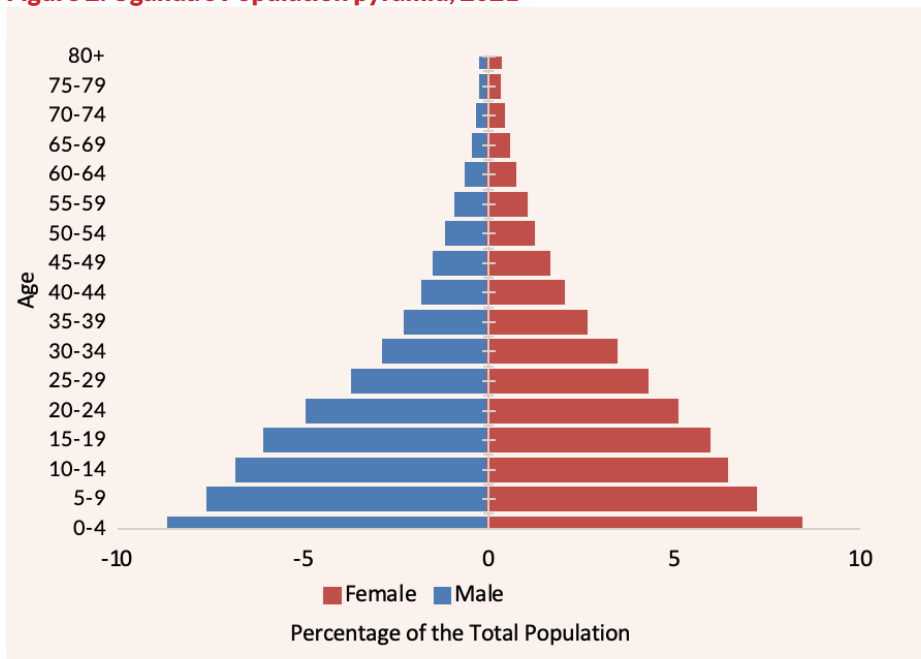
Despite the mixed picture, some of the successful vital interventions that Uganda can learn include;

- Rwanda has had a consistent increase in mCPR due to its strong political commitment and sustainable financing through the National Health Insurance in Rwanda, the adaption of a multitude of national and international development frameworks to their context, e.g. establishment of a community health insurance scheme, a system of cooperative-financed community health workers (CHWs) in every village, and secured high-level political support.
- Use of PLHIV and advocates to increase demand for FP services¹⁶.

2.3 NATIONAL CONTEXT

Uganda's current estimated population of 42.8 million (2021) is projected to reach 55 million by 2030¹⁷ resulting from a high population growth rate and total fertility rate of 3% and 5.4% respectively. This rapid growth is contributing to a youthful structure where young people under the age of 30 represent 75 percent of the population as illustrated in Figure 2 below.

Figure 2: Uganda's Population pyramid, 2021



Total Estimated Population 42.9M

0-14	44.80%
15-24	21.80%
25-64	31%
65+	2.50%
Growth Rate	3.32%

Unmet need for FP leads to unintended pregnancy:

- High unintended pregnancies at 44%
 - high levels of unplanned births,
 - unsafe abortion,
 - maternal injury and death.
- Women give birth to two children more than they want.
- Unmet need for limiting is 28.4%

Despite the decline in maternal mortality ratio (MMR), the current ratio of 336 deaths per 100,000 live births in 2016¹⁸ is still unacceptably high. Fertility indicators have improved over time, with the mCPR for married women increasing from 27.1% in 2012 to 38.7% in 2020¹⁹ and 21.3% to 30.4%²⁰ for all women. The most significant increase in mCPR was for married women/in a union. There was a reduction in the unmet need for FP (MW) from 37.3% to 30.5%, short of the FP-CIP I target of 10%. There has been a gradual increase in demand satisfied over the years, increasing from 42.2% in 2012 to 55.9% in 2020. The low contraception use has resulted in very high-unintended pregnancies (44%), with nearly 2 out of 5 of the last pregnancies wanted later or not wanted at all²¹. Teenage pregnancies have stagnated at 25% since 2006.²²

Despite this increase in mCPR, it has remained below the FP-CIP I projected target of 50% for married women and those in union.²³ Even though the unmet need for FP for married women has reduced from 37.3 % in 2012 to 30.5% in 2020,²⁴ it has remained high and above the 2020 national CIP target of 10%.²⁵ There is a consistent increase in LARC and traditional methods. In the same period, PMA data indicates traditional methods use doubled from 3% to 6%²⁶ while implants increased from 14% in 2015 to 31% in 2020.

In addition, there is a consistent rise of DMPA-SC as a method of injectable, increasing from 5% in 2017 to 18% and impacting DMPA-IM, which decreased from 44% in 2017 to 18% in 2020.²⁷

Despite the increase in mCPR, the country continues to experience high discontinuation rates, with 52% of women on contraception discontinuing for several reasons in 2020. The most common reason for quitting was fear of side effects (15%).²⁸

2.3.1 CONTRACEPTION THROUGH SELF-CARE AND DRUG SHOPS IN UGANDA

Uganda is in the process of identifying relevant tools, interventions, and approaches recommended by WHO and developing its own set of National Self-Care Guidelines, expected to cover FP and therefore providing an opportunity for inclusion of self-care in this FP-CIP II. Nonetheless, evidence shows that self-care is already being implemented in Uganda. In 2016, there was commitment to scale up DMPA-SC using Village Health Teams (VHTs), with DMPA-SC uptake increasing from 5% in 2017 to 18% in 2020. In 2017, DMPA-SC was registered for home use and self-injection, while a socially-marketed brand of DMPA-SC was introduced in 2017 for distribution through the private sector. By June 2017, DMPA-SC was being administered by VHTs and public-sector midwives in 28 out of 112 districts and self-injection pilots were underway (PMA, 2020). However, the goal of including drug shops as providers of an expanded FP method mix, is currently faced with the challenge of National Drug Authority (NDA) and MoH having declassified the contraceptive injection DMPA or Depo Provera® and/or Sayana® Press and emergency contraceptives. In the instance of over-the-counter contraception, another category of self-care, 29% of university students were found to have accessed emergency contraceptive pills over-the-counter from pharmacies.²⁹

Multitudes of clients buy male condoms, oral contraceptive pills and emergency contraceptive pills over-the-counter in pharmacies and drug shops.

2.4 KEY CHALLENGES

Although FP is one of the core interventions to address maternal mortality and prioritised in the national policies and strategic frameworks, it experiences various challenges, as described below.

Poor uptake of contraception by sexually active adolescents (10-19 years).

Adolescents comprise 30% of the national population. Slightly more than half of the women have had their first sex by 18 years in Uganda. The percentage of women aged 15-19 years who have begun childbearing by sub-region range from the lowest at 15.5% (in Kigezi) to the highest at 31.4% (in Teso)³¹. Child-bearing is a common issue among different sub-regions including 30.3% North Buganda, 30.3% Tooro, 29.5% Bukedi, 29% Bunyoro and 28.2% Bugisu. In Uganda, the practice of child marriage affects over 60% of the young girls, of which 15% are married by the age of 15 years and 49% by the age of 18 years.³²

Studies show that 11% of girls aged 15-17 years have given birth and further leaps to 47% for those aged 18-19 years and 78% for 20-24 years (as shown in Figure 3).³³ Teenage pregnancy and childbearing, as a result, contribute to the high maternal mortality ratio, with about one-third of all the maternal deaths that occur among young people aged 10 – 24 years. The breakdown is 11% being adolescents aged 10 – 19 years, and 25% being youth aged 20 – 24 years.³⁴ Adolescent girls have a 35% to 55% higher risk of delivering a pre-term or low-birth-weight infant than mothers older than 19 years, and the infant mortality rate is 60% higher amongst newborns of child mothers.³⁵

In Uganda, the practice of child marriage affects over 60% of the young girls of which 15% are married by age of 15 and 49% by the age of 18 years.

Figure 3: Child bearing trends among youth in Uganda

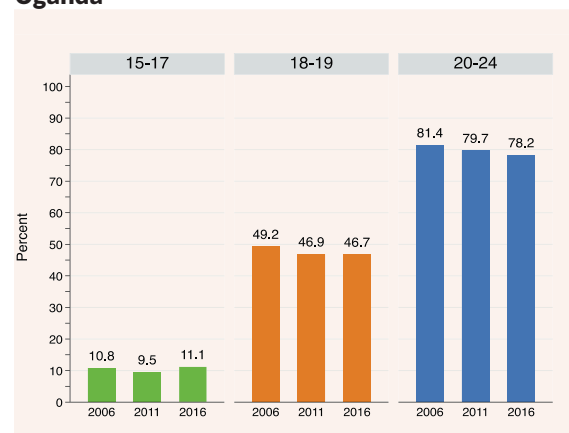
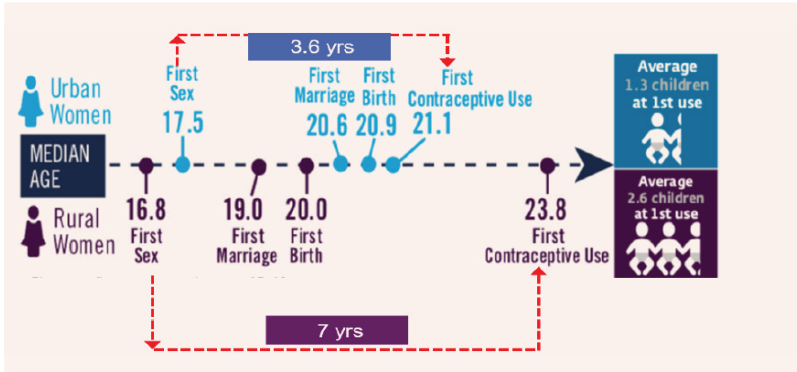


Figure 4 describes the differences between urban and rural youth regarding early sexual debut, teenage pregnancies and early marriages. This is attributed to adolescents' lack of desire to avoid, delay, space, or limit childbearing; the lack of willingness to use contraception; and the lack of confidence and ability to seek/negotiate contraception use, poor access to contraceptive services and quality respectful service provision.³⁶

Figure 4: Median Age at Sexual debut, First sex and Contraceptive Use

Source: PMA2018/Uganda R6

Post-abortion FP, a missed opportunity

Return to ovulation after abortion and therefore, the ability to conceive takes a minimum of two weeks but, on average, three weeks.³⁷ Post-abortion FP at the service delivery point for abortion was identified by a technical advisory group of international experts as a HIP.³⁸ In Uganda, only 16% of women who gave birth in facilities and 28% with a miscarriage or abortion were counselled on FP before discharge.³⁹ Between January and September 2020, 14,909 post-abortion women received FP services.⁴⁰ This is only a proportion of all the post-abortion clients served in the public sector. In a study conducted in Ethiopia, the prevalence of repeat-induced abortion was found to be 20.3%,⁴¹ increasing the risk of maternal mortality.

FP integration into HIV services, a missed opportunity

Family Planning is documented to contribute up to a 30% decrease in MTCT of HIV but is not well integrated to optimise outcomes with individuals. The current national use of FP methods was estimated at 24%⁴² for people living with HIV. A study done in 2017 revealed that the total unmet need for modern methods of FP was 27.8% and use among women living with HIV was 32% (above the national average of 28% among married women),⁴³ with 24.5% for limiting and 7.5% for spacing. Even though FP is documented to contribute up to a 30% decrease in MTCT of HIV, gaps in the provision of FP services for people living with HIV has remained low due to the parallel nature of provision of the two services⁴⁴ and because HIV/SRH integration at service delivery points is still weak without adequate operational guidance.⁴⁵

“If the woman we treat for post-abortion complications is there because she could not get contraception, we have failed her. If she leaves without family planning, we have failed her twice.”

- Verme, 1994

Poor quality of FP services

The Method Information Index Plus (MII+) measures the quality of FP services and counselling. Only 2 in 5 current FP users reported receiving comprehensive information on contraceptive methods.

Adolescent girls are least likely to have received FP comprehensive information from the community health worker/Village Health team, with 18% of 15–19 year-olds receiving information and increasing to 34% among 20–24 year-olds. A high percentage of women (58%) said no to any of the four MII+ questions, with 40% having not been told about the side effects, 14% not informed about what to do when side effects occur, 35% not told about the availability of method options and 34% not described the possibility of switching. A poor MII+ is an indicator of poor-quality FP services and information. Nearly half of all women exiting health facilities were not effectively counselled of the FP methods received.⁴⁶

Limited desire to space among young girls

Evidence shows that a more significant percentage (26%) of younger women (15–24 years) wanted another child within two years compared to older women (16%) aged 25–34 years within the same period. Middle-aged women in Uganda tend to use the FP methods in higher proportions than younger and older ones.⁴⁷

Increasing FP inequities. There exist inequities to access to FP that continue to negatively impact FP uptake among vulnerable groups. The use of modern methods varies significantly according to women's social and economic status. Unmet need for FP is higher among married women with “no education” (31.1%) relative to those with “a higher than secondary education” (26%); and similarly higher among women in the “lowest wealth quintile” (37.3%) in comparison to women in the “highest wealth quintile” (21.5%).

Nearly nine of ten women (86%) report at least one problem accessing health care; lack of money for treatment ranks first, and distance to the health facility was the second most mentioned problem.⁴⁹ Women's attitudes toward family planning are influenced by experiences such as education and prior pregnancy/childbearing. It was found that women with a primary school or higher education had 1–3 pregnancies and did not want more children in the future. As the level of education increases, the number of children required decreases. The reason for this can be explained by the opportunity to learn about family planning and raise awareness about the issue as women's education levels increase. Improving women's access to education and encouraging continuous and constant exposure would significantly increase the use of family planning and reduce unmet need.⁵⁰ Karamoja sub-region has a very low mCPR of 5.7%,⁵¹ attributable to unique service accessibility challenges arising from geospatial factors (e.g. homesteads located in mountainous areas, flooding, poor transport system, wide apart homesteads), with additional challenges specific to service providers in the form of hard to stay and hard to retain.⁵²

HIGH IMPACT PRACTICE

Lessons learned: Maternal Voucher Scheme on PFP in South Western and Eastern Uganda demonstrated increased uptake of FP methods by 21% and among adolescents by 31%.

Missed Opportunities for FP in Uganda

- Integrating FP services into other RMNCAH services including HIV/AIDS, Cervical cancer, Youth responsive services.
- Counselling and provision of FP services to patient attendants.
- Counselling and FP services provision at workplaces, tertiary and vocational institutions.

Gender dynamics. Among women using modern contraception, 20% report that their partner does not know that they are using contraception, discussion of fertility decisions among couples is still sub-optimal, and 15% of current users said that the decision to use contraception was by the partner or someone else.⁵³ In Uganda, some women who have decided to take up FP clandestinely, against the wish of their spouses, have suffered gender-based violence⁵⁴, which is sometimes extended to the service provider.⁵⁵ In the past three years, public facilities in Uganda have attended to 253,927 cases of abortion, out of which 6,431 (3%) occurred among women that had conceived following gender-based violence.⁵⁶

Limited male engagement and support. The MOH launched the Uganda Male Involvement Strategy in 2014, which was disseminated to some districts with limited resources for its implementation. Most of the interventions revolve around women, and there has been low male engagement and, generally, a lack of support for FP.⁵⁸ The limited male engagement has continued to impede the utilisation of FP services by women.⁵⁷ FP is considered an issue for women, however, some men still want to be consulted or given directions on the use or non-use of FP. Men have misconceptions about the use of FP, thereby hampering FP uptake, and on many occasions, there have been incidences of related domestic violence.⁵⁹ Only 5.6% of couples are using male-dependent contraceptive methods.

Why men are not engaged:

- Limited funding for the Male Involvement Strategy.
- Lack of provider skills to engage males.
- Poor dissemination of guidelines.
- FP Program design is focused on women.

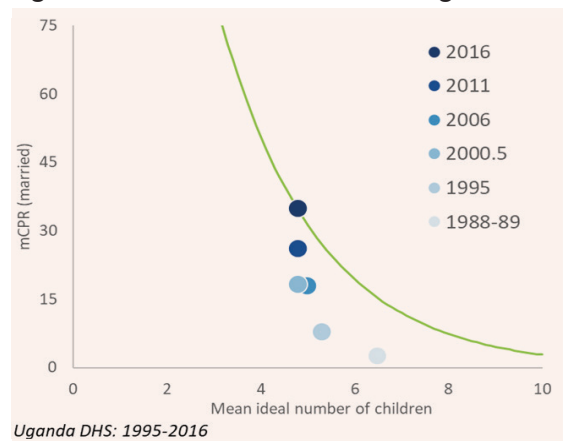
Other barriers to male engagement included the perception that FP is a woman's activity and was not their custom to participate in the FP programme.⁶⁰

Women empowerment. As part of SRHR, men, women and couples have a right to determine their family size using an FP method. This can only be ensured by equipping and allowing women to make informed decisions. Engaging in economic activities and delaying childbearing and marriage are likely to significantly impact adolescent girls' life trajectories. Furthermore, this will improve marriage quality, increase household decision-making and reduce exposure to domestic violence.⁶¹ A study done in five countries, including Uganda, found a strong association between the overall score of women's empowerment and contraceptive use. When women's and community's characteristics are controlled, the dimensions that emerge include household economic decision-making, fertility preferences, and sexual activity negotiation.

The study found that different strategies were needed if programs want to increase contraceptive use, including those that address economic independence, women's ability to negotiate sexual activity and improve couple communications on fertility preferences and use.⁶² In yet another Uganda study, child marriage or early childbearing were found to be statistically significant in relation to fertility, population growth, intimate partner violence and women's earnings.⁶³ Therefore, ending child marriage, preventing early childbearing and improving education opportunities for girls is not only the right thing to do from a moral and ethical standpoint; it is also a smart investment for Uganda's development.⁶⁴ Additionally, self-care interventions and approaches can promote autonomy, urgency and empowerment.

Nascent FP total market. The private sector plays an essential role in delivering FP methods. In Uganda, the sources of women's FP methods/supplies are either public (55%) or private (45%) facilities.⁶⁵ Female sterilisations and implants are performed mainly in the public sector (79% and 85%, respectively). Injections are primarily sourced in the private sector; 60% compared to 39% from the public sector. And pills and condoms are equally from public and private sectors (46% private compared to 52% public for pills and 46% private compared to 45% public for male condoms).⁶⁶ Most (70%) women in the poorest and (50%) poorer quintiles obtain their FP methods for free at a public facility, while most (67%) of the wealthiest women rely on the private sector. Yet a large percentage of the poorest (27%) and more impoverished women (45%) still get their FP method from a private facility, primarily because of the constant stock-outs in public facilities.⁶⁷ Even though FP services in the private sector are not free, women from all quintiles continue to access FP in the private sector⁶⁸.

Figure 5: Trend in demand curve for Uganda



Private health providers have no standardised service pricing guidelines, are sub-optimally regulated, receive minimal support from the public sector, and have no guiding market analysis to select bankable health sector investments. The Total Market Approach has been tested in Uganda

extensively and showed an increase in the uptake of LARCs, specifically IUDs. For instance, TMA-specific activities increased national IUD-specific CPR from 2% to 5%⁶⁹ between 2013 and 2015. In Mali, Uganda and Kenya, it was also found that TMA provided an essential platform for strengthening coordination and stewardship by the Ministry of Health, leading to the higher contribution of the private sector and complementing the public sector.⁷⁰ The TMA strategy has been developed through multi-stakeholder engagement for improving access to FP services and commodities. Its implementation commenced initially with a focus on condoms as an FP commodity and is expected to expand and cover other commodities and service delivery components. TMA provides an excellent opportunity for rapidly increasing access to a family planning method with deficient coverage and regulating the commercial private sector FP commodities and services.

Social cultural barriers to FP.

Since the UDHS 2001, Uganda's mean ideal family size has not changed from around 4.8 children per woman despite an increasing mCPR. The desire for large family sizes has been propagated by cultural practices such as polygamy, bride price, high child mortality rates, security in having many children, and sex preference, among others.^{71,72}

Based on the demand curve (Figure 5), which allows countries to assess the maximum mCPR growth a country can achieve based on ideal family size, Uganda is at the "potential maximum." However, in recent years some African countries have been able to grow their mCPR without changes in fertility desires. For example, Zambia is one of these exceptional cases. Zambia, where women have similar fertility desires to women in Uganda, growth of nearly 10% beyond the potential maximum has been achieved.⁷³ While these countries have been able to grow outside the possible maximum, they are the exception.

Religious and political groups.

Arising from dialogues of the RMNCAH forum with the religious leaders, the Inter-Religious Council of Uganda (IRCU) endorsed a joint pastoral letter on Responsible Procreation that supports FP from religious perspectives. The FP advocacy messages were incorporated into a booklet, with a schedule to disseminate the booklet and transmit messages to audiences during different seasons of the calendar year.⁷⁴ Political statements linking increased population with development are also cited in some districts. Some politicians encourage high fertility at the district level by telling their constituents that a high population will lead to more resource allocation and development. In contrast, others do so for the sake of earning more votes.⁷⁵ Politicians would even give incentives to women to entice them to have more children.⁷⁶ Continued engagement of religious, political, and traditional leaders is therefore paramount for participation and engagement in the FP-CIP II implementation.

Health systems issues that negatively impact provision FP services

This sub-section refers to the Ministry of Health taking charge of all processes that are key in running the national FP program. These include national stewardship/ownership, policy and strategy development, review processes, resource mobilization and utilization, and monitoring and evaluation.

Poor implementation of a multi-sectoral approach

To render FP a social and economic development issue, the inherent institutional framework of the National FP-CIP I was hinged on having a multi-sectoral approach aimed at bringing on board key health and non-health sectors.⁷⁷ Orientation of the Office of the Prime Minister by the UN agencies on their task of multi-sectoral FP coordination was done. The National Population Council (NPC) subsequently contacted the Office of the Prime Minister to support FP sectoral coordination.

Furthermore, a Family Planning National Coordination Committee was constituted.⁷⁸

The committee registered progress through advocating for inclusion of FP interventions in the sectoral Budget Framework Papers by each of the respective Ministries. However, the multi-sectoral framework faced challenges because FP continued to be considered a health sector priority leading to the FP sectoral interventions remaining an “unfunded priority.” Going forward, other sectors should be engaged in promoting social and gender normative change to rescue barriers to access (young girls and boys, marginalized populations, etc.)

Extra attention to strengthening national stewardship and ownership.

Regarding national stewardship, GoU has spearheaded and coordinated the various Technical Working Groups through which policy and strategic priority decisions are endorsed with the engagement of the public and private sector stakeholders.⁷⁹ The Government has, in addition, committed resources (financial and human) for the implementation of the FP program as well as providing and improving health infrastructure.⁸⁰ Several interventions are predominantly spearheaded by Implementing Partners but with limited stewardship from MoH. Without GoU committing resources (financial, human and material) and oversight, the interventions cannot be sustainable. In sub-regions, the distribution of IPs is not equitable, resulting in over or under-representation of IPs and IP-supported activities as well as limited information on activities done by some of the IPs. This arises from a failure to coordinate, monitor and enforce the selection of districts by IPs for FP implementation.⁸¹

Capacity building

For a couple of years, a quantifiable in-service training gap was not readily available despite MoH training and support provided by IPs for in-service training. The effect was a duplication in training, with many service providers undergoing the same activity within a short time period and not

creating opportunities for others to be trained.⁸² In this regard, an Integrated Human Resource Information System (iHRIS) was developed and introduced for managing and updating the national inventory on human resource in-service training for FP, including determining in-service training needs and planning for future training. Table 2 below reflects the number of health workers who had in-service training in the FP service area, as captured in the iHRIS by May 2020.

Table 2: In-service health workers trained on Family Planning

Focus	FP	Short term		Long-term			Permanent	PPFP	ADH & YFS	SRH & Rights	FP Education;- Client Referral
		Short term	Sayana Press	Long-term	Implanon NXT	Counselling for IUD					
Numbers	418	139	750	37	708	30	19	122	53	2	319
	27 TOT			251 On-site	251 on-site						
				200 TOT							
Total	445	889			1,477		19	122	53	2	319

Source: iHRIS database, May 2020

More training has been conducted beyond what is reflected in the database, and reasons for the gap include a lack of designated individual(s) at some IPs to support uploads into iHRIS; the upload is also poor.⁸³ Other openings in the capacity building include the public sector lacking a pool of trainers on the FP innovations and different FP approaches; FP trainers are usually obtained from the private sector. Capacity building is, therefore, another area in which stewardship by the public sector has challenges.

Service delivery. Conducting FP integrated outreaches at both public sector health facilities and in the community is heavily supported by IPs (technically and financially). The schedule for follow-up consultation by FP clients who have taken up LARCs is heavily dependent on the set outreach schedule; these outreaches are typically conducted three months apart at a particular health facility, thereby indirectly affecting the acceptability of the methods and uptake of the services.⁸⁴

Service delivery gaps:

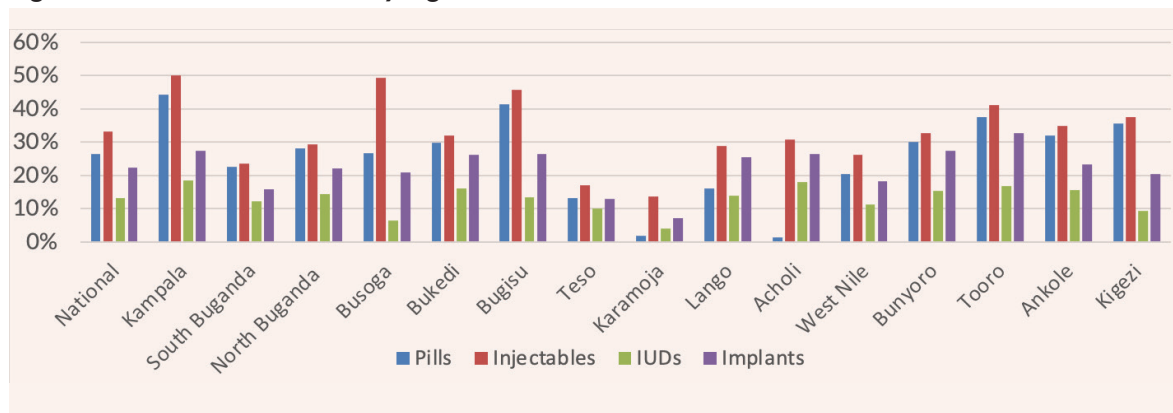
- Shortages of equipment and supplies
- Low staffing
- Poor provider skills and knowledge
- Work overload
- Absence of SOPs and job aides
- Continuity of care
- Attrition of Health workers and absenteeism
- Weak coordination of partner outreach services to exploit synergies between public and private sector

Pharmacies and drug shops remain an important service delivery point, and a channel that can be opened up with policy change and adequate trainings.

Access to methods: Across different levels of health facilities, women have varying access to other forms of FP. Nationally and sub-nationally, in most regions, women have the least access to IUDs followed by implants.

Injectables are the most common FP method in Uganda with a higher proportion of accessibility (though it is still below 50% in all regions). (Figure 6).

Figure 6: Access to FP methods by region



Source: HMIS and Uganda Projection Data

Policies, strategies and standards.

The Adolescent Health Policy and Service Standards (2012) is being revised to the National Health Policy for Adolescents, 4th Edition.⁸⁵ Uganda developed a draft National Sexual and Reproductive Health and Rights (SRHR) Policy in 2017 that is not yet approved.⁸⁶ The draft SRHR policy noted that the GoU ratified a myriad of human rights instruments, including covenants, treaties, charters and made several commitments under various regional and global initiatives. The draft SRHR policy further re-iterates that “common across most of these instruments, in the context of health, they impose upon the governments an obligation to respect, protect and fulfil reproductive health as a right to health.”⁸⁷ These may indeed be “impositions” given that the draft SRHR and the adolescent health policies were considered “contentious” in the FP-CIP I (2015-2020) review.

The draft SRHR policy details and itemizes numerous national documents (policies, guidelines, standards, etc.) that speak to the issue of teenage pregnancy. A review of the implementation of these federal documents may guide in understanding progress with performance, particularly adolescent access to contraception. Uganda’s fertility and teenage pregnancy rates are higher than other East African countries and some of the highest globally. The draft SRHR policy provides clear guidance on what needs to be done, “there is need to focus efforts on delaying sex debut, providing information and services to sexually active adolescents and youth.”⁸⁸

There is generally poor dissemination and application of FP policies, standards and guidelines at all levels of care. At the service delivery points, there is a general lack of relevant SOPs on the provision of Youth/Adolescent-responsive services in the public and private sectors.

Domestic financing. As committed at the FP2020 London summit in 2012 and subsequently recommitted in 2017, the GoU was to allocate USD 5 million annually from domestic resources for procurement and distribution of a range of FP supplies and RH commodities up to the health facility level. The annual financial allocation shows that this commitment has been met only in FY 2013/14 and 2014/15.⁸⁹ Of note, funds have been used to procure contraceptives and other RH commodities such as MVA kits and mama (safe delivery) kits. In 2017/18, the allocation was for the procurement, storage and distribution of reproductive health commodities (Medroxy progesterone and safe delivery kits). This fell short of the FP2020 commitment of USD 5 million, leaving a funding gap of USD 2,788,833. There is no data on the current level of expenditure on allocated funds.

The financial data shows a higher commitment of donors relative to the GoU on procurement of FP commodities, as shown from the FP/RHCS working group quarterly reports.⁹⁰ This is further emphasized by the FP2020 commitment to raise USD 20 million annually through continued partnership with development agencies and the private sector. As a result, donor-supported, IP-driven and dominated interventions exist for several components of the FP program, such as commodity security, service delivery, especially FP outreaches, behaviour change communication (BCC) interventions, and adolescent health interventions. Looking at lessons learnt from other countries (i.e., India and Rwanda)⁹¹, countries endeavouring to transit from donor to public-funded FP commodity security are demonstrating greater sustainability of the FP program and a growing mCPR. The promotion of transition from complete donor dependency towards domestic financing for national and sub-national levels is therefore very crucial.

Reproductive health commodity security

Availability of RH commodities - and a robust method mix of modern contraceptive methods in particular - is critical to the delivery of effective FP services. National Medical Stores (NMS) supplies RH commodities to health facilities and MDAs, including public sector health facilities and uniformed services (prisons, army and police). The Alternative Distribution System, through Joint Medical Stores (JMS), serves PNFPs and NGOs. Commodities are procured primarily through funding from GoU, USAID, UNFPA, and Uganda Reproductive Maternal Child Health Improvement Project (URMCHIP), among others, and delivered to the respective warehouses for distribution. Where there is a supply shortage in either warehouse, inter-warehouse transfers allow the stock to move from NMS to JMS and vice versa.

The country has registered overall improvement in the performance of the supply chain, forecasting, financing and procurement of commodities, as well as advocacy for commodity security with GoU and development partners. A three-year rolling forecast and supply plan has ensured coordinated procurement and supply of commodities from various sources. Strides have also been made to address capacity gaps at the service delivery points to ensure that health workers can quantify, order, and handle inventory management and record-keeping for FP commodities.

The method mix for contraceptives was also expanded, and new formulations were added, including the radiopaque Implanon NXT (Etonogestrel 68mg implant) and DMPA-SC. As a result, the stock out of FP commodities declined from an average of approximately 40% in 2018 to about 24.9% in 2020.⁹²

Despite the above milestones, there are three major challenges that have persisted and continue to disrupt supply of contraceptives at the last mile level.

Firstly, is a lack of data visibility and analytics of contraceptive consumption and stock balances at the service delivery point (SDP), due to the logistics management information system (LMIS) only tracking a set of tracer commodities. Whereas there is provision for reporting on the consumption of the different methods in the HMIS 105, the reporting rate has been poor, and the data quality is insufficient to support accountability and planning/ordering for FP commodities at that level.

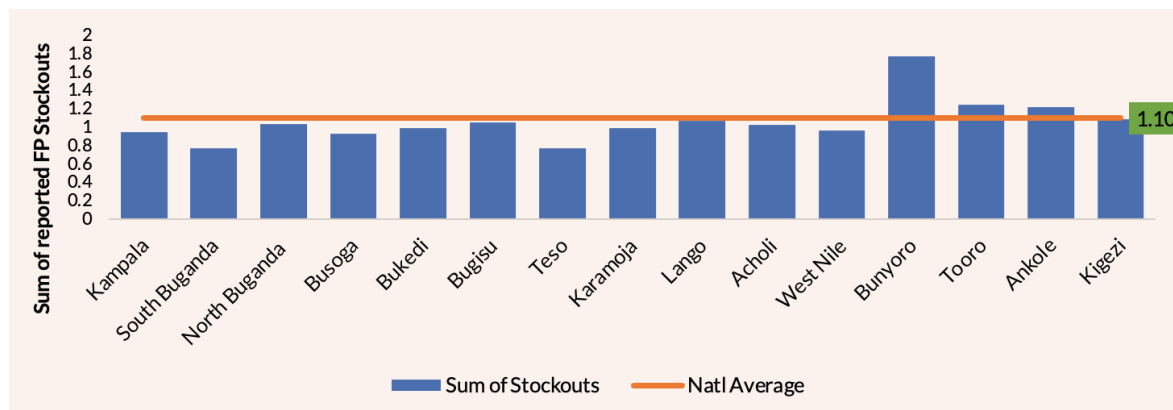
Secondly, poor stock management practices and overall accountability for FP commodities remain a challenge. The above have made it difficult to match supply to demand, including addressing inequities in the distribution of the commodities. Ensuring a steady supply of contraceptives for community health workers and outreach mechanisms in particular, has not been achieved.

Thirdly, the reliance on the kit system to supply commodities at HC IIs and HC IIIs that account for 50-70% of the consumption of most methods has led to regular reports of concurrent over and under-stocking at the SDPs due to mismatch to the client load. In some instances, commodities are delivered to facilities that lack the capacity or trained staff to administer them to clients. There has also been an inadequate focus on non-contraceptive commodities, including pregnancy kits, implant removal kits, and FP-related consumables like local anaesthetics, among others, required for some methods to be administered.

Reproductive Health Commodity Security in the Private Sector (social-marketing, cost recovery and profit recovery) is critical for increasing access to FP services. Progress made under FP-CIP I on social marketing of highly subsidised products and for the commercial sector to increase their demand, brand-free condoms (Hot Pink) are provided through the Alternative Distribution System (ADS) under Joint Medical Stores (JMS) and NMS to public health facilities. Still, there is very minimal evidence that the pilot study described in the FP-CIP I was ever conducted. Despite this, there is wide usage and distribution of free-branded condoms across the county—condom dispensers in hotels and other public places supported by IPs supplement this effort. Unfortunately, the ADS has been affected by the scale-back of social marketing support. The Ministry of Health instituted the “One Facility, One Warehouse” guidelines to rationalize the flow of commodities. However, stakeholder sensitization has remained low, leading to limited effective implementation. Additionally, there have been sub-national level transfers of stock from the ADS to the government facilities that have systematically weakened the ordering from these facilities to NMS.

Contraceptive stockouts: Using data from the SDP survey conducted by UNFPA 2020, it was established that Uganda experienced high stockouts (24.9%) of FP commodities. On average, at the national level, all facilities were stocked with one of the following methods: implants, male condoms, IUDs, injectables, and pills. See Figure 7 below.

Figure 7: Sum of contraceptive stock outs by method



Monitoring and evaluation. The FP-CIP I performance-monitoring plan was supposed to identify and address bottlenecks to be implemented. Altogether the FP-CIP I had over 35 strategic outcomes, some of which were not monitored because they were project-focused.⁹³

FP implementing partners. The FP program has attracted many IPs supporting or involved in the implementation in the various sub-regions in the country. The geographical distribution or allocation of IPs is inconsistent with the principle of equitable allocation to provide service where the need is most required. To this effect, a resolution was made during the 2020 RMNCAH Assembly to rationalize IP support and its coverage in the sub-regions. Through mapping, eight regions were created for coordinating partner activities for better FP IPs programming in the districts, requiring identification of at least one IP representative by region responsible for partner activity coordination. This resolution has also contributed to the new technical strategies in the ADS requiring coordination of procurement plans within the districts to improve the supply chain.

Advocacy and accountability platforms. Advocacy is an integral part of FP programming. This role in Uganda has been dominated by CSOs, religious and cultural leaders, some political leaders, and the Parliamentary forum (such as the Committee on Health, Women members of Parliament). The Ministry of Health approved the National FP Advocacy Strategy (2020-2025) to address FP advocacy challenges. The Parliamentary forums and CSO coalitions and networks have played a key role in influencing policy and budget allocation for SRH/FP.

Notable examples include lobbying for a health budget increase of approximately USD 20 million, part of which went into the recruitment of over 6,000 health workers and enhancement of salaries and allowances of doctors working at community level health centres, doubling the budget allocation for FP and RH commodities from USD 2.3 million to USD 4.2 million in FY 2018/19. The CSO coalitions have further played a role in re-tabling the draft SRHR policy and national health policy for adolescents.

The Inter-Religious Council of Uganda (IRCU) developed pastoral letters that compel all denominations to promote FP with harmonized messaging.⁹⁴ Further, IRCU developed and endorsed six-issue papers on maternal health, small family size, Adolescent Health, HIV Prevention, GBV and FGM. However, there are still pockets of religious and cultural leaders that oppose the use of family planning in the different parts of the country. Additionally, some religious-based PNFP health facilities are in support of provision of natural methods of family planning.⁹⁵ Furthermore, the RMNCAH forum had dialogue with the religious leaders resulting in their commitment to implement and monitor the progress of selected FP activities. Still, there remains a gap in documenting and reporting experiences, the lessons learnt, and challenges encountered. The Inter-Religious Council assembled a set of packaged messages that are to be transmitted to audiences. The messages were tallied into a booklet and scheduled for different calendar year seasons.



Strategic Framework

03

3.1 INTRODUCTION

The FP-CIP I (2015-2020) provided an overarching framework for scaling up access and utilisation of FP services in the country. It focused on leveraging, re-alignment and harnessing government and partner resources that resulted in increased service provision, as evidenced by the improved performance of FP and fertility indicators in the situational analysis (Section 2).

Evaluation of the FP-CIP I and stakeholder consultations revealed the design and programmatic challenges that limited its overall performance. On the design side, there were limited inter-linkages across the six thematic areas, hence the difficulty in assessing the overall impact of the interventions. On the programmatic side, there was inadequate financing; limited targeting of adolescents, young people and first-time parents; limited use of data to drive programming; weaknesses in the multi-sectoral engagement for FP service delivery, as well as uneven sub-regional partner support that contributed to inequitable access to FP information and services. The total market potential is also underutilized, leading to over-reliance on the public sector for the provision of FP services primarily supported by donors and implementing partners.

The FP-CIP II (2020/21-2024/25) addresses the above challenges by focusing on a programmatic rather than a thematic approach through technical strategies. It recognizes the importance of prioritization, domestic resource mobilization and efficient use of available resources to reduce heavy reliance on external financing and the likelihood of an under-funded plan. The above approach will galvanize the stakeholders to perceive FP as a social-economic development issue, focus on regional variations and inequities and reducing the program dependency on the health sector for sustainability. The FP-CIP II (2020/21-2024/25) is explicitly aligned to the NDP III, HSDP goals, and RMNCAH Sharpened Plan.

3.2 STRATEGIC ALIGNMENT TO NATIONAL POLICIES

The FP-CIP II (2020/21-2024/25) strategic framework is aligned with the national FP-related policies, the RMNCAH investment case, and the 2030 sustainable development goal 3 (target 3.7 on universal access to SRH and FP) and the global FP post-2020 framework and builds on lessons learned from the FP-CIP I implementation.

National Population Policy (2020)

The National Population Policy⁹⁶ recognizes the importance of shifting norms on family size to address Uganda's burgeoning population, fueled by its youthful population. The policy seeks to accelerate fertility and mortality decline for a more favourable population age structure and a lower dependency burden. It further recognizes ASRH as one of the critical components of reproductive health. This is particularly important if Uganda addresses the current high childbearing levels, especially for young girls with a high associated burden of sexual and reproductive morbidity and mortality.

Two strategic actions within the National Population Policy that directly relate to FP are; **Increase and expansion of access to FP.** Advocate for increased FP services, including community-based distribution and embrace public-private partnerships to ensure that commodities reach the last user.

Increase demand for FP. Promote the use of FP as a development intervention by targeting various audiences such as rural/urban youth, adolescents in and out of school settings, married youth, men and people living with HIV and persons with disabilities. Specific interventions in changing mindset on use of FP as well as misconceptions on FP side effects and myths.

The policy emphasizes expanding access to quality RMNCAH services and promoting integrated service delivery for mothers and children from pre-pregnancy to delivery and the immediate postnatal period, childhood, and adolescence.

National Development Plan (2020/21 – 2024/25)

Uganda's Third National Development Plan 2020/21 – 2024/25 (NDP III)⁹⁷ seeks to transform the country from a predominantly peasant country to a modern and prosperous one by 2040 to increase household income and improve the quality of life for Ugandans. In addition, the GoU, through Vision 2040 aims at, among other things, raising per capita income from USD 500 in 2013 to USD 9,500 by 2040.⁹⁸

Currently, population growth in Uganda is outstripping growth in vital services, including housing, employment, education and health care. Uganda's population growth rate of 3.0%⁹⁹ adds over 1 million people every year to the population and is straining further the already stretched health care system. The increasing client load requires an expanding infrastructure, health workers, materials, equipment, commodities and other resources. Uganda has a window of opportunity to capture the demographic dividend by ensuring a decline in fertility levels, reducing the youth dependency ratios and expanding the working-age group's size.

A clear linkage between the HSDP and the NDP is affirmed through investing in a health system that guarantees efficient use of available resources; ensures universal access to a primary health care package; supports a solid and viable public-private partnership for health; and an equitable and sustainable financing mechanism. The HSDP notes that healthcare financing needs to be more accountable to the public, particularly regarding inefficiencies and better utilization of public funds and resources.





National Demographic Dividend

The demographic dividend refers to a society's economic benefit when fertility and mortality decline rapidly as the ratio of working-age adults significantly increases relative to young dependents. Uganda has embarked on attaining the demographic dividends through strengthening, Health, Education, Agriculture, Social Development, Water and the Environment.

For the country to succeed, it calls for setting up mechanisms for implementing policies and strategies that allow for a continuous fertility transition (i.e. reduction) along with increased child survival rates and reduced child dependency rates, as well as a decrease in the prevalence of child marriage and early pregnancy. Attainment of the five demographic dividends would improve the existing linkages between the national development goals, the 2030 SDGs and the country's demographic transition.¹⁰⁰ This FP-CIP is therefore, a cornerstone in this endeavour.

Uganda Health Sector Development Plan (2015/16 - 2019/20)

The Uganda health sector development plan (HSDP)¹⁰¹ seeks to ensure the provision of equitable, safe and sustainable health services; increase financial risk protection of households against impoverishment due to health expenditures; address the key determinants of health through strengthening intersectoral collaboration and partnerships, and enhance health sector competitiveness in the region and globally.

The HSDP indicates that FP services provision is considered to be improving, albeit too slowly to achieve country targets. This recognition may give impetus to addressing the next generation of targets.

The RMNCAH-N Sharpened Plan (2016/17-2019/20)

The Sharpened Plan¹⁰² considered all critical RMNCAH-N interventions, equity (including age, location, education, etc.) and systems barriers (using bottleneck analysis). The bottleneck analysis identified significant barriers within all health-systems building blocks, but the most pressing was perceived as human resources, health financing and health service delivery. Weaknesses in health financing include:

- Under-resourcing with a heavy reliance on donor funding.
- High out-of-pocket (OOP) expenditures, estimated at 70% and 63% for reproductive health and child health services, respectively.
- Gross inequities in distribution based upon facility, not population need.¹⁰³

The plan further acknowledged that there has been 'abundant' innovation, not scaled beyond demonstrations, with **'systemic limitations in commissioning, design and implementation.'**¹⁰⁴

The underlying factors include a weak RMNCAH M&E system, national knowledge management and learning framework to guide priority areas and scale-up mechanisms in the RMNCAH.¹⁰⁵ There were recognized challenges of fragmentation around RMNCAH in Uganda. Too often, partners use their criteria to select their own set of districts and selectively implement some elements of the package using one or a few service delivery mechanisms. **As noted, the Sharpened Plan will only succeed if partners participate and engage in its implementation. This is also the case for the FP-CIP II.** The Sharpened Plan includes five strategic shifts shown below:

- Emphasizing evidence-based, high-impact solutions
- Increasing access for high-burden populations
- Geographical focusing/sequencing
- Address the broader multi-sectoral context
- Ensuring mutual accountability for RMNCAH outcomes;

The FP-CIP II (2020/21-2024/25) has been aligned with the above strategic shifts. During the alignment, FP high-impact interventions were presented separately from the five strategic pathways and referred to as **'interventions to sustain impact.'** Modern Contraceptive Prevalence Rate was included as an outcome indicator. At the same time, a reduction in teenage pregnancy target of 15% (2020) was placed at the impact level.¹⁰⁶

While the strategic shifts provide a helpful framework, FP integration can be strengthened. They have been summarised below and may be updated based on the review and revision of the Sharpened plan (which is underway).

Evidence-based, high-impact solutions. Focus on a priority intervention package that addresses the “continuum of health care” that extends through adolescence, pregnancy, childbirth and childhood. Plan to accelerate coverage and quality of selected high-impact interventions and reduce disparity within the scope of interventions along the continuum of care.

Increasing access for high-burden populations. The Sharpened plan noted that Uganda is rich in innovations addressing the widespread challenges of delivering quality services. Still, many of these have remained at a small scale or pilot level as different actors focus on other components of the continuum of care and in other regions of the country. A set of approaches and mechanisms to improve service delivery were included:

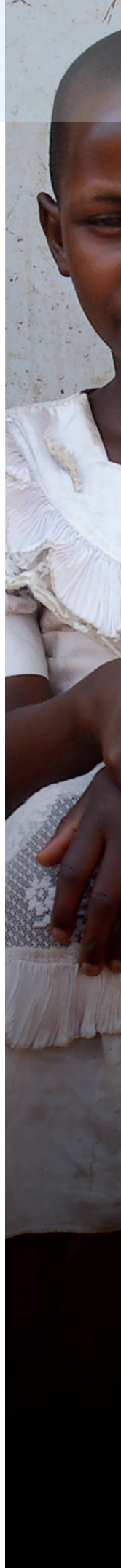
- Strengthen district management for improved RMNCAH outcomes
- Scale-up community-based service delivery
- Develop capacity through skills hubs
- Scale-up results-based financing for facilities

- Scale-up vouchers
- Strengthen demand for RMNCAH services.

Based on FP stakeholder ranking and prioritisation, some of the above approaches and mechanisms have been included within the FP-CIP II (2020/21-2024/25). Other critical cross-cutting issues in the health sector have also been prioritised – human resources, quality of care, supply chain management, and demand generation.

Multi-sectoral action. The high RMNCAH burden is rooted in inequalities within the social determinants of RMNCAH over the life course of women. Therefore, multi-sectoral action is needed to tackle the drivers of disparities contributing to preventable deaths in the country. Nowhere is a multi-sectoral response more important than around adolescent health and well-being. The sharing and use of compelling data to make a case for RMNCAH health are critical in gaining support and advocacy across other sectors within the national multi-sectoral coordination mechanism.

Ensuring mutual accountability. There is a need for an effective, sound public system that is responsive to people’s needs, supports information sharing, and permits scrutiny so that citizens can see exactly where their resources are spent. Annual RMNCAH Assemblies will serve as the leading platform for accountability at national and regional/district levels. This will be complemented by strengthening critical systems for producing the data at the heart of responsibility: civil registration and vital statistics, maternal and perinatal deaths surveillance and review (MPDSR), routine monitoring and feedback systems, and the ability of the country to track resources.





Family Planning Costed Implemen- tation Plan

04

4.1 VISION

Improved quality of life of Ugandans by enhancing their productivity.

4.2 PROGRAMMATIC GOALS

Two programmatic mCPR goals are provided under an ambitious scenario.

Ambitious Goals

1. Increase national mCPR from 30.4% in 2020 to 39.6% (All Women) by 2025 through improving access to sexual and reproductive health and rights information and services.
2. Increase national mCPR from 38.7% in 2020 to 46.6% (married women or women in union) by 2025 through improving access to sexual and reproductive health and rights information and services.
3. Reduce the unmet need to 15% with the ultimate goal of achieving below 10% by 2025.

4.3 RATIONALE FOR ALL WOMEN GOAL

Regardless of marital status, all women should be able to choose from a full range of high-quality FP methods. Having an all-women goal reflects a rights-based approach to FP, bringing attention to the FP needs of all women of reproductive age, not just married women.

Furthermore, the global partnership, FP2020, is transitioning to FP2030 this year. The future of this partnership envisions: “Voluntary modern contraceptive use by everyone who wants it, achieved through individuals’ informed choice and agency, responsive and sustainable systems providing a range of contraceptives, and a supportive policy environment.”

4.4 TARGETS

This FP-CIP II (2020/21 – 2024/25) is aligned to the national targets as follows;

Table 3: Uganda’s national FP Targets

INDICATOR	Baseline (UDHS 2020)	Uganda Targets		
		HSDP II (2015/16 – 2019/2020)	NDP III 2020/21- 2024/25	VISION 2040
Population Growth Rate (%)	3.3		2.5	2
Total Fertility Rate	5.4	4.5	4.4	3.0
Adolescent Birth Rate (per 1000 women)	132	128		
Teenage Pregnancy Rate	25%	14%		
mCPR – married women	38.7%	50%		

4.5 TECHNICAL STRATEGIES

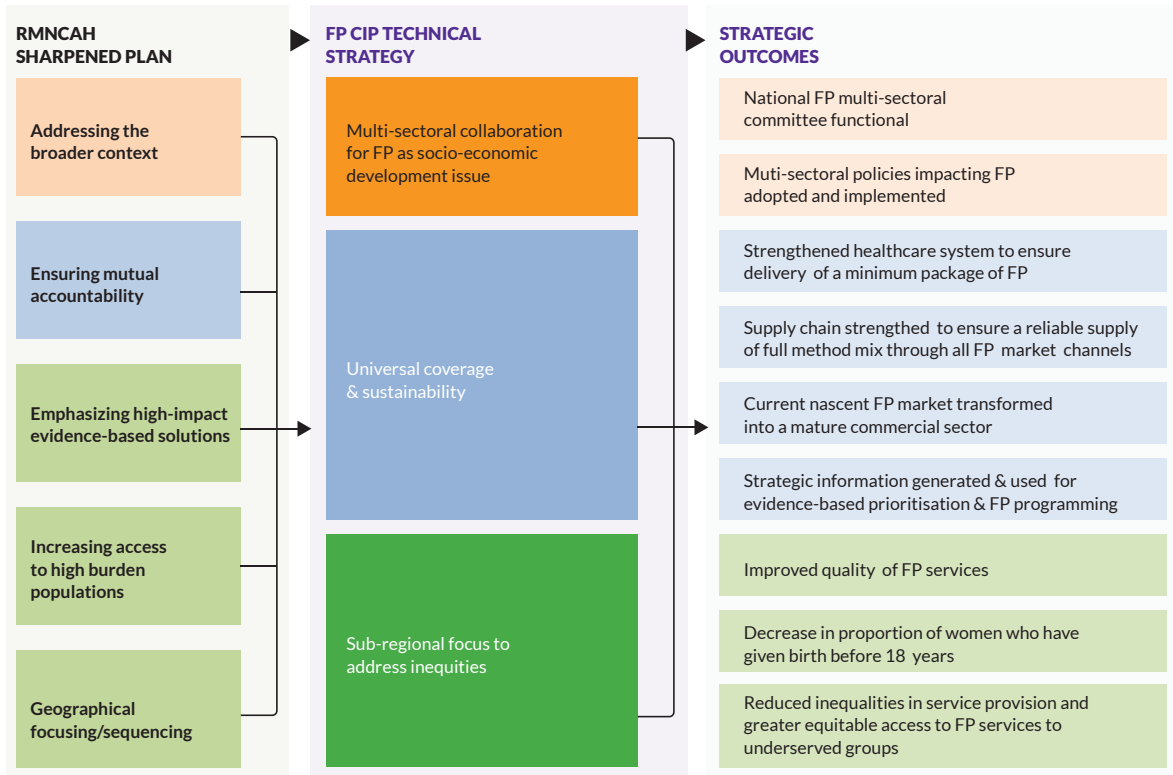
This FP-CIP II (2020/21 – 2024/25) will be implemented through 3 technical strategies shown in Figure 8 below;

Technical Strategy One: Shift from health sector dependent to multi-sectoral collaboration for socio-economic development.

Technical Strategy Two: Shift from predominantly public to a Total Market Approach for universal health coverage and sustainability.

Technical Strategy Three: Shift from nationally driven to sub-regional focus to address inequities.

Figure 8: FP-CIP II Technical Strategies and Outcomes aligned to those of the RMNCAH Sharpened Plan



Technical Strategy 1: Multi-sectoral Collaboration for Socio-Economic Development

The health sector has played a vital role in increasing mCPR. The FP-CIP I (2015-2020) placed the health sector as the primary driver to achieve the FP targets, with little emphasis on ownership by non-health sector players. Interventions in the health sector remain fundamental to achieving success in FP programming. The FP-CIP II will support the implementation of lessons learned and best practices, scaling up high-impact FP interventions/practices.

However, there have been slow gains due to underlying bottlenecks beyond the health sector. These issues include the high teenage pregnancy rate associated with an early sexual debut, high school dropout rates, early and child marriages, and low socio-economic status that hinders healthy choices. Gender power relations also affect the uptake of FP. This combination of factors has resulted in high fertility, negatively impacted service delivery in health, education, and agricultural sectors, and contributed to reduced employment opportunities, environmental degradation, and increased rural-urban migration. Furthermore, the extent of these effects differs from one region to another.

There are mutual benefits to different sectors investing in FP. For instance, improved utilization of FP will keep girls in school longer, reduce dropout rates and ultimately improve employment and economic well-being. Addressing gender imbalances, poverty, and socio-cultural norms will improve FP uptake, resulting in more manageable family sizes and better access to social services. Family Planning is a socio-economic development issue, and messaging should also link with its impact on other sectors. Studies have demonstrated that investing in FP is a development “best buy”. Analysis has shown that meeting the contraceptive needs of all women in developing countries more than pays for itself; for every single dollar spent on contraceptives, four dollars are saved.¹⁰⁷

The FP-CIP I recognized the importance of multi-sectoral coordination as one of the priority issues for increasing access to FP. However, positioning this priority as an institutional arrangement in the plan meant that it was neither budgeted for nor monitored during implementation, thereby not taking root. Despite establishing a national steering committee comprising MoLG, MoES, MoFPED, MoGLSD, MoWE, NDA, NPA, NPC, UBOS and UHRC, with clear terms of reference and sectors developing budgeted work plans, the FP sectoral interventions remained “unfunded priorities”. The multi-sectoral district structures experienced the same challenges.

PRIORITY AREAS

Family planning is viewed as a health sector rather than a socio-development issue with lack of ownership of FP by non-health sectors.

The importance of shifting from a health sector dependent FP programming to a multi-sectoral focus is that the non-health sectors can more effectively reach the target population that require FP services, more especially those facing inequities.

This technical strategy therefore calls for putting emphasis on provision of FP information and services beyond the health facilities.

The FP-CIP II (2020/21-2024/25) will elevate multi-sectoral collaboration as a cornerstone strategy for FP over the next five years and address ownership in each non-health sector. Implementation arrangements under the multi-sectoral approach are further elaborated under section 7 on an institutional structure. Table 3 outlines the recommended strategic outcomes and interventions under this technical strategy in line with the priority issues.

Technical Strategy 2: Universal Coverage and Sustainability

The Government of Uganda, together with development partners, finances Uganda's FP program. By 2020, 95% of women of reproductive age were projected to be accessing FP services from the public and PNFP sectors. Social marketing of FP services and commodities in Uganda is mainly carried out by Implementing Partners through franchised private clinics (Good Life clinics, Blue Star clinics, Pro-fam network) and SBCC interventions. It has successfully contributed to increased access to FP information, FP service innovations and various brands of FP commodities and devices. It has also contributed to increased uptake of FP services at affordable costs. Social marketing has further been applied in advancing the Total Market Approach for FP.¹⁰⁸ The predominant donor-funded social marketing channel, although high impact, is not sustainable. The current global shift in funding pandemics and natural disasters has put pressure on funding for FP programs. With a GDP per capita of \$777 by 2019, Uganda remains a low-income country with limited domestic revenue to sustain health expenditure. There is a need to increase allocative efficiency for the preventive and curative services within the health sector.

By 2020, more than 1.5 million women of reproductive age in the highest wealth quintiles that are ideally able to pay OOP are accessing contraceptives free from the public sector. This continues to unnecessarily burden spending for FP in the public sector while stifling the development of a vibrant commercial sector.

Historically, donors have tended to reduce funding for FP and encouraged greater dependence on domestic resources and the private sector. For instance, USAID – one of the leading development partners supporting the FP program – has a country graduation policy that transitions countries off US foreign assistance for FP/RH programs, among others, upon attaining mCPR of >51% for married women and TFR below 3.1 children per woman.¹⁰⁹ The FP-CIP II (2020/21-2024/25) targets to prepare the system for self-reliance as the 51% target is likely to be met over the next ten years, hence the need to explore alternative funding mechanisms to increase access and coverage to FP.



PRIORITY AREAS

Weak health systems coupled with inequitable access to FP information and services by special groups.

Uganda's family planning program is jointly financed by Government and development partners.

There is need to transition from donor to nationally funded sustainable program as we draw closer to attaining the >51% mCPR target.

The FP-CIP II (2020/21-2024/25) will therefore strive to institutionalize high-impact interventions/practices in policy and operational implementation; strengthen the private sector to expand access to and reach of the FP program; improve targeting to reach vulnerable groups, including persons that are living with disabilities, commercial sex workers, armed forces and persons affected by humanitarian situations (refugees, internally displaced persons from natural disasters); and overall system strengthening to weather unpredictable events that could disrupt access to FP services as learned from the experience of the COVID-19 pandemic.

Some opportunities for attaining universal coverage and sustainability in FP programming include the TMA, health insurance schemes, results-based financing, increased reliance on locally generated revenue, voucher schemes and self-care initiatives. The FP-CIP II (2020/21-2024/25) also aims to scale best practices, and successful interventions rolled out from the FP-CIP I period.

The FP-CIP II (2020/21-2024/25) will ensure complementarity between strengthening the existing supply chain for FP in the public sector and leveraging the private sector capacities to provide quality FP services. This will reduce the burden on the public sector regarding the need for extra human resources and contraceptive and non-contraceptive commodities. It will also strengthen the functionality of the ADS to increase access through the community-based organizations and providers. Integrated FP programming is handled under Technical Strategy 3.

In line with the priority issues identified above, below are recommended strategic outcomes and interventions under this technical strategy.

Technical Strategy 3: Sub-Regional Focus to Address Inequities

While there has been a general improvement in FP indicators, there have been marked differences in the uptake rate at the sub-regional level and across populations with different socio-demographic characteristics. The FP-CIP I (2015-2020) assumed a homogenous set of bottlenecks affecting FP uptake and recommended a set of centrally developed strategies to address them. However, this one-size-fits-all approach ignored sub-regional geographical disparities in fertility and socio-demographic factors.¹¹⁰

Figure 9 provides additional details on inequities in FP performance. These are focused on supply and demand-side factors at a sub-national level but ultimately attributed to institutional and organizational factors that undermine FP's policy and enabling environment.

Inequities are prevalent across the 15 sub-regions concerning at least one component of FP (namely, access to FP information, access to FP services, acceptability for clients to use FP services, FP quality of care, and demand satisfied).¹¹¹ In Bugisu and Bunyoro, marginalized women (least educated, youngest, poorest, unmarried, ethnic minority, rural residence, religious minority) experience inequity in every FP component. In addition, in six sub-regions, Acholi, Ankole, Bukedi, Busoga, Lango and Teso, - inequities exist in 4 of the five components of FP. In contrast, conditions are the least equitable in Kigezi and West Nile.¹¹² Figure 9 provides a heat map illustrating which FP areas inequities exist by sub-region. Furthermore, while over 65% of women in Uganda are reached with FP information through mass media (TV, radio, newspaper, etc.), there are significant inequities in who receives this information.

The fertility hotspot identification study further confirmed the geographic disparities at a micro-level.

It established inequitable access to FP and recommended adopting geospatial considerations in the FP sector to enable programs to target interventions where they are most needed, improve resource allocation, and introduce cost efficiencies with the potential to maximize outcomes.¹¹³ The hotspot identification study further provides a model for districts to identify and map out these differences.

PRIORITY ISSUES

The existing FP program does not tailor interventions to address sub-regional socio-demographic & geo-spatial contexts. This has led to disparities & inequities in FP uptake across districts.

Underlying determinants of the above inequities can be traced to regional differences in age distribution, marital status, literacy rate, poverty levels, urbanization, and predominant ethnic and religious groups & their practices.

Inequities are prevalent across regions in relation to at least one of five components of family planning: access to information, access to services, acceptability, quality, and demand satisfied.

UDHS and PMA studies show that the fertility rates, teenage pregnancies, are higher in rural and hard to reach areas. Access to family planning services among women in urban areas is mainly from the private sector. Another reason behind the inequity is attributed to the inequitable distribution of the FP Implementing partners some of whom are running fragmented FP projects, while some districts are performing better due to the huge presence of IPs in the districts.



Figure 9: Significant differences in inequity among marginalized groups regarding various aspects of FP program across sub-regions

	Acceptability	Demand Satisfied	Access to Information	Quality	Services
Acholi					
Ankole					
Bugisu					
Bukedi					
Bunyoro					
Busoga					
Kampala					
Karamoja					
Kigezi					
Lango					
North Buganda					
South Buganda					
Teso					
Tooro					
West Nile					

Inequity ($p < .05$) No inequity

The FP-CIP II (2020/21-2024/25) addresses the underlying factors contributing to inequities in FP (access to information, access to services, acceptability, quality, and demand satisfied) and will tailor interventions to address regional disparities. The FP-CIP II will address sub-regional differences through scaling up interventions on integrated FP programming, health insurance schemes targeting especially the poor communities, and context-specific service delivery and sub-regional-responsive SBCC interventions.

Table 4 below shows that the proportion of youth already married is 30%, but a low percentage of them are using contraceptives. There are, in addition, sub-regional disparities in mCPR among married youth, with Karamoja having the most insufficient coverage for mCPR and none of the sub-regions exceeding 40%.

POOR ACCESS TO FP FOR AGYW

The UDHS (2016) shows there is disproportionately poor access to FP among adolescents and young girls between 15-24 years across sub-regions. In age distribution terms, Uganda is a relatively young country; over 40% of the population is young women aged 15-24 years. Among young women in this age group, nearly a third of them are married. However, contraceptive use among married young couples is 28% which is significantly lower than the national average of 37%. At sub-regional level, this varies from 9% in Karamoja to 39% in Kampala.

Table 4: mCPR for married youth aged 15-24 years across regions in Uganda

Regions	% of population aged 15-24 years	% Married among 15-24 years	mCPR for married youth aged 15-24 years
Acholi	46%	39%	26%
Ankole	36%	36%	27%
Bugisu	45%	43%	29%
Bukedi	48%	43%	23%
Bunyoro	46%	43%	26%
Busoga	43%	47%	21%
Kampala	45%	36%	39%
Karamoja	40%	47%	9%
Kigezi	40%	31%	31%
Lango	44%	38%	28%
North Buganda	43%	40%	37%
South Buganda	44%	41%	35%
Teso	48%	49%	25%
Tooro	44%	44%	24%
West Nile	45%	45%	18%
National	44%	31%	28%

Implementing interventions that address the “continuum of health care” and extend through adolescence, pregnancy, childbirth, and childhood is crucial; this will reduce disparity within the coverage of interventions along the continuum of care. Lessons learned from the provision of Postpartum Family Planning Services (PPFP) through Maternal Voucher Scheme in South Western, and Eastern Uganda demonstrated increased uptake of FP methods by 21% and among adolescents by 31%. This CIP will include interventions to promote child spacing by scaling up postpartum family planning (PPFP) through the integration of PPFP counselling into ANC and integrating FP service provision into postnatal care, child vaccination and other health services during the initial 12 months following childbirth.

Awareness creation, and subsidization of services (for example, through a voucher scheme), coupled with capacity building of health workers and equipment of health facilities, can increase the uptake of postpartum family planning services. Integration of FP counselling and services into other SRH services such as HIV/AIDS, adolescent-responsive services, post-abortion care and cervical cancer program will also comprise interventions for improving access. The strategic outcomes and interventions that will address inequity in access to and utilization of family planning services are highlighted under section 6.



FP Goals Modelling

05

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5.1 SELECTED INTERVENTIONS USED IN FP-GOALS MODELLING

Priority FP-specific interventions include those already in the Sharpened Plan as well as those prioritised from the FP-CIP I.¹¹⁴ These include:

- Interventions to increase mCPR (program expansion).
- Increase access to post-pregnancy FP (post-abortion and postpartum).
- Strengthen the supply chain for public and private facilities.
- Address teenage pregnancy and adolescent and youth access to contraception.
- Target FP outreach in underserved sub-regions.
- Expand access to FP through community-based service delivery (pharmacies, CHWs and self-care).
- Expand access to LARCs in the public and private sector.

Interventions to sustain existing levels of FP use (program maintenance)

- Sustain and improve FP access through existing public sector channels (with a specific focus on quality – reducing stockouts).
- Sustain and enhance FP access through existing PNFP channels (outreach, social marketing, social franchising).

Interventions will be operationalised based upon geographic prioritisation applied through the lens of inequity and feasibility. This will allow for “elasticity” based on the sub-regional context; in other words, the level of effort will vary based on sub-regional requirements. Furthermore, interventions draw from “cross-cutting” thematic areas and are not viewed in isolation. This is in recognition that interventions cut across the socio-ecological model and require institutional, organisational, communal, and interpersonal engagement. Thematic areas (based on the FP-CIP I) include service delivery, commodity security, demand creation, policy and an enabling environment, financing, stewardship, coordination, management and accountability.

A sub-set of priority FP interventions has been modelled under the feasible scenario to show impact on mCPR, overall and by sub-region. Table 7 provides baseline data used in the model. It also provides the scale-up by region that must be reached by 2025. As noted in the previous section, not all interventions have been modelled.

Table 5: Baseline data for the FP Goals model

Focus Area	Intervention	Kampala	South Buganda	North Buganda	Busoga	Bukedi	Bugisu
PPFP Integration	Increase % of women coming into the PNC facilities	21%	39%	40%	55%	39%	40%
	Increase % of facilities offering quality PPFP in Immunization	0%	0%	0%	0%	0%	0%
Demand Generation	Increase comprehensive community engagement	0%	0%	0%	0%	0%	0%
	% of women reached by Interpersonal interventions	0%	0%	0%	0%	0%	0%
	Increase FP Mass Media	82%	77%	74%	68%	64%	75%
Youth AYSRH	Multi-Component Youth Programming (Married Youth)	29%	100%	1%	14%	1%	1%
	Multi-Component Youth Programming (Unmarried Youth)	18%	26%	0%	9%	0%	0%
	Multi-Component Programming with Youth Friendly Service (Married Youth)	3%	0%	0%	1%	0%	0%
	Multi-Component Programming with Youth Friendly Service (Unmarried Youth)	1%	0%	0%	0%	0%	0%
Increase Services	Increase Health Center III and IVs providing IUDs	88%	70%	62%	28%	60%	45%
	Increase Health Center III and IVs providing Implants	75%	78%	92%	61%	93%	75%
	Reduce stockouts	0.95	0.77	1.03	0.93	0.99	1.05

	Teso	Karamoja	Lango	Acholi	West Nile	Bunyoro	Tooro	Ankole	Kigezi	Scale Up
	32%	11%	43%	46%	37%	60%	53%	56%	51%	Increase to 60% where it is not
	0%	0%	0%	0%	0%	0%	0%	0%	0%	Increase to 50% in every region
	0%	0%	0%	0%	0%	0%	0%	0%	0%	Increase to 20% (except South Buganda, North Buganda, Bugisu, and Tooro - increase to 35%)
	0%	0%	0%	0%	0%	0%	0%	0%	0%	Increase to 15% in every region
	79%	66%	54%	48%	63%	51%	69%	65%	81%	Increase to 75% if it's not; if between 75-80%, increase to 80%
	2%	12%	0%	1%	2%	5%	1%	1%	17%	Increase combined services to 75% in every region
	0%	12%	0%	0%	1%	3%	0%	0%	5%	
	0%	0%	0%	0%	1%	0%	0%	8%	0%	Increase combined services to 20% in every region
	0%	0%	0%	0%	1%	0%	0%	2%	0%	
	58%	13%	62%	75%	63%	30%	43%	53%	20%	Increase to 75% where it is not
	83%	38%	92%	100%	95%	100%	91%	77%	70%	Increase to 80% where it is not
	0.77	0.99	1.07	1.02	0.96	1.77	1.25	1.22	1.08	Reduce by 50% in every region

ACTIVITIES UNDER EACH INTERVENTION

Table 6 below provides a summary of key activities to be implemented under each of the modelled interventions.

Table 6: Key Activities per modelled Intervention

Focus Area	Intervention	Activities
PPFP	Increase % of facilities offering quality PPFP counseling in ANC	<ol style="list-style-type: none"> 1. Increase additional personnel 2. Task sharing 3. Add additional training both on counseling and couple counseling and accountability frameworks (e.g. supervision and monitoring) 4. Increase couples counseling 5. Enhance QIs
PPFP	Increase % of women attending PNC within 6 weeks	<ol style="list-style-type: none"> 1. MOH-sponsored public service messaging on radios and other communications mediums in 6 regions below 75% facility delivery (Bukedi, Bugisu, Lango, Bunyoro, Ankole, and Kigezi)
PPFP	Increase % of facilities offering quality PPFP in Immunization	<ol style="list-style-type: none"> 1. Distribute postpartum checklists 2. Conduct trainings to use the Post Partum FP compendium 3. Ensure integrated point of delivery
Demand Generation	Increase comprehensive community engagement	<ol style="list-style-type: none"> 1. Increase VHTs by government to do community engagement 2. Increase capacity building for VHTs to help step up efforts for male involvement.
Demand Generation	Increase FP Mass Media	<ol style="list-style-type: none"> 1. MOH to increase FP messages via public radio in every region (and via other channels like TV in all regions esp. those with below average mCPR) 2. Conduct campaigns on social media platform to especially target youth. 3. Increase engagements with mass media managers on the importance of FP-programming.
Demand Generation	% of women reached by interpersonal interventions	<ol style="list-style-type: none"> 1. Increase the number of VHTs
Youth	Youth programming (Both Multi-Component Youth Programming and Multi-Component Programming with Youth Friendly Services)	<ol style="list-style-type: none"> 1. Recruit a youth focal person at both VHT and facility level. 2. Increase in-service training for health workers on youth friendly service provision.
Increase Services	Increase Health Center III providing IUDs	<ol style="list-style-type: none"> 1. Train and where possible, hire additional personnel 2. Ensure availability of insertion kits (Implants and IUDs) 3. Ensure storage facilities for these
Increase Services	Increase Health Center III providing Implants	<ol style="list-style-type: none"> 1. Train and where possible, hire additional personnel

Increase Services	Make the supply chain for FP functional (RH-WAOS)	<ol style="list-style-type: none"> 1. Continuous training of health workers at all levels on how to use the RH-WAOS to ensure FP commodities availability and last mile delivery. 2. Monitor over and under stocks for family planning commodities at all levels to foster redistribution.
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Self-care interventions are not created equal; feasibility and levels of impact are highly dependent on context and the interest and capacity of the MoH and district health departments to embrace self-care innovations, given that these may challenge traditional boundaries of health systems. Given the increasing use of intramuscular and sub-cutaneous methods, and the interest in self-injection (DMPA-SC), new technologies and delivery methods could significantly increase mCPR and potentially lower the high discontinuation rates associated with injectable contraception.¹¹⁵

However, because self-injection is a relatively new approach, there is a need to understand better the impact of self-injection from user and system perspectives. Table 7 provides an overview of the considerations and outcomes to be tested.

Table 7: Self-care considerations to be tested

User (client and provider)	System	Outcomes to be tested
<ul style="list-style-type: none"> • Over the life course (WRA) and for underserved populations (adolescents) • Continuum of responsibility and power between provider and client • Continuum of assisted to self-injection • Disposal of self-injection products 	<ul style="list-style-type: none"> • Delivery modalities (public, private, CHW) • Reorganization of health care • Redistribution of resources • Integration within purchasing schemes • Supply chain 	<ul style="list-style-type: none"> • Increased coverage and access • Increased equity, reduced disparities, client empowerment • Increased quality • Reduced cost

OPERATIONALIZING ACTIVITIES UNDER SOME MODELLED INTERVENTIONS

This section provides information on how to operationalize the activities (e.g. how many health facilities should provide services or how many women to reach) by 2025.

Table 8: Some selected modelled interventions

	Kampala	South BBuganda	North Buganda	Busoga	Bukedi
Number of Health Facilities to provide services and women to reach by 2025					
Increase % of facilities offering quality PFP counseling in ANC (Health Center III and up)	31	55	95	14	55
Additional women to reach for PNC within 6 weeks	14,124	20,364	20,939		14,838
Increase % of facilities offering quality PFP in immunization (Health Center II and up)	70	83	188	20	91
Number of women to reach by 2025					
Increase comprehensive community engagement	100,321	246,243	193,346	165,986	114,913
Increase FP Mass Media **number of additional women to reach**		574,567	451,142	221,315	153,218
Increase FP Mass Media **number of total women to reach**	21,434	52,611	41,309	35,464	24,552
% of women to reach by interpersonal interventions	650,751	1,559,539	1,160,078	995,916	689,481
Number of young people to reach					
Married youth using modern contraception	42,343	82,320	105,975	52,864	54,864
Unmarried sexually active youth using modern contraception	16,383	45,166	29,170	28,480	18,185

	Bugisu	Teso	Karamoja	Lango	Acholi	West Nile	Bunyoro	Tooro	Ankole	Kigexi	Total
	62	77	52	98	85	10	77	89	76	50	923
	9,687	21,390	21,549	6,200	3,885	16,326					149,300
	96	138	127	193	192	46	187	155	104	90	
	91,201	107,617	36,480	100,321	91,201	122,210	100,321	133,154	147,746	72,961	1,824,023
	212,803	143,490	48,641	133,762	121,602	162,946	133,762	310,692	196,994		2,864,932
	19,486	22,993	7,794	21,434	19,486	26,111	21,434	28,449	31,567	15,588	389,711
	577,607	681,576	218,883	601,927	547,207	733,257	601,927	798,922	886,475	468,895	11,172,442
	43,307	49,653	5,640	52,308	36,283	35,238	46,971	71,248	52,831	26,904	758,748
	18,827	17,912	919	12,606	14,764	15,565	13,840	20,287	19,360	11,514	282,979

5.2 PROJECTED IMPACT OF SCALE UP BETWEEN 2021-2025 BY SUB-REGION

Figure 10 provides the national impact projections for mCPR based on scale up of selected high impact practices for the period 2021-2025. The sub-regional impact is reflected in Figure 11 below.

Figure 10: Impact projections, 2021-2025

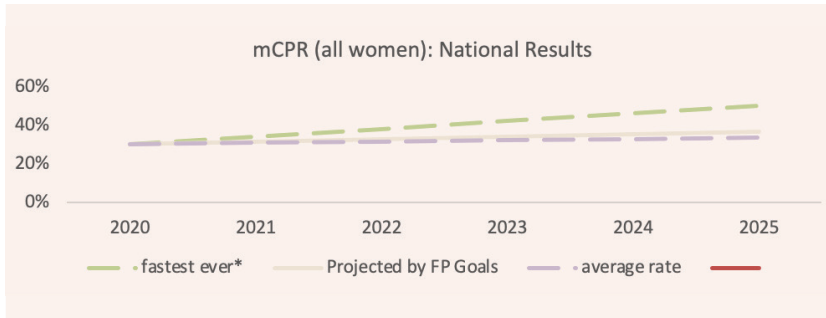


Figure 11: Impact by intervention by sub-region

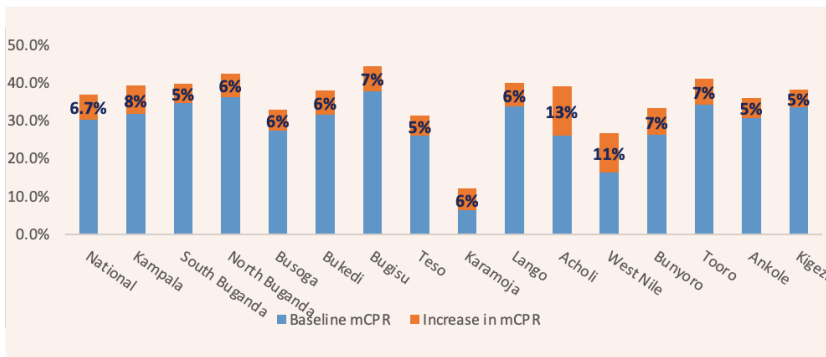


Figure 12 illustrates the impact each intervention has on increasing mCPR. For example, at the national level, most of the effects of growing mCPR over five can be attributed to reducing stockouts and generating demand through mass media campaigns, comprehensive community engagement, and interpersonal communication. However, demand generation activities (mass media campaigns, extensive community engagement, and interpersonal communication) will have the most impact on increasing mCPR (Figure 12). Nearly half of the mCPR growth in most regions will come from generating demand (see Figure 12).

At the national level, most of the impact in increasing mCPR over five can be attributed to reducing stockouts and generating demand through mass media campaigns, comprehensive community engagement, and interpersonal communication.

Figure 12: Impact by intervention by sub-region

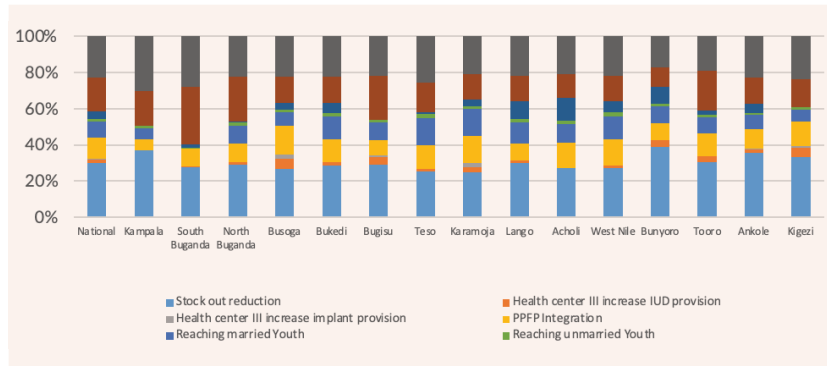
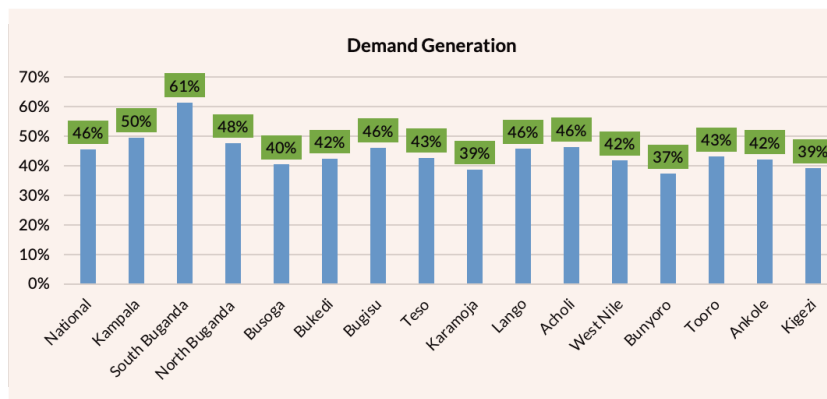


Figure 13 below reflects the impact that demand creation can have on the sub-regional mCPR.

Figure 13: Attribution of mCPR increase through demand generation



All in all, efforts to improve FP commodity supply chain, service provider capacity building, FP counseling, availing of FP information, and improvement in all aspects of the health system, will be aimed at ensuring access by FP clients to a full method mix.

5.3 PROJECTED FP COMMODITIES REQUIRED IN THE NEXT 5 YEARS AND COST, ENSURING A METHOD MIX

Based on the trends in FP uptake in the DHIS II, over five years, it is projected that injections will remain the most used method among modern contraceptive users. However, the share of women using IUDs, implants, and pills will increase. The number of women using injections increases by more than one-third, whereas the number of IUD users doubles. Tables 9 and 10 and figures 14 and 15 below illustrate the change in method mix over the five years with the implementation of the CIP. The figures represent the number of users in each way.

All in all, efforts to improve FP commodity supply chain, service provider capacity building, FP counselling, availing of FP information, and improvement in all aspects of the health system will ensure FP clients' access to a complete method mix. This will support the Government of Uganda in attaining the FP standard on free choice and informed decisions by clients.

Table 9 below, reflects projections for FP commodities required in the next 5 years. This has been projected using the annual increase in FP uptake by method. The table also shows the estimated cost of these commodities for both the public sector and private sector, annually and the total by FP commodity type from 2020/21 to 2024/25.

Table 9: Feasible scenario for projections on women reached by FP method in the next 5 years

	Feasible Scenario			
	Method Mix		Users by Method	
	Baseline	Endline	Baseline	Endline
Sterilization	7%	4%	225,840	215,892
Implant	17%	21%	574,562	1,005,390
IUD	4%	6%	136,168	305,286
Injection	51%	48%	1,693,797	2,294,904
Pill	6%	8%	185,986	366,828
Condoms (male)	11%	10%	378,613	466,850
LAM	2%	3%	76,387	122,312
Other modern methods	1%	1%	43,175	40,339

Table 10: Ambitious scenario for projections on women reached by FP method in the next 5 years

	Ambitious Scenario			
	Method Mix		Users by Method	
	Baseline	Endline	Baseline	Endline
Sterilization	7%	4%	225,840	225,096
Implant	17%	21%	574,562	1,081,331
IUD	4%	7%	136,168	339,041
Injection	51%	47%	1,693,797	2,437,007
Pill	6%	8%	185,986	394,506
Condoms (male)	11%	10%	378,613	493,273
LAM	2%	3%	76,387	130,705
Other modern methods	1%	1%	43,175	41,934

Figure 14: Change in FP Method mix (Ambitious Scenario)

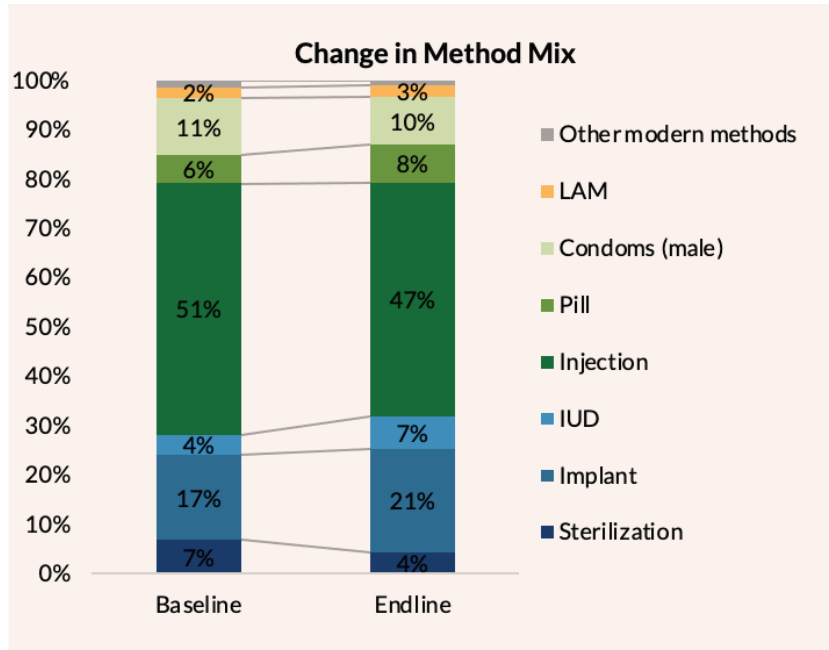
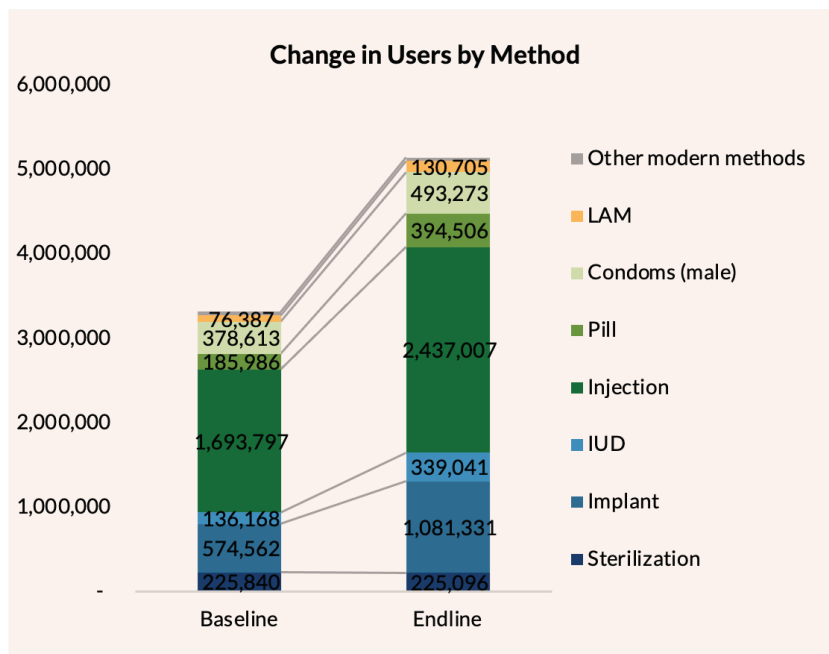


Figure 15: Change in FP Method mix (Ambitious Scenario)



A close-up photograph of a smiling woman looking at a young child. The woman is on the right, smiling broadly, showing her teeth. The child is on the left, looking towards the woman. The background is blurred.

Implementation Framework for the FP CIP II

06

6.1 IMPLEMENTATION PLAN FOR THE FP-CIP 2020/21 – 2024/25

The National FP-CIP implementation will be carried out according to the schedule set under Table 11 below. Altogether there are 3 strategies; namely, Multi-sectoral collaboration for economic development, Universal coverage and sustainability, Sub-regional focus to address inequities. Several activities shown in this implementation plan will be implemented to attain the 11 strategic outcomes (also highlighted in this implementation plan).

Table 11: The activity schedule by technical strategy, intervention and Cost

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
Technical Strategy 1: Multi-sectoral Collaboration for Socio-Economic Development									
Strategic Outcome 1: National FP Multi-sectoral Steering Committee	Re-activate the National FP Multi-sectoral Steering Committee	Multi-sectoral approach for FP operational at national level	National level advocacy meetings to orient sectors on the national multi-sectoral approach, the FP CIP and their role.	X	X				OPM, MOH, NPC, NPA
				X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs)
				X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs)
Multi-sectoral committee functional	Support sub-regions to set up multi-sectoral FP committees	Multi-sectoral approach for FP operational at district level	Bi-annual National FP Multi-sectoral steering committee coordination meetings, Annual Sector-led resource mobilization campaigns for FP. (All relevant sectors)	X	X				OPM, NPC, NPA, MOH, All districts
				X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs)
			Induction meetings for the District FP multi-sectoral steering committees. (100% districts)	X	X				OPM, NPC, NPA, MOH, All districts

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
Strategic Outcome 2: FP supportive policies adopted and implemented	Finalization and roll out implementation of sectoral FP-related guidelines, policies and laws	Proportion of service delivery points (all relevant sectors) with FP-relevant policies, guidelines, SOPs, jobs.	Annual Planning meetings to include FP in the District departmental (all relevant sectors) annual plans and allocate funds for implementation. (100% districts)	X	X	X	X	X	All districts
			Set up sub-county FP multi-sectoral committees anchored and led by the subcounty chiefs with support from CDOs. (100% districts)	X	X				CDOs, District Local Governments
Strategic Outcome 2: FP supportive policies adopted and implemented	Finalization and roll out implementation of sectoral FP-related guidelines, policies and laws	Proportion of service delivery points (all relevant sectors) with FP-relevant policies, guidelines, SOPs, jobs.	Bi-annual District FP Multi-sectoral steering committee coordination meetings. (100% districts)	X	X	X	X	X	All districts
			Revise policies (ADH, SRHR, TMA, Self-care, OTC, Task-shifting). Revise and roll out Age-appropriate sexuality framework.	X	X	X			MOH, IPs
Strategic Outcome 2: FP supportive policies adopted and implemented	Finalization and roll out implementation of sectoral FP-related guidelines, policies and laws	Proportion of service delivery points (all relevant sectors) with FP-relevant policies, guidelines, SOPs, jobs.	Produce all national sector-specific Guidelines, Standard Operating Procedures (SOPs), quality standards, job aids which are relevant to FP.	X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs)
			Disseminate to 100% districts, all national sector-specific Policies, strategies, Guidelines, Standard Operating Procedures (SOPs), quality standards, job aids which are relevant to FP.	X	X	X	X	X	
Strategic Outcome 2: FP supportive policies adopted and implemented	Implement advocacy activities on FP through each line sector	FP Line sectors knowledgeable about FP and owning the FP program.	Form district FP Advocacy groups (100% districts).	X					All districts, CDOs, IPs

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY	
				20/21	21/22	22/23	23/24	24/25		
			FP promotional events (e.g. Meetings, Sector-led FP mass media campaigns) at national and in 100% districts.	X	X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs)
			Sector-led FP promotional campaigns (Mass media; meetings (All relevant Ministries, Religious sector) and 100% districts.	X	X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs)
			Hold advocacy meetings between line sector representatives	X	X	X	X	X	X	
			Convene national and sub-regional high-level dialogues and engagements with stakeholders from various sectors to facilitate alignment of FP as a development agenda. (Relevant sectors; 100% districts)	X	X	X	X	X	X	All relevant sectors (MoH, MoES, MoLG, MoGLSD, MoWE, NPC, Private Sector, CSOs, HDPs, Community, Religious leaders, and IPs); All districts

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
			Strengthen UFPC to coordinate implementing partners supporting the private sector	X	X	X	X	X	UFPC
			Annual FP Quality audits of private sector facilities (100% districts).	X	X	X	X	X	IPs, MOH
			Disseminate guidelines and supervise providers on Self-care (drug shops and pharmacies in 100% districts).	X	X	X	X	X	IPs, MOH
			NDA to fast-track the policy on provision of injectable contraception in pharmacies and drug shops	X	X				IPs, MOH
Strategic Outcome 4: Supply chain strengthened to ensure a reliable supply of full method mix through all FP market channels.	Streamline the FP commodities security in the public and private sectors	Availability of at least 3 FP methods at service delivery points	Annual meetings to forecast, quantify, supply planning and monitor FP commodities, related supplies and consumables.	X	X	X	X	X	IPs, MOH
			Procure relevant FP commodities, FP consumables, FP instruments and related equipment.	X	X	X	X	X	MOH, Development Partners
			Orient District Local Governments and Monitor operationalization of "One facility one warehouse". (100% districts)	X	X	X	X	X	MOH
			Carry out quality of contraceptive commodities including post-market surveillance	X	X	X	X	X	MOH

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
Ensure functionality of the ADS and strengthen the public sector supply system	Order fulfillment rate in the National Medical Stores	Order fulfillment rate in the Alternative Distribution System (ADS)	Train the national team on eLMIS for supply chain management targeting public sector.	X					MOH
			Run and maintain the National Web-based FP commodity electronic logistics management system (eLMIS).	X	X	X	X		MOH
		Transition from "PUSH" to "PULL" system for ordering contraceptives at lower-level facilities at lower health facilities	Train the national team on eLMIS for supply chain management targeting the Alternative Distribution System.	X	X				IPs, MOH
			Link the private clinics and drug shops to the Alternative Distribution System (ADS) and within the TMA for commodity security.						
Address mismatch in classification of contraceptives in the laws vs. distribution channels	Relevant laws appropriate for addressing commodity security		Train District Local Governments on Web-based FP commodity electronic logistics management (eLMIS) - RH-WAOS	X	X	X			IPs, MOH
			Run and maintain the District Local Government Web-based FP commodity electronic logistics management system (eLMIS). Target 100% districts	X	X	X	X	X	District Local Governments, IPs
			Train service providers at facility level and community level on logistics management. (Target 100% HC IIs and HC IIIs)	X	X			X	District Local Governments
			Meetings to amend the NDA Act on contraceptive classification and distribution	X	X	X			MOH

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
		Updated FP-CIP indicators	Develop the FP-CIP 2020/21 - 2024/25 performance monitoring, learning and evaluation plan.	X					MOH
			Implement the FP-CIP 2020/21 - 2024/25 performance monitoring and evaluation plan (Data source being DHIS2, PMA, UDHS, assessments, surveys, Activity reports).	X	X	X	X	X	MOH, IPs
			Review and update the electronic FP-CIP database.	X	X	X	X	X	MOH, IPs
			Bi-annual FP-targeted technical support supervision	X	X	X	X	X	MOH, IPs
Technical Strategy 3: Sub-Regional Focus to Address Inequities									
Strategic Outcome 8: Improved quality of FP services	Improve client satisfaction with FP services (availability, acceptability)	% FP Client satisfaction	Mentor and supervise service providers on Provider Behavioral Change Communication (PBCC). (100% HC IIIs, HC IVs, hospitals)	X	X		X		MOH, IPs
		Method Information Index	Mentor service providers on FP counselling and management of side effects (100% public sector HC IIIs).	X	X		X		MOH, IPs
	Develop and implement comprehensive CQI initiatives	FP quality assurance and improvement institutionalized	Set up FP sub-regional Quality audit teams, and conduct annual sub-regional FP Quality audits of public sector health facilities (15 sub-regions), (Target 100% HC IIIs, HC IVs, Hospitals)	X	X		X		MOH; Professional associations

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY	
				20/21	21/22	22/23	23/24	24/25		
Strategic Outcome 9: Decrease in proportion of women that have had a child before 18 years	Youth programming (both multi-component youth programming and integrated youth responsive services into FP services)	Teenage pregnancy rate	Support youth-led organizations to provide youth-responsive services (15 sub-regions)	X	X	X	X	X	X	Development partners
	Integrate adolescent-responsive services into FP service delivery points.	Improved knowledge of young people on FP Increased access to contraceptive services among married adolescents. Increased male engagement	Incorporate age-appropriate sexuality education framework in school curricula and community engagements. Mentor and supervise service providers on adolescent-responsive services integration into FP services. (100% HC IVs, 100% HC IIIs, 100% hospitals). Sub-region age-appropriate SBCC activities (Mass media, peer to peer communication using FP champions, Promotion campaigns on socio-cultural values using parent/ guardian dialogues) (100% sub-regions). Male-led community dialogues (15 sub-regions) GBV prevention Couple dialogues. (15 sub-regions)	X	X	X	X	X	X	MOH, MOES MOH, IPs MOH, IPs
					X	X	X	X	X	X

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
Strategic Outcome 10: High Impact Practices scaled-up			Male support groups (15 sub-regions)	X	X	X	X	X	MOH, IPs
			GBV prevention advocacy campaigns. (15 sub-regions)	X	X	X	X	X	MOH, IPs
	Increase % of women attending PNC within 6 weeks	% PNC attendance by postpartum women	Equip and train VHTs on referral of post partum mothers for FP	X	X	X	X	X	IPs, MOH
	Integrate FP into RMNCAH-N services	% HC IIIIs and IVs integrating FP into RMNCAH services	Train and mentor service providers on provision and integration of FP into RMNCAH-N service delivery (PPFP, PAFP, FP integrated into HIV, etc) (100% HC IIIIs, 100% HC IVs, 100% hospitals)	X	X	X	X	X	MOH, Professional Associations
		% of health facilities offering quality PPFP counseling in ANC	Recruit midwives (Facilities not meeting staffing norm)	X	X	X	X	X	District Local Governments
	% of post-partum women taking up FP.		Task sharing FP service provision (100% districts)	X	X	X	X	X	All districts
	% of women taking up post-abortion FP.								
	% of HIV positive clients taking up FP		Train service providers on comprehensive FP. (target HIV-related clinics, child health clinics service providers at 100% HC IIIIs and IVs).	X	X			X	IPs, MOH

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	TIMELINE & COST					LEAD AGENCY
				20/21	21/22	22/23	23/24	24/25	
	Provide FP services to hard-to-reach communities and other special groups.	% FP uptake by persons living in hard-to-reach areas and High fertility hotspots	Targeted outreach services to underserved sub-regions and hard-to-reach communities (5 sub-regions)	X	X	X	X	X	IPs, MOH
			Fertility Hotspot mapping-targeted FP service provision and SBCC interventions.	X	X	X	X	X	IPs, MOH
			Print, disseminate and orient FP providers on guidelines and SOPs for Self-care interventions [e.g. Self-injection, self-awareness (in 5 hard-to-reach sub-regions)]	X	X				IPs, MOH
			Implement the guidelines and SOPs for Self-care interventions [e.g. Self-injection, self-awareness (in 5 hard-to-reach sub-regions)]	X	X	X	X	X	IPs, MOH



Costing of the FP Implementation Plan II

07

7.1 COSTING ASSUMPTIONS AND CONSIDERATIONS

Most of the activities/products for each of the strategic outcomes areas are cross-cutting and were therefore costed as a package cost for the FP-CIP, using specific validated data sources from MOH and Implementing Partners.¹¹⁶ Contraceptive costs were calculated from 2021 to 2025, using the 2016 Uganda Demographic and Health Survey (UDHS) contraceptive prevalence rate (CPR) and method mix as a baseline for the 2016 method mix. The 2020/21-2024/25 CPR for all women of reproductive age was then extrapolated for each intermediate year between 2020 and 2025. Regional CPR data was used to calculate the regional contraceptive requirements and, ultimately, the costs. The quantities and the cost estimates (Tables 12 and 13) done by the Ministry of Health Pharmacy Division below were also crucial in determining FP contraceptive requirements for the subsequent five years.

The costing exercise assumes prices of services and goods remain stable but only adjusted to reflect the forecasted inflations in the subsequent years. For products, the cost of producing a product was established based on the current market rates and prices. All consumable costs, e.g. per diem rates, fuel costs, TV, Radio adverts and talk shows venue hire, public address system, etc., are based on the current costs as of 2021 from the widely listened and preferred stations as per a given locality. The costs were adjusted for a base rate of inflation and Bank of Uganda inflation rates projections/PPP, over time determining the variation of the costs across the strategy. The inflation rate was adjusted to accommodate the changing conditions. However, the impact of COVID-19 was not analysed into usable inflation indicators. All costs were calculated in US dollars and Uganda shillings. The strategy is expected to create demand with an additional approximately one million two hundred fifty-thousand women of reproductive age taking up the different family planning services.

Table 12: Family Planning commodity needs for all sectors

		FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 20/21 to 24/25
Product	Unit	Quantity	Quantity	Quantity	Quantity	Quantity	Quantity
Pills (PoPs) microlut	cycles	142,429	276,755	294,052	312,142	331,059	1,356,438
Pills (CoCs) microgynon	cycles	2,706,154	2,490,799	2,6646,466	2,809,280	2,979,530	13,632,230
Injectables (DMPA-IM) depo provera	vial	3,234,316	2,545,674	2,704,771	2,871,171	3,045,173	14,401,104
Injectables (DMPA-SC) sayana press	vial	2,156,211	2,445,844	2,598,701	2,758,576	2,925,754	12,885,086
UIDs	each	319,824	383,789	460,701	552,656	663,188	2,380,044
Implants (5-year)	each	379,258	436,146	501,568	576,803	663,324	2,557,099
Implants (3-year) implanon NXT	each	612,273	765,342	956,677	1,195,847	1,494,808	5,024,947
Emergency Contraceptives	blister pack	1,370,824	3,727,648	3,955,849	4,194,458	4,43,895	17,692,674
Cycle beads	each	67,891	62,993	66,930	71,048	75,353	344,215
Male Condoms	each	24,758,004	195,201,362	282,277,370	261,576,751	289,494,171	1,270,307,657
Female Condoms	each	2,417,580	2,164,127	3,051,748	2,863,122	3,162,292	13,658,869

Source: Pharmacy Department, MOH

Table 13: Family Planning commodity financial needs for all sectors

		FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 20/21 to 24/26
Product	Unit	Costs	Costs	Costs	Costs	Costs	Costs
Pills (PoPs) microlut	cycles	\$42,729	\$45,885	\$882,216	\$93,643	\$99,318	\$369,790
Pills (CoCs) microgynon	cycles	\$730,662	\$784,641	\$714,546	\$758,506	\$804,473	\$3,792,827
Injectables (DMPA-IM) depo provera	vial	\$2,587,453	\$2,778,608	\$2,163,816	\$2,296,937	\$2,436,138	\$12,262,958
Injectables (DMPA-SC) sayana press	vial	\$1,832,779	\$1,968,181	\$2,208,896	\$2,344,790	\$2,486,891	\$10,841,537
UIDs	each	\$201,489	\$241,787	\$290,145	\$48,173	\$417,808	\$1,499,403
Implants (5-year) implanon	each	\$3,223,689	\$3,707,243	\$4,263,329	\$4,902,828	\$5,638,253	\$21,735,342
Implants (3-year) implanon NXT	each	\$5,204,324	\$6,505,405	\$8,131,757	\$10,164,696	\$12,705,870	\$42,712,051
Emergency Contraceptives	blister pack	\$507,205	\$540,249	\$1,463,664	\$1,551,950	\$1,644,241	\$5,707,309
Cycle beads	each	\$100,478	\$107,901	\$99,056	\$105,150	\$111,523	\$524,109
Male Condoms	each	\$6,769,224	\$7,791,496	\$7,903,776	\$7,324,149	\$8,105,837	\$37,894,472
Female Condoms	each	\$1,208,790	\$1,391,339	\$1,525,874	\$1,431,561	\$1,581,146	\$7,138,709
Total Product Costs		\$22,408,822	\$25,862,735	\$28,853,065	\$31,322,383	\$36,031,497	\$144,478,502
PSM Costs	30%	\$6,772,647	\$7,758,821	\$8,655,919	\$9,396,715	\$10,809,449	\$43,343,551
Overall Total (incl. PSM)		\$29,131,469	\$33,621,556	\$37,508,984	\$40,719,097	\$46,840,946	\$332,300,555

Source: Pharmacy Department, MOH

7.2 COSTING METHODOLOGY

The methodology adopted a micro-costing/ ingredients approach based on the 11 identified strategic outcomes of the approved National Family Planning Implementation 2020/21-2024/25. The activities and sub-activities required to produce a strategic outcome were identified, quantified, and evaluated. Experts in the stakeholder consultative meetings validated these activities and products. The total cost of the National FP 5-year implementation plan was obtained by summing the total cost of each activity/product for the five years based on the total cost of the annual activities in the Implementation Plan. Costs of activities in the subsequent years were adjusted using projected inflation rates from the Bank of Uganda. For detailed procedures in costing, refer to the FP-CIP II Costing

report.

7.3 COSTING SUMMARY

The costs of the implementation plan have been estimated using the Uganda Government and partners' operational rates with a tool developed and linked to the activity framework that is easy to adjust for further revisions. The costs have been estimated for the overall costs of the plan, as well as the costs for each year for the five years. The average costs per woman of reproductive age in terms of activity and commodity cost were also determined.



The total cost of the FP-CIP for 2020/2021–2024/2025 is \$295 million (1,089 billion UGX), an increase of approximately 24% from the previous 2014/2020 strategy. This increase in cost is justifiable as the population to increase by 22.6% over the period by 2021, higher target for mCPR in the current FP-CIP II (2020/21-2024/25), inflation, a rise in commodity prices and an increase in administrative units in the country.

A total of \$61.6 million (226.8 billion UGX) for 2020/2021; \$61.8 million (227.3 billion UGX) for 2021/2022; \$56.4 million (207.6 billion UGX) for year 2022/2023; \$49.2 million (181.1 billion UGX) for year 2023/2024; \$ 66.9 million (246.2 billion UGX) for year 2024/2025 as summarized in the table 14 below.

Table 14: Summary of the cost estimates of the FP-CIP 20/21-24/25 per year

FINANCIAL YEAR	ESTIMATED COST	
	COST IN UGX ('000)	COST IN USD
2020/2021	226,834,118	61,639,706
2021/2022	227,259,207	61,755,220
2022/2023	207,588,727	56,409,981
2023/2024	181,083,479	49,207,469
2024/2025	246,245,661	66,914,583
TOTAL	1,089,011,192	295,926,959

The average unit cost for providing family planning services under the FP-CIP II, considering commodities and consumables only, is USD 3.9 (14,188 UGX). This is comparable with other cost estimates done in other related countries with ranges of (USD 4 - USD 4.4). Considering the cost of activities for Family Planning alone, the average price is USD 2.1 (7,560 UGX), comparable with other related cost estimates ranging from USD 2 - USD 5. As per the FP-CIP II (2020/21-2024/25) strategy target, the cost of providing FP service per client is USD 66.5 (244,684

UGX), reflecting quite a low level of uptake.

Table 15: Average cost of providing FP services to a woman of reproductive age under the FP-CIPII

SCENARIO	AVERAGE COST		Related Countries
	UGX	USD	USD
Commodities & Consumables only	14,188	3.9	4-4.4
Activities for Family Planning only	7,560	2.1	2-5
Both Activities & Commodities	21,748	5.9	
As per FP-CIP II strategy target	244,684	66,5	

Figure 16 below presents the estimated resource distribution based on the proportion of the unmet need of the region, with West Nile claiming the highest, followed by Lango, Teso and Busoga regions.

Figure 16: Estimated distribution of the resources by region based on the unmet needs

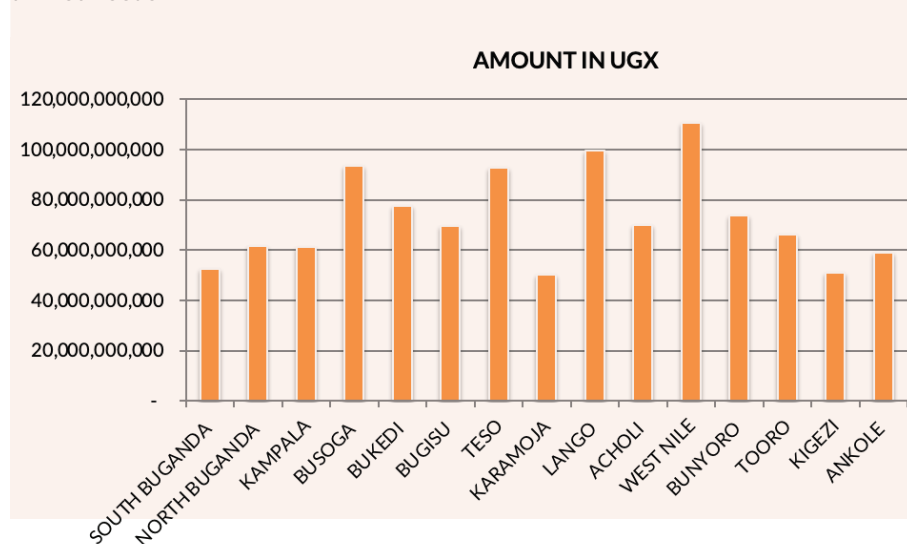


Table 16 below reflects the annual financial allocation by strategic outcome.

Table 16: Cost of the FP-CIP 20/21-24/25 per strategic outcome in UGX ('000')

STRATEGIC OUTCOME COSTED	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	TOTAL COST
1 National FP Multi-Sectoral committee functional	4,625,790	4,850,140	3,006,906	3,117,251	3,227,597	18,827,684
2 FP supportive policies adopted and implemented	6,015,672	5,625,907	5,848,582	6,336,669	6,560,976	30,387,806
3 Strengthened health care system to ensure delivery of a standardized minimum package of FP	16,617,675	17,423,632	12,222,360	14,314,783	18,055,849	78,634,299
4 Supply chain strengthened to ensure a reliable supply of full method mix through all channels.	132,335,581	130,177,439	150,334,852	118,572,352	141,024,441	672,444,665
5 Current nascent FP market transformed into a mature commercial sector	927,448	907,422	912,818	977,956	979,814	4,705,458
6 Sustainable financing to enhance government contribution of the FP program at all levels	835,435	-	-	944,041	977,458	2,756,934
7 Strategic information generated & used for evidence-based prioritization & programming	1,576,805	1,653,280	1,718,717	1,781,789	1,844,861	8,575,452
8 Improved quality of FP services	601,632	630,811	171,675	679,844	184,275	2,268,237
9 Decrease in proportion of women that have had a child before 18 years	25,560,984	26,423,231	27,469,072	28,477,111	29,485,151	137,415,549
10 High Impact Practices scaled-up	32,575,096	34,154,988	277,165	287,336	38,112,862	105,407,447
11 Reduced inequities in FP service provision especially among the underserved groups	5,162,000	5,412,357	5,626,580	5,594,347	5,792,377	27,587,661
TOTAL COST PER YEAR	226,834,118	227,259,207	207,588,727	181,083,479	246,245,661	1,089,011,192

The highest proportion of cost is in the strategic Outcome 4 (Supply chain strengthened to ensure a reliable supply of full method mix through all channels) which is majorly commodity and consumables supply, procurement and logistics amounting to 61.7%; followed by strategic outcome 9 (Decrease in proportion of women that have had a child before 18 years) amounting to 12.6%; and strategic outcome 10 (High Impact Practices scaled-up) taking up 9.7%. Refer to Table 17 below.

Table 17: Cost of the FP-CIP 20/21-24/25 per strategic outcome in USD (Exchange rate 3,680)

	STRATEGIC OUTCOME COSTED	20/21	21/22	22/23	23/24	24/25	TOTAL COST	%
1	National FP Multi-Sectoral committee functional	1,257,008	1,317,973	817,094	847,079	877,064	5,116,219	1.7
2	FP supportive policies adopted and implemented	1,634,693	1,528,779	1,589,289	1,721,921	1,782,874	8,257,556	2.8
3	Strengthened health care system to ensure delivery of a standardized minimum package of FP	4,515,673	4,734,683	3,321,294	3,889,887	4,906,481	21,368,017	7.2
4	Supply chain strengthened to ensure a reliable supply of full method mix through all channels.	35,960,756	35,374,304	40,851,862	32,220,748	38,321,859	182,729,529	61.7
5	Current nascent FP market transformed into a mature commercial sector	252,024	246,582	248,048	265,749	266,254	1,278,657	0.4
6	Sustainable financing to enhance government contribution of the FP program at all levels	227,020	-	-	256,533	265,614	749,167	0.3
7	Strategic information generated & used for evidence-based prioritization & programming	428,480	449,261	467,043	484,182	501,321	2,330,286	0.8
8	Improved quality of FP services	163,487	171,416	46,651	184,740	50,075	616,369	0.2
9	Decrease proportion of women that have had a child before 18 years	6,945,920	7,180,226	7,464,422	7,738,346	8,012,269	37,341,182	12.6
10	High Impact Practices scaled-up	8,851,928	9,281,247	75,317	78,081	10,356,756	28,643,328	9.7
11	Reduced inequities in FP service provision especially among the underserved groups	1,402,717	1,470,749	1,528,962	1,520,203	1,574,016	7,496,647	2.5
	TOTAL COST PER YEAR	61,639,706	61,755,220	56,409,981	49,207,469	66,914,583	295,926,959	100





Monitoring & Evaluation

08

The country will continue to use existing monitoring and accountability mechanisms to monitor the CIP. The principal of these will be the DHIS2, the health information system used by the program. DHIS2 will be supplemented with national consensus estimates using MoH-endorsed tools based on survey data and DHIS2 routine data and other mechanisms endorsed by the FP Task Force and Technical Working Group of the Ministry of Health in Uganda.

This plan is framed to support the achievement of Uganda's near-term goals set within the National Development Plan III 2020-2025 within the current context of socio-demographic factors (e.g. Uganda's age structure, contraceptive use, fertility desire), existing family planning programs, and available evidence of growth opportunities. It was also developed to position the family planning programme to achieve the broader goals of Vision 2040 of universal access to family planning. Among all women, the most recent estimate of CPR (all methods) is 35%, while mCPR (modern methods only) is 30.4% in 2020.¹¹⁸

While the target set in the HSDP was 50% CPR for MW by 2020, and in the NDP III, 50% CPR for all women by 2025. As such, the strategy of the CIP is to obtain levels in mCPR achievement as close to the target set in the NDP III as possible through an ambitious and deliberate focus on interventions and geographic areas that are most likely to respond to investments. Through its singular focus on expanding current contraceptive use that incorporates existing differences in preferences for ideal family size and contraceptive use, this CIP responds directly to Vision 2040's focus on achieving universal access.

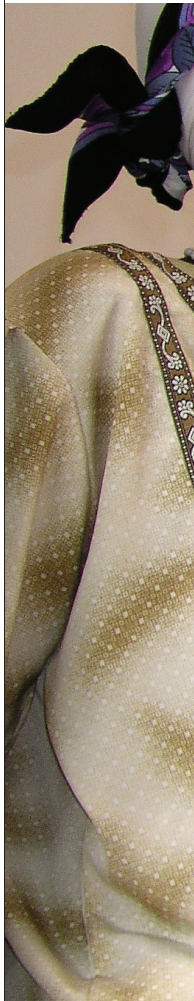
Figures 17 and 18 describe the results framework for obtaining the ambitious scenario of increased mCPR of 37%/39.6% by 2025 from a base of 30.4% in 2020 (for all women). This scenario is guided by investments in both maintaining current levels of use and increased levels of service.

To maintain current levels of use, priority interventions must focus on improving the quality of services, which are tuned to ensuring equity in services, and reducing risks of discontinuation while still in need of contraception, as well as incrementally increase service provision to account for the growing number of women entering their reproductive years. To increase levels of use (higher than 1% annually), priority interventions exploit the evidence of:

1. Substantial low utilization of contraception during the post-pregnancy period (post-partum, post-abortion) when women do not want to be pregnant, and for whom short birth spacing is detrimental to their health and that of the child;
2. Strong preferences for a large family size which has not shifted for over multiple decades, which implies that increases in mCPR will depend on demand generation, mainly for spacing, in the near term;
3. High stockouts of all methods, including dominant forms of injectables and implants;
4. High rates of pregnancy and unmet need for contraception among adolescents and youth across the sub-regions in Uganda.

The interventions to increase mCPR take note of the high levels of stockouts in preferred methods by targeting stockout reductions and the limiting role that current fertility preferences play by focusing on-demand generation and community mobilization on shifting social norms and demand for children. We expect investments in demand generation to contribute nearly half of the anticipated increase in mCPR, followed by stock out reductions of almost 30% and post-pregnancy and youth-focused interventions of over 10% in most regions.

Assumptions: The ability of the programme to generate expected increases in mCPR requires clarity on which interventions are within the programme's sphere of control, influence and interest.

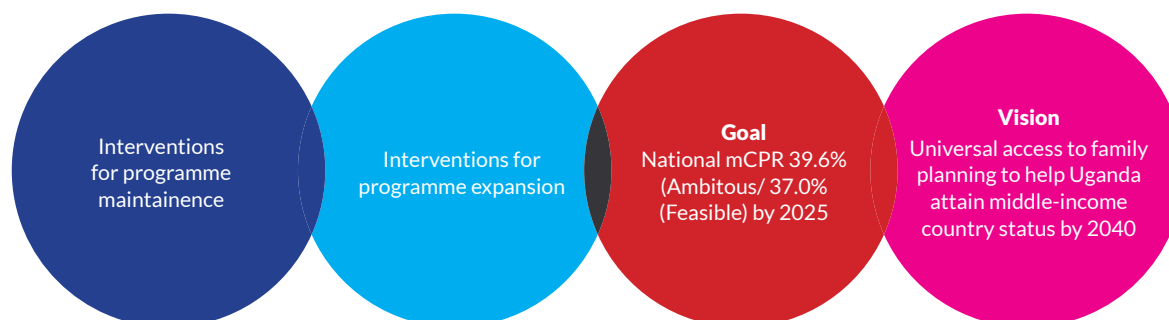


Interventions within the sphere of control are those that directly expand the supply of services of PFP, reduce stockouts and expand the availability of counselling and information on services via targeted campaigns, facilities and VHT providers and increase the availability of short and long-acting methods within the public and private sector. This CIP has not considered planned investments to alter the architecture of community-based services now designed under a new cadre of community health extension workers (CHEWs).¹¹⁹ CHEWs are intended to expand provider access from a base of 4 VHTs per village to these plus two CHEWs per parish, but their likely impact on expanding access is unclear at this time.

Interventions outside immediate programme control but primarily within its influence include those that depend on more women accessing PNC and immunization services.

Interventions within the programme's interest are those that influence social norms relating to spacing and even limiting, and more critically, those that improve levels of girls' education, skills and labour market opportunities. These interventions are outside the manageable interest of the family planning programme and therefore represent an essential risk for programme performance. Other hazards include the long-term effects of the global pandemic on girls' education and opportunities. Evidence from other epidemics has shown a substantial impact on teenage childbearing and early marriage.¹²⁰



Figure 17: Monitoring and Evaluation Framework**Assumptions:** Girls education, skilling, and labour market opportunities improve**Figure 18: Detailed M&E framework**

INPUTS	OUTPUTS	OUTCOMES	IMPACT
Increased availability of quality FP services	Stockout levels for each method are reduced by 50% by 2025.	Increased use of modern contraception with equitable access to services by sub-geography, by age group and marital status with social norms that promote women's health and well being	Unintended and poorly timed pregnancies are reduced, and women's health and economic productivity improve by 2040 as planned in Vision 2040
Existing PNFP channels including outreach, social marketing and social franchising are sustained	Increased proportion of post-pregnant women provided with access to counselling and PPFP services via increased PPFP offer in ANC, PNC and immunization.		
	Increased proportion of married and unmarried youth 15-24 years are reached with information and services on contraception through a multi-component programme at VHT and facility level and youth-friendly services.		
	75% of Health Centre III facilities will provide IUDs and 80% provide implants by 2025.		

Figure 18: Detailed M&E framework

INPUTS	OUTPUTS	OUTCOMES	IMPACT
<ol style="list-style-type: none"> 1. ANC, Maternity, PNC and PAC providers trained to counsel and provide PFP 2. DHIS2 develops data elements and indicators to monitor PFP at the facility level 3. VHTs trained to provide comprehensive community engagement for FP. 4. VHTs provide and refer women for FP services 5. FP mass media campaign produced and disseminated in all regions 6. VHTs and facility providers trained to counsel and provide service to married and unmarried youth 7. Web-based supply chain monitoring implemented for FP 8. 100% of supply chain staff at HC II level will be trained to use a pull system 9. 100% of DHOs will implement a national accreditation process for the private sector in their districts 10. 100% of HC III and above staff will be trained to provide IUDs and Implants 11. FP programme will develop process and orient public sector facilities to conduct annual FP quality audit 	<ol style="list-style-type: none"> 1. 923 facilities nationally offer quality PFP counseling during ANC 2. 149,300 women use PFP through PNC services (60% of all women post-partum attend PNC services) 3. 1,778 facilities Health Centre 11 and above (50% of all facilities in each region) integrate PFP in immunisation services 4. 1.8 million women are reached by VHTs in comprehensive community engagement on FP 5. 2.9 million additional women are reached through FP mass media campaign 6. 11.1 million women reached through expanded Interpersonal communications 7. Over 750,000 married and 282,000 unmarried youth 15-24 are reached with information and services on contraception through a multi-component programme at VHT and facility level 8. 100% of districts implement the one facility, one warehouse systems 9. 100% of FP stocks will be monitored using the web-based system 10. 100% of HC II will move from "Push to Pull system 11. An additional 228 HC IIIs will routinely provide IUD insertions (baseline?) 12. An additional 37 facilities will routinely provide Implant insertions (baseline?) 13. 100% of public facilities will have at least one FP quality audit per year 14. 100% of private facilities providing FP will be accredited 	<ol style="list-style-type: none"> 1. Increased proportion of women are reached with comprehensive community engagement, interpersonal communications and FP Mass Media 2. Stockout levels for each method is reduced by 50% by 2025 3. Increased proportion of post-pregnant women provided with access to counselling and PFP services via increased PFP offer in ANC, PNC and immunisation 4. 759,000 married youth are using contraception 5. 75% of Health Centre III facilities will provide IUDs and Implants by 2025 6. 100% of public and private facilities will comply with national quality standards for FP provision 	<p>mCPR increases to 37%/39.6% by 2025</p>



Institutional Arrangements for Implementation

09

9.1 NATIONAL LEVEL

National Family Planning Multi-Sectoral Steering Committee

As stipulated under the technical strategies, this FP-CIP II (2020/21-2024/25) will be implemented using a multi-sectoral approach. The Government of Uganda is implementing the Human Capital Development program following the prioritization of five key growth drivers with the most significant multiplier effect identified in the Uganda Vision 2040, namely, Human Capital Development; Agriculture; Tourism; Minerals, Oil and Gas; and Infrastructure.¹²¹ Under the Human Capital Development program, the Government of Uganda has set several priorities, including investing in the health sector, specifically:

- To provide inclusive and quality health care services through policy formulation and strategic direction, planning and coordination of health care provision in Uganda.
- Addressing the critical determinants of health through strengthening inter-sectoral collaborations and partnerships.¹²²

The human capital development program is one of the 18 programs prioritized for implementation under the National Development Plan III.¹²³ Under the human capital interventions and critical actors, the NDP III highlights key agencies, namely, MoH, MWEO, NPC, MoLG, MoGLSD, Private Sector, CSOs, HDPs, Community, Religious Leaders, and DPs, as significant players in attaining increased access to SRHR with particular focus on FP services. Under the HCD program, the line sectors (highlighted below) will be working together to implement FP through a multi-sectoral approach. As such, FP will be implemented as a program with cross-cutting interventions requiring sectoral planning, financial, and budgetary allocation. After revival, the National Family Planning Multi-sectoral Steering Committee will be responsible for coordinating implementation

and will be chaired by the Office of the Prime Minister. The Ministry of Health will be the Secretariat to the FP Multi-Sectoral Steering Committee. Membership of the Steering committee will consist of a representative from each key implementing entity. The implementing entities will comprise the Ministry of Health (MoH), Ministry of Education and Sports (MoES), Ministry of Local Government (MoLG), Ministry of Gender, Labour and Social Development (MoGLSD), Ministry of Water and Environment (MoWE), National Population Council (NPC), Private Sector, CSOs, HDPs, Community, Religious Leaders, and Implementing Partners.

Ministry of Health

The key mandate of MOH is to provide oversight on the FP-CIP II (2020/21-2024/25) implementation. As such, MOH will be responsible for monitoring and evaluating the FP-CIP II (2020/21-2024/25), allocating resources in liaison with other sectors, and maintaining the FP standards, including capacity building, among others. Under the Multi-sectoral approach, MOH will take up the Secretariat role.

Other sectoral ministries and institutions

Each line sector will be charged with advocating for FP through their sectors in advancing national and district socio-economic development related to each sectoral mandate. The sectors will be responsible for raising resources to realize this function and draw benefits from using FP to advance these mandates.

Ministry of Local Government (MoLG)

All districts are under the jurisdiction of MoLG; therefore, this ministry is also among the FP line Ministries to be engaged under the multi-sectoral approach. Under this sector, financial resource mobilization is expected to ease, mainly encompassing all levels (community, sub-county and district).

Adopting the multi-sectoral approach in planning and resource allocation is also expected to become more accessible within the district through endorsement by this sector.

Ministry of Finance, Planning and Economic Development (MoFPED)

The Ministry of Finance and Economic Development is responsible for the annual sectoral allocation of Government funds. Bringing them on board in implementing the National FP-CIP is paramount so that financing of the National and District Development Plans and the national and district FP-CIP and of the sectoral policies and strategies related to FP; are set as national policies to be funded.

Ministry of Education and Sports (MoES)

By advancing FP and age-appropriate sexuality education, the education sector will contribute to reducing school dropouts and promoting school enrolment for girls and boys. MoES will be responsible for ascertaining that the National Sexuality education framework is updated and disseminated to improve accessing fertility-related age-appropriate information. The ministry will also support a review of related pre-service curricula and basic education frameworks.

Ministry of Gender, Labour and Social Development (MoGLSD)

Will be responsible for spearheading issues related to gender, social issues, the family unit and youth that impact community development and thereby impact FP access and utilization. By handling any issue related to gender, women's affairs, family affairs, and cultural affairs that hinder access to FP information, or quality of FP services, the sector is expected to contribute to preventing early sexual debut, especially outside marriage.

Ministry of Water and the Environment (MoWE)

Ministry of the environment is among the line ministries that will be key in advancing FP for national development but from the perspective of environment management (water and environmental resources) and the impact of high fertility on the environment. Policy and decision-makers, together with technical staff in this sector, will therefore work closely with those in the health sector and other line Ministries under the multi-sectoral framework at national and sub-regional levels. This will mainly target the use of FP advocacy in improving environmental management.

Religious sector

The religious sector also has a role when it comes to groups whose FP choices are bound by their religious beliefs. The industry will therefore use its platforms as they advocate for FP. Through the religious Medical Bureaus, national guidelines, especially those on the use of Fertility Awareness Methods (FAM) and referral for FP, will be disseminated, and capacity will be built for the provision of these services in the respective PNFP health facilities.

Office of the Prime Minister (OPM)

The Office of the Prime Minister will revive its role of coordinating cross-sectoral collaboration efforts. This office will be supported by the National Population Council, the National Planning Authority, and MOH to operationalize the National level multi-sectoral FP framework. The office will also re-activate the National FP Multi-sectoral Steering Committee coordination meetings by resuming its role as Chair of the multi-sectoral steering committee. It will also hold the Government under the FP multi-sectoral framework accountable for the FP-CIP implementation.

National Population Council (NPC)

Will lead the development and dissemination of FP issue papers to the various line ministries and stakeholders, making a case for FP as a development tool. NPC will further work with sectors to promote the integration of population variables into development policies, plans, and programmes. The National Population Council will further guide the sectors in working with the District Local Governments during incorporating FP into the district departmental annual work plans.

National Planning Authority (NPA)

The National Planning Authority, working in liaison with the National Population Council, will continue to provide technical guidance to all the line sectors within the FP multi-sectoral framework in using FP as a critical development issue and harnessing the demographic dividend in a bid to attain Vision 2040.

National Medical Stores (NMS) and the Joint Medical Store (JMS)

In the public sector health facility system, the National Medical Stores will continue to take charge of the national procurement of FP commodities and related health supplies based on forecasting FP commodities and supplies information gathered by MOH in collaboration with FP stakeholders. NMS will also continue to store these commodities and distribute them to the last mile. Currently, Joint Medical Stores (JMS) is supporting the private sector health facilities and will continue to do so about storing the FP commodities and related health supplies in readiness for the facilities to access them during the implementation of FP services.

National Drug Authority (NDA)

The National Drug Authority will be responsible for making sure that FP commodities and related devices, especially those imported and those in use, maintain a high level of quality, safety, and efficacy.

Other coordinating bodies will continue to provide their functions like before. These include the following:

Health Policy Advisory Committee (HPAC)

The advisory committee will continue its role of harmonization of National policies and identification of financing priorities. The committee comprises high-level leadership at MOH and the Development partners and is chaired by the Permanent Secretary of MOH.

Top Management Committee (STMC)

The Senior Top Management will provide a good forum for engaging other line Ministries through the multi-sectoral approach because of the capacity to engage at a high level of Governance, especially regarding coordination and resource mobilization. The committee consists of directors of departments and parastatal institutions within the MOH. This is because the Minister of Health chairs it, comprising members placed at a high level within the MOH.

Senior Management Committee (SMC)

Senior Management Committee has membership from the national programs and comprises technical staff from MOH. This committee is among the high-level committee responsible for endorsing policies, strategies and interventions. The committee will therefore carry on with this critical role, especially regarding FP-CIP technical guidance.

The Maternal and Child Health Technical Working Group

This working group will continue to advance its advisory and guidance role to the MOH and FP stakeholders. The technical working group will also provide a forum for checking on the implementation of FP-CIP activities that align with the RMNCAH investment case.

Family Planning / Reproductive Health Commodity Security Working Group (FP/RHCS)

WG)

This working group provides a forum for national FP stakeholders to discuss and review FP-related policies, strategies, guidelines and standards, as well as providing solutions to challenges in FP programming in the country. It is chaired by the Assistant Commissioner in charge of Reproductive and Infant Health and co-chaired by the Assistant Commissioner for Pharmacy. It has membership from the IPs, Government, development partners and civil society.

The Uganda Family Planning Consortium (UFPC)

This is the umbrella of the significant FP implementing Partners charged with coordination of FP activity implementation of the IPs. The consortium will continue to provide a forum for coordination and advocacy on family planning by stakeholders in the private sector, ensuring that it strengthens the collaboration between the private and public sector stakeholders. UFPC will work with the National Population Council (NPC) to support the districts in improving or setting up advocacy groups to promote FP as a district development issue.

Parliamentary forum

At a national level, the multi-sectoral Steering Committee will engage the Parliamentary committees (on Health, for Women Parliamentarians, on Policy development) to advocate for increasing funding for FP by Government and ascertaining that it is captured in the sectoral Budget framework Paper.

Development partners

Funding of the FP programs, both on

commodities and program implementation, has had a significant contribution from Development Partners and UN agencies. These agencies have also been instrumental in the provision of technical support as well as the strengthening of health systems through equipping. They also form part of coordination structures such as the FP2020 and the Health Policy Advisory Committee (HPAC).

Civil society organizations, Implementing partners and non-governmental organizations.

This set of FP stakeholders has been having a significant role in advocacy, demand creation for FP, supporting Government in implementing FP interventions, accountability and holding the Government accountable, and increasing access to FP through innovative approaches. They will continue to advance these roles as the need arises.

Professional associations

The professional associations will support addressing capacity-building gaps, ensuring adherence to accreditation processes. They will include the Medical and Dental Practitioners Council, Pharmacists Council, Nurses and Midwives Council, Private Midwives Association, and Allied Health Professional Council.

Research and academia

These stakeholders will contribute to evidence generation in support of policy development and review, monitoring and evaluation of the national FP programs, including the FP-CIP. Stakeholders under this category include the Uganda Bureau of Statistics (UBOS), Makerere University, Implementing Partners and development partners.

9.2 DISTRICT LEVEL

District Local Government (DLG)

In addition to using this forum in mobilizing domestic resources and departmental resources for implementing FP, the DLG will be used as a forum to ensure the inclusion of FP into the departmental plans. This entity will also support districts in enacting by-laws related to fertility and population or family planning, e.g. prevention of early marriages, to ensure that girls and boys go for Universal Primary and Secondary Education (UPE, USE) and remain in school.

Chief Administrative Officers

Will supervise the district Local Government as they set up a multi-sectoral framework at the district and community levels. The CAO will also support the fundraising process for the FP-CIP under the District Local Government.

District Health Officers and Assistant DHOs

The DHOs will continue undertaking their role as stipulated under FP CIP I (2015 - 2020) of overseeing the district-level implementation of the FP-CIP. The DHO in each district will be the Secretariat to the District multi-sectoral steering committee. The DHO will work with the Chief Administrative Officer to plan, ensure that all the district departments are followed up to include FP in the departmental annual work plans and ensure that financial resources are allocated and mobilized for the FP-CIP within the district. The DHO will work with other departments using the comparative advantage of each department to mobilize the lower levels (sub-county) in planning for and mobilizing local resources for the FP-CIP implementation.

District Family Planning Multi-Sectoral Steering Committees

Functionalization of the FP multi-sectoral approach will not be complete without the presence of multi-sectoral frameworks at the district and lower levels. District FP multi-sectoral committees will be identified and oriented on their responsibilities under this FP role. Each district will assemble this committee, chaired by the Local Council V (LC 5), with the Chief Administrative Officer as Deputy to the Chair. The District Local Government departments will be enrolled on this role through the engagement of the respective district departments, namely Health, Community development, Education, Agriculture, and Planning. Other committee members will include religious heads, cultural leaders, CSOs working on FP, and IPs working on FP within each district. Structures similar to those for HIV will be set up at the sub-counties and will therefore be responsible for sub-county level FP advocacy, FP planning and resource allocation especially involving domestic resources.

ANNEX 1: SUMMARY FP CIP 2015 - 2020 EVALUATION FINDINGS

Thematic Areas	Priority Issues	Suggestions for FP – CIP II
Goals:	Regional disparities in modern contraceptive prevalence and unmet need: unmet need higher in northern and Eastern Uganda.	Consider planning to address regional disparities when setting national goals. Data use/evidence could be used to inform local interventions.
Demand Creation	Low contraceptive prevalence rates among teenagers; COVID- 19 has made the situation worse.	<ul style="list-style-type: none"> • Tested and Innovative High Impact Practices be planned for and implemented. These need to be scaled up and at a reasonable scale with quality. It will involve benchmarking from countries with lower rates and identify more effective measures.
	Consistently high pregnancy rates with differing levels at sub regions.	<ul style="list-style-type: none"> • Roll out SBCC strategy and maintain the ecological model of intervention. Need to incorporate human centred design approach to ensure effectiveness of the packages developed. • MoGLSD to step up efforts in promoting life skills among school and out of school youths and also through the Community Development Department, encourage parents to improve upon their parenting skills. This could be informed by operational research. • Demand driven prescriptions, • Adopt high impact messaging practices.
	Low listenership in demand driven messages especially in islands and mountainous areas: Young people have affordability challenges of radios, internet and TVs.	<ul style="list-style-type: none"> • Use targeted conduits for demand creation to conduct listenership surveys to inform contributions towards intended outcomes. These could include interpersonal communication approaches, community FP. • Use of multiple channels of communication including IPC - to ensure all different audiences are reached • Use youth led campaigns to create demand such as peer education, MDD could be useful.
	Low male involvement in FP programming, due to myths and misconceptions. Limited targeting of boys.	<ul style="list-style-type: none"> • FP messages should reflect the practical realities over the potential benefits of FP like the RAPID model creates deeper understanding of the potential benefits of FP at the family, community and national level. Action research could be useful in developing new innovative approaches. • Using evidence of the Male Action Groups and Satisfied Users/Champions to continue to appeal to community to utilize FP services. Implementation Research could be useful in measuring its effect. • Devise culturally appropriate and age sensitive information packages targeting the boys (both in and out of school).

Thematic Areas	Priority Issues	Suggestions for FP – CIP II
	Limited targeting of adolescents both in school, tertiary institutions and the out of school adolescents.	<ul style="list-style-type: none"> • The Education Department to operationalize the Sexuality Education Framework 2018. • Build capacity of health workers to provide youth friendly services. • Empower and support the Peer Educators.
	Youth corners have not largely benefited in-school youth - after work hours not yielding intended results.	<ul style="list-style-type: none"> • DHOs and health facility managers to extend working hours to cater for the in school youths. • Active and complete referral of youths in need of SRH/FP services. • Promote multi sectoral approach, with active involvement of MOES, MGLSD. • Inclusion of other stakeholders also need to be brought on board like the CSOs, youth organizations to further enhance response.
	Lack of impact assessments on the contributions of radio spots, messages and outreaches on increased mCPR and reduced unmet need.	<ul style="list-style-type: none"> • UFPC to take coordination and tracking role for indicators and activities not captured in the DHIS2. • Implementation research on impact assessment like on use of deep stick monitoring to measures.
	Low sensitivity and prioritization accorded to key constituent populations including: PLWDs, refugees, men and women in uniform, hoteliers, and minorities – Batwa.	<ul style="list-style-type: none"> • Mainstream needs assessments and design programming approaches that meet interests of such constituencies in all interventions – including service delivery. • Survey’s and routine data, to monitor progress among these sub-populations. • Integrated refugee response plan.
	Expand engagement of influential champions for family planning.	<ul style="list-style-type: none"> • Continue to engage religious, cultural and local leaders at all levels to utilize their structures to promote the uptake of FP.
	Cultural nuances in the country have an influence on FP uptake.	<ul style="list-style-type: none"> • Develop Program for appreciative inquiries of cultural values and norms and also tailor FP programs to needs of local communities or adapt culturally sensitive programming.
Service Delivery and Access	Regional disparities in access to FP services and information on FP – inequalities and inequities in service exist in FP.	<ul style="list-style-type: none"> • Targeted outreaches and use of community-based distributors should be strengthened. • Strengthening the supply side of FP commodities.
	FP uptake is influenced by education, age, residence and wealth quantile.	<ul style="list-style-type: none"> • Strengthen the Total Market Approach (TMA) to reduce the service burden on public facilities.

Thematic Areas	Priority Issues	Suggestions for FP – CIP II
	A majority of potential FP service consumers turn to public facilities + limited involvement of the private sector in FP service provision.	<ul style="list-style-type: none"> Strengthen the total market approach to reduce the service burden on public facilities.
	Spaces for FP service provision in high volume facilities do not guarantee privacy and confidentiality – some are in a sorry state.	<ul style="list-style-type: none"> Push for funding allocation to invest in infrastructural developments that guarantee confidentiality and privacy in high volume facilities.
	Lack of medical equipment for FP in many of the health facilities.	<ul style="list-style-type: none"> Plan should consider funding for procurement and maintenance of basic medical equipment.
	<p>Motivation of health workers remains low.</p> <p>Marked levels of absenteeism and sometimes, poor attitudes to PWDs, young people and HIV Positives from both staff and Clients.</p>	<ul style="list-style-type: none"> FP – CIP II should focus on learning from the gains of RBF to attain increasing FP health workers' motivation. To up skills of Health workers, capacity building opportunities be offered to staff under the in-service training arrangements. Functionalize the Rewards and Sanctions Committee to deal with cases of irregular attendance to duty and reward the excellent staff.
	<p>In consistent and lack of a uniform Training Curriculum to VHT / CBD involvement in FP programming across regions of Uganda –</p> <p>IP support to VHTs not sustainable.</p>	<ul style="list-style-type: none"> The Department of Reproductive health /MoH to Develop and Standardize VHT training Curriculum with the right content, duration and training approaches. Govt should recognize and support the VHTs e.g. offer them a uniform and stipend if they meet particular set targets.
Commodity Security	Though minimal, stock outs still engrained in the service sector.	<ul style="list-style-type: none"> Continue improving supply chain for FP commodities at national level through improved quantification and forecasting. Speed government effort to transit to pull system. Re-train logistics managers in districts with in quantification and forecasting. Continue operationalizing re-distribution strategy + one facility, one warehouse policy.
	Real time monitoring of stock in facilities is still poor and uses paper based tracking system.	<ul style="list-style-type: none"> FP–CIP II should emphasize transition to the web based LMIS during the tenure of FP-CIP II.

Thematic Areas	Priority Issues	Suggestions for FP – CIP II
Policy and Enabling Environment	Poor dissemination of policy and legal framework at sub national level; knowledge about legal framework is limited amongst key actors.	<ul style="list-style-type: none"> • Use innovative ways to disseminate all relevant policies to key stakeholders including updating the MoH website to capture all the national policies that inform and influence FP service provision in the country. • Continue to create an enabling environment for health workers in both public and private sector.
Financing	Limited financing of FP interventions at national and sub national levels in Uganda	<ul style="list-style-type: none"> • Continue to lobby Members of Parliament, DPs and national leaders for increased resource allocation specifically to FP agenda. • Earmark funding for FP commodities and basket funding (pooled/basket funding) is proposed. • Advocate for a streamlined process for development of DCIPs in order to reflect the local priority needs and also ensure that FP is mainstreamed. • The Ministry of Local Government should direct districts to ensure that FP is incorporated by all sectors in the budgeting process and further that a minimum of 10% of the local revenue to financing FP.
	Low involvement of corporations in financing family planning.	<ul style="list-style-type: none"> • Map out all corporations that have health financing as part of their corporate social responsibility; advocate for pooled resources to ensure block financing is enhanced; engage PSF.
Stewardship, Management and Accountability	Multi sectoral approach prescribed in the FP-CIP I did not meet expectations – both at national and sub national levels.	<ul style="list-style-type: none"> • Involve/solicit for multi sector views in the development of the various sector to ensure there is increased ownership of the plan, but also prescribe agreed responsibility based on capacity. • Maintain existing coordinating structures, but allocate budgets to support activities of coordination – OPM oversight should be budgeted and financed.
	IPs are not well coordinated and supervised by district authorities and sometimes, there is duplication of efforts in districts that have two or more IPs.	<ul style="list-style-type: none"> • With Support from MoH, Districts need to fully to exercise their mandate and effectively coordinate the activities of the different IPs.
	Improve data collection, use and storage on gains registered by the FP-CIP I.	<ul style="list-style-type: none"> • Designated a one stop centre for all contributing parties to the FP-CIP II. • The UFPC should step up its efforts to coordinate and monitor the interventions of IPs especially those that are not captured in the DHIS2. • At all levels (national and district), stakeholders should use the FP data to inform program decisions.

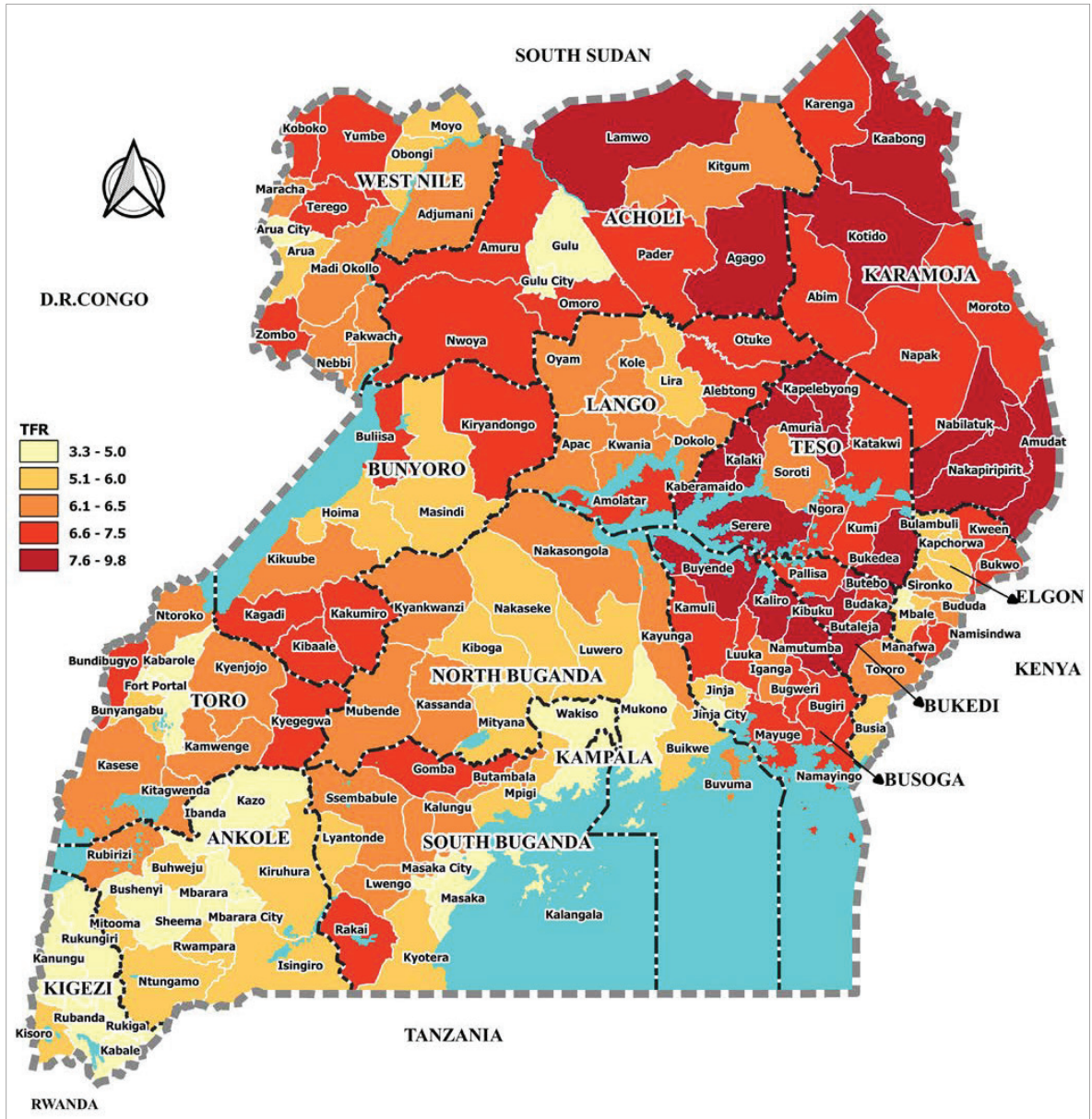
ANNEX 2: SUB-REGION DEMOGRAPHIC FACTORS AND FP PERFORMANCE

Sub-region	Districts	Demographic factors	FP performance	Key sub-regional issues
South Buganda	Butambala, Gomba, Mpigi, Bukomansimbi, Kalangala, Kalungu, Lwengo, Lyantonde, Masaka, Rakai, Sembabule and Wakiso	<ul style="list-style-type: none"> Population 4,981,360 Growth rate 2.3% (as high as 6.7% Wasiko) TFR 4.7 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 31.2% unmet need 20.5% teenage pregnancy rate 19.6% 	<ul style="list-style-type: none"> Rapid urbanization without a corresponding increase in socio-economic growth (health infrastructure, human resource for health, district budget). Geo-spatial factors (islands) affecting access to FP services. Private health facilities (63%) are more readily available than public facilities (13.4%) - issue of cost and limited method mix.
North Buganda	Buikwe, Buvuma, Kayunga, Kiboga, Kyankwanzi, Luwero, Mityana, Mubende, Mukono, Nakaseke, and Nakasongola	<ul style="list-style-type: none"> Population 4,490,089 Growth rate 3.2% (as high as 6.3% Buvuma) TFR 5.4 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 32.6% unmet need 24.1% teenage pregnancy rate 30.3% 	<ul style="list-style-type: none"> Rapid urbanization without a corresponding increase in socio-economic growth (health infrastructure, human resource for health, district budget). Inequitable access to FP among the vulnerable populations. Geo-spatial factors (islands) affecting access to FP services. Private health facilities (48.6%) are more readily available than public facilities (7.1%) - issue of cost and limited method mix private.
Kampala	Kampala Metropolitan Area	<ul style="list-style-type: none"> Population 1,516,210 Growth rate 2% (below national average) TFR 3.5 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 28.6% unmet need 24% teenage pregnancy rate 16.8% 	<ul style="list-style-type: none"> Rapid urbanization and cosmopolitan population. Contains almost one third of Uganda's health facilities (public (2%), PNFP (4%), PFP (94%)). Social demographic inequitable access to FP.
Busoga	Bugiri, Namutumba, Buyende, Iganga, Jinja, Kaliro, Kamuli, Luuka, Mayuge, and Namayingo	<ul style="list-style-type: none"> Population 4,704,815 Growth rate 3% TFR 6.1 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 24.6% unmet need 36.5% teenage pregnancy rate 20.7% 	<ul style="list-style-type: none"> High dependency and poverty rates. Geo-spatial factors (islands) affecting access to FP services (mobile fisher folk). Increasing urbanization (Jinja).

Bukedi	Budaka, Butaleja, Kibuku, Pallisa, Tororo, and Busia	<ul style="list-style-type: none"> Population 2,309,160 Growth rate 3.4% TFR 6.1 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 38.5% unmet need 30.4% teenage pregnancy rate 29.5% 	<ul style="list-style-type: none"> High dependency and poverty rates. Geo-spatial factors (islands) affecting access to FP services. Hotspots for sexual activity for inter-country truck drivers, such as towns and villages located along the major highway and border towns (Busia and Malaba).
Bugisu	Bulambuli, Kapchorwa, Kween, Bududa, Manafwa, Mbale, Sironko, and Bukwo	<ul style="list-style-type: none"> Population 2,176,722 Growth rate 3.5% TFR 5.6 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 34.1% unmet need 27.2% teenage pregnancy rate 28.2% 	<ul style="list-style-type: none"> High dependency and poverty rates Geographical access (landslides, hard-to-reach). Urbanization .
Teso	Amuria, Bukedea, Katakwi, Kumi, Ngora, Soroti, Kaberamaido, and Serere	<ul style="list-style-type: none"> Population 2,244,779 Growth rate 3.56% TFR 6 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 23.5% unmet need 36.3% teenage pregnancy rate 31.4% (highest in country) 	<ul style="list-style-type: none"> High levels of illiteracy. Uneven distribution of health facilities, with greater reliance on private facilities (cost barriers, limited method mix). Cattle keepers, tendency to value children for labor and dowry thereby encouraging large families. Geographical access (floods, drought).
Karamoja	Abim, Amudat, Kaabong, Kotido, Moroto, Nakapiripirit, and Napak	<ul style="list-style-type: none"> Population 1,194,053 Growth rate 3.2% (as high as 6.2% in Abim, one district with negative growth of 1.5%) TFR 8 (highest in country) Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 5.7% unmet need 19.7% teenage pregnancy rate 23.6% 	<ul style="list-style-type: none"> High levels of dependency, poverty and illiteracy. High levels of malnutrition. Children viewed as a source of income and economic support. Physical/geographical access challenges (predominantly rural population). Some of the population are semi-nomadic. Insecurity due to cattle rustling. Strong cultural norms, myths and misconceptions about FP.
Lango	Alebtong, Amolatar, Dokolo, Lira, Otuke, Apac, Kole, and Oyam	<ul style="list-style-type: none"> Population 1,828,201 Growth rate 3.24% TFR 5.5 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 23.5% unmet need 39% teenage pregnancy rate 23.8% 	<ul style="list-style-type: none"> High rates of urbanization coupled with remote populations. Early marriage and rising levels of child marriage. Geo-spatial barriers .
Acholi	Agago, Amuru, Gulu, Lamwo, Pader, Kitgum, and Nwoya	<ul style="list-style-type: none"> Population 2,069,618 Growth rate 3.2% TFR 5.1 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 30.4% unmet need 27.4% teenage pregnancy rate 27.9% 	<ul style="list-style-type: none"> High poverty levels and low human development. Large refugee population. High rates of urbanization .

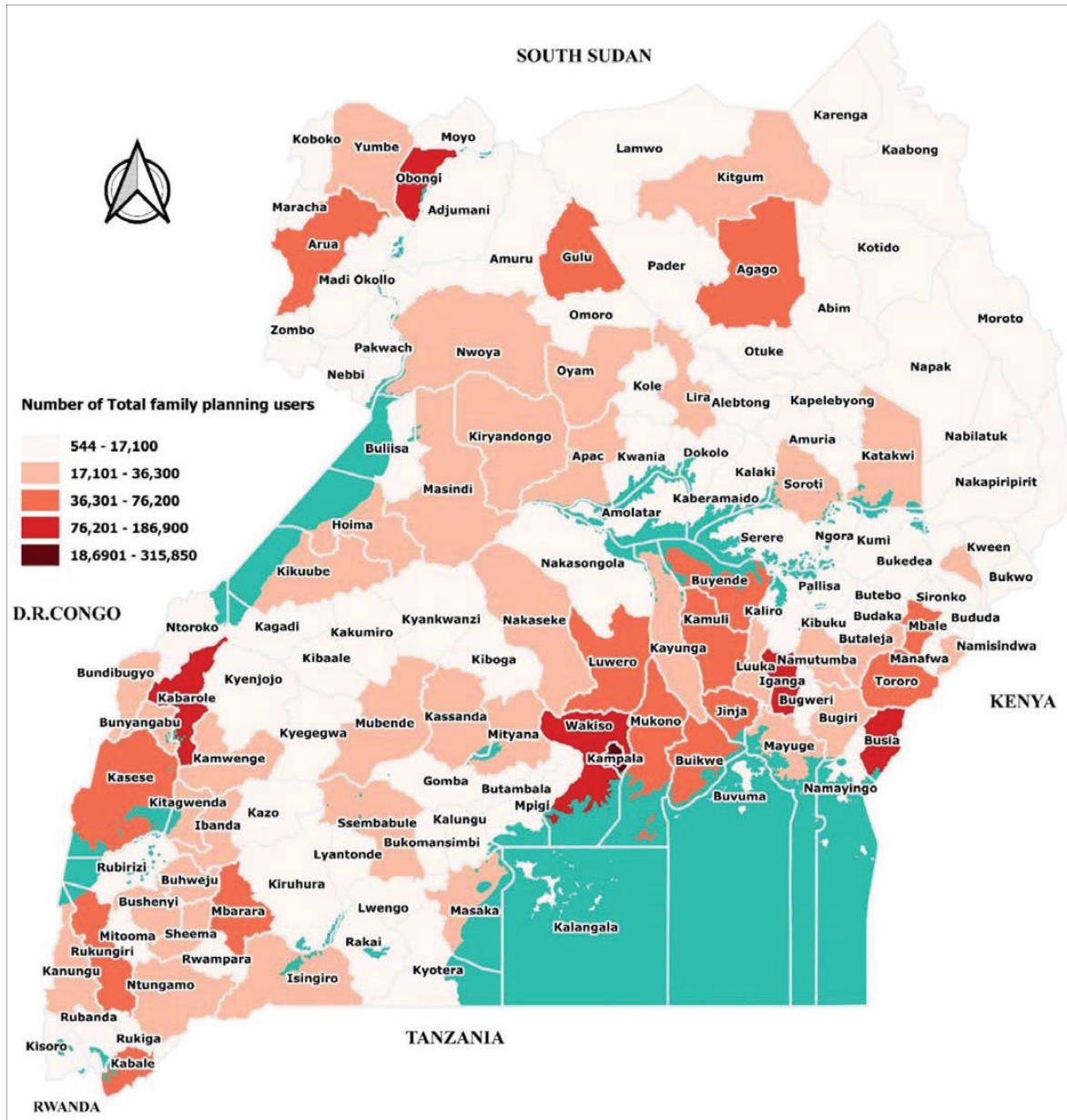
West Nile	Adjumani, Arua, Koboko, Maracha, Moyo, Nebbi, Yumbe, and Zombo	<ul style="list-style-type: none"> Population 2,661,000 Growth rate 1.96% (below national average) TFR 6 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 31.2% unmet need 43.2% teenage pregnancy rate 22.4% 	<ul style="list-style-type: none"> Rapid urbanization, high poverty levels, low human development index. FP perceived to promote immorality and prostitution especially among religious and cultural leaders.
Bunyoro	Buliisa, Hoima, Kibaale, Kiryandongo, and Masindi	<ul style="list-style-type: none"> Population 2,625,825 Growth rate 4.3% TFR 6 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 23.6% unmet need 28.8% teenage pregnancy rate 29% 	<ul style="list-style-type: none"> The region contains some of the most populated districts in Uganda Rapid urbanization, low literacy and human development Emphasis on public provision of FP despite low availability of government health facilities (12.3%)
Tooro	Bundibugyo, Kabarole, Kasese, Ntoroko, Kyenjojo, Kamwenge, and Kyegegwa	<ul style="list-style-type: none"> Population 2,589,652 Growth rate 3.65% TFR 4.7 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 30.8% unmet need 25.9% teenage pregnancy rate 30.3% 	<ul style="list-style-type: none"> Rapid urbanization, low adult literacy and low human development. Physical accessibility challenges coupled with natural disasters, i.e., floods and landslides.
Kigezi	Kabale, Kisoro, Kanungu, and Rukungiri	<ul style="list-style-type: none"> Population 1,525,140 Growth rate 1.5% (below national average) TFR 4.6 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 30.2% unmet need 19.9% teenage pregnancy rate 15.5% 	<ul style="list-style-type: none"> Low adult literacy and human development. Hard to reach populations, i.e., impassable roads during the rainy season. Poor birth spacing.
Ankole	Buhweju, Bushenyi, Ibanda, Isingiro, Kiruhura, Mbarara, Mitooma, Ntungamo, Rubirizi, Sheema	<ul style="list-style-type: none"> Population 3,358,773 Growth rate 2.4% (below national average) TFR 4.9 Primary school dropout rate 43% 	<ul style="list-style-type: none"> mCPR 30.2% unmet need 23% teenage pregnancy rate 18.9% 	<ul style="list-style-type: none"> Rapid urbanization, low human development. Poor birth spacing.

ANNEX 3: TOTAL FERTILITY RATE BY SUB-REGION AND DISTRICT, 2020



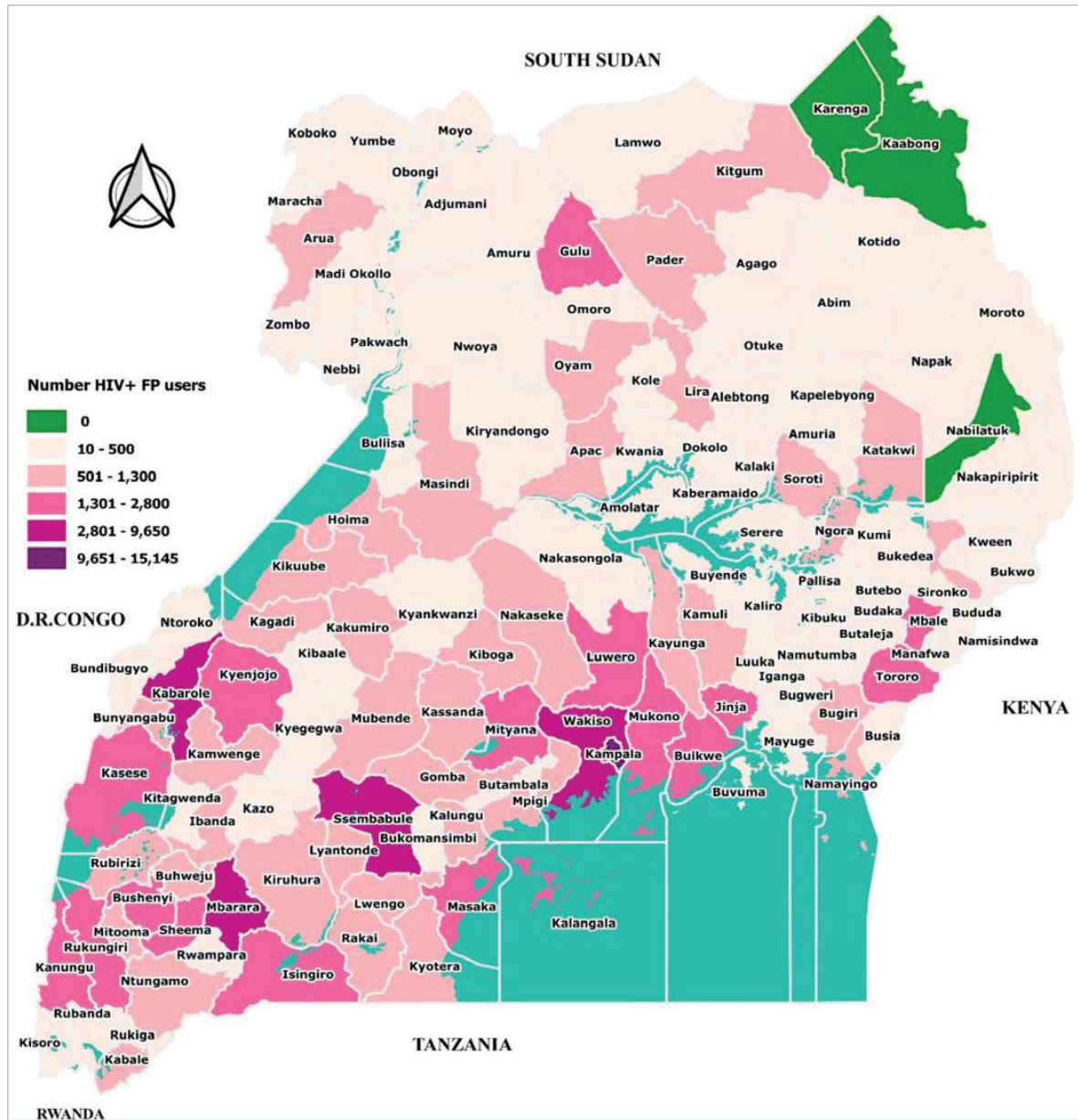
Source: Family Planning Atlas 2020

ANNEX 4: REGISTERED FAMILY PLANNING USERS BY SUB-REGION AND DISTRICT:



Source: Family Planning Atlas 2020, based on DHIS2 data

ANNEX 5: DISTRIBUTION OF HIV POSITIVE CLIENTS USING FP



Source: Family Planning Atlas 2020, using DHIS2 data.

Endnotes

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