HEALTH SYSTEMS ADVOCACY PARTNERSHIP

HEALTHY SYSTEMS, HEALTHY PEOPLE

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ASSESSING UGANDA'S PROGRESS ON FAMILY PLANNING 2020 COMMITMENTS

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LIST OF ACRONYMS

BMGF	Bill & Melinda Gates Foundation
CSE	Comprehensive sexuality education
CSO	Civil society organization
FBO	Faith-based organization
FP	Family planning
FP2020	Family Planning 2020
GOU	Government of Uganda
HC	Health center
HSAP	Health Systems Advocacy Partnership (project)
ICPD	International Conference on Population and Development
IDA	International Development Agency
MFPED	Ministry of Finance, Planning and Economic Development
MMR	Maternal mortality ratio
NGO	Non-governmental organizations
NHA	National Health Accounts
NMS	National Medical Stores
NPC	National Population Council
PEPFAR	US President's Plan for Emergency Relief for AIDS
PMA2020	Performance Monitoring and Accountability 2020
PNFP	Private-not-for-profit (health facilities)
PPD ARO	Partners in Population and Development Africa Regional Office
R&D	Research and development
RHSC	Reproductive Health Supplies Coalition
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
S&Gs	Standard and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHMG	Uganda Health Marketing Group
UNCST	Uganda National Council for Science and Technology

EXECUTIVE SUMMARY

Introduction

During the 2012 Family Planning Summit in London, the Government of Uganda (GOU) made political, financial, program and service delivery commitments to reduce unmet need for family planning from the current 40% to 10% and improve the modern contraceptive prevalence rate among married women and women in union to at least 50% by 2022.[1]

Study objective

The overall objective of this study was to assess progress towards FP2020 commitments.

Methods

The study used a qualitative approach. Primary and secondary data were collected at the national level, as well as at district and service point levels in Kabale and Soroti districts. Data were obtained from policy makers, program managers and service providers, using personal interviews. Secondary data were obtained through an internet search and desk review of official and unofficial documents, records and reports. Data were analyzed using a thematic content analysis.

Progress on financial commitments

The available data about GOU allocations to NMS for reproductive health commodities has over the past five financial years (FY2012/13-FY2016/17) been a constant Ushs 8 billion (US$2.2 million) per annum, equivalent to 44% of the US$5 million it committed to provide. The official country FP2020 Annual Commitment Update for 2016 shows that GOU maintained its allocation of USD $3.3 million (Ushs 11.9 billion) – equivalent to 66% of the amount it pledged.

However, GOU has been more successful in mobilizing additional resources from donors. As of end of FY2014/15, a total of US$25.54 million had been raised from USAID, UNFPA, DFID and IPPF. Additional resources (US$ 30 million) have been committed from the World Bank through the Global Financing Facility (GFF) Trust Fund. Of this amount, US$7 million will go towards family planning supplies between 2017-2021.

Progress on policy commitments

The major policy developments include the development of the Family Planning Costed Implementation Plan 2015-2020; the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Case in 2016; as well as the Guidelines for Alternative Distribution Strategy for Family Planning Commodities. The Population Secretariat has been upgraded to National Population Council (NPC).

The major policy setbacks have included: 1) Ministry of Health stayed the Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (S&Gs) after they were published in April 2015; 2) The ban on comprehensive sexuality education (CSE) in 2016; and Ministry of Health stayed the revised National Guidelines and Standards for Sexual and Reproductive Health and Rights in 2017.

Progress on programming and service delivery commitments

A family planning campaign that followed the FP2020 summit has improved the family planning policy environment, funding, commodity security, service provider capacities, collaborations with non-state actors, service availability, and overall uptake of family planning services and information. At the national level, the proportion of married women currently using a modern contraceptive method improved from 26% in the 2011 UDHS to 35% in the 2016 UDHS.

1 Fp 2020 commitments for uganda available at http://www.pamilyplanning2020.org/uganda

At the local level, each of the facilities reached by the study team in Kabale and Soroti districts reported to be providing family planning services, some on a daily basis. All service providers and program managers reached in this study reported an improvement in the uptake of family planning services as well as in the overall availability of commodities. None of the facilities reached in this study reported experiencing a stock out of all commodities at ago, with Depo Provera reported to be always available and in a few cases, to be in excess of need.

On the promotion of the midwifery profession, the midwifery curriculum has been reviewed; more midwifery tutors have been trained; and more midwives have been recruited. Youth friendly services have been promoted at Health Center IVs (HC IVs) and hospitals in some seven districts, and there is a rising appreciation of the special sexual and reproductive health needs of adolescents.

Factors affecting achievement of FP2020 commitments

- Service providers are generally not aware of FP2020, its objectives and the commitments therein. FP2020 has remained at the policy and programming level, and has not been scaled to the operational and implementation level.
- In spite of the reported improvement in commodity supplies, the problem of stock-outs persists, limiting choice of options. None of the facilities reached reported to have emergency contraceptive pills or female condoms. There is a shortage of equipment for insertion and removal of IUDs and implants.
- All the facilities reached in this survey reported a shortage of staff and are constrained in provision of family planning counselling for lack of adequate time. None of the facilities had a member of staff dedicated to the provision of family planning services.
- The training of service providers is not systematic. Most of the training in the provision of long-term methods is being conducted by implementing partners, but their capacity to train all service providers regularly appears limited.
- Progress on ensuring that service points are youth friendly is slow. Facilities report a critical shortage of infrastructure and staff that they are unable to dedicate a separate room and a service provider for a youth corner.

Implications of the US Mexico City Policy

The recently re-instated 'Mexico City Policy', which bars the US Government and its agencies from providing support to organizations providing abortion services, counseling or making referrals for abortion, or advocating for abortion law reform, is projected to reduce US global health assistance by at least US$8.8 billion.[2] Without this funding, many organizations working in sub-Saharan Africa, Uganda inclusive, will be unable to provide integrated maternal health care with contraceptive services, among other services. The findings indicate that the program of the new, self-injectable method – Sayana press – being rolled out in part of Uganda with USAID support is likely to be one of the first to be affected.

2 The 1973 "Helms Amendment" to the Foreign Assistance Act prohibits the use of US funds from paying "for the performance of abortion as a method of family planning."

Recommendations

1) The FP2020 commitments need to be popularized not only among program managers but also among service providers and service users.
2) Ministry of Health should convene stakeholder a dialogue to find a way forward on comprehensive sexuality education, and adolescent access to contraceptives.
3) The RHSC and its member institutions should expand its "commitments compendium" to define activities needed to achieve all FP2020 commitments.
4) Partners should agree a standard minimum range of commodities that have to be supplied to service points and resolve supply chain hurdles.
5) Ministry of Health should mainstream the training of family planning service providers and increase their numbers.
6) Ministry of Health should engage partners to invest in the health system's capacity to reach young people.
7) The family planning campaign should be more aggressive in meeting the unmet need for family planning and in cultivating demand through community mobilization and education.

1. BACKGROUND

1.1 Introduction

By the time the London Family Planning Summit convened in 2012, there were concerns that family planning had never really been prioritized since the 1994 International Conference on Population and Development (ICPD) in Cairo, which set a plan of action for, among other things, access to sexual and reproductive health (SRH) services including family planning.

In spite of the long-standing and widely accepted rationale for voluntary family planning programs which culminated into the ICPD and its plan of action, funding for family planning declined by 30% in the decade following the ICPD.[3] A number of reasons were cited, including opposition from conservative governments, in particular the George W. Bush administration and its so-called Mexico City Policy, which was implemented over the period.[4]

In 2012, on World Population Day (11th July), different stakeholders convened in London to address the low attention given to family planning as a global health priority[5], and particularly, the unmet need for family planning among the world's poorest populations.

According to a study by the Guttmacher Institute and UNFPA, by 2012, an estimated 645 million girls and women in the developing world were accessing modern contraception. An estimated 222 million others had an unmet need for modern family planning, especially in 69 of the world's poorest countries.[6] The London summit on family planning targeted to secure US$4.3 billion for provision of modern methods of contraception to 120 million more girls and women in the 69 lower income countries by 2020.[7]

Four African presidents from Malawi, Rwanda, Tanzania and Uganda attended the summit, as well as the then UK Prime Minister – a reflection of political commitment. Many other stakeholders including UN agencies, philanthropists, academia, USAID and the private sector also showed strong commitment by gracing the summit.

Strong financial commitments to improve access were made by 11 African and 3 Asian countries, totaling to US$2 billion by 2020. The donors pledged US$2.6 billion, totaling to US$4.6 billion – a figure in excess of the original target of US$4.3 billion.[8] The British Government which co-hosted the summit together with the Bill & Melinda Gates Foundation (BMGF), was the largest donor with a commitment of US$800 million over the 8-year period. The second largest donor was summit co-convener BMGF with US$560 million. Pharmaceutical companies also pledged to increase availability of low cost or no cost contraceptives. While the US Government did not commit new funds, the representative pledged to increase efforts in research and development (R&D) in the area of contraceptives.

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3 Speidel J (2006). Funds for family planning and reproductive health. A paper presented at the International Parliamentarians Conference on the Implementation of the ICPD Program of Action, Bangkok, Nov. 21-22, 2006.

4 Bongaarts J and Sinding S.W (2009). A Response to Critics of Family Planning Programs. *International Perspectives* on Sexual and Reproductive Health, vol.35 Issue 1. https://www.guttmacher.org/journals/ipsrh/2009/03/response-critics-family-planning-programs

5 Cohen. S.A (2012). London Summit Puts Family Planning Back on the Agenda, Offers New Lease on Life for Millions of Women and Girls. Guttmacher Policy Review Summer 2012 | Volume 15 | Number 3

6 Singh. S and Darroch. J.E (2012). Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012. Guttmacher Institute and UNFPA. https://www.guttmacher.org/sites/default/files/report_pdf/aiu-2012-estimates_0.pdf

7 Bill & Melinda Gates Foundation. Press release (2012). Landmark Summit Puts Women at Heart of Global Health Agenda.https://www.gatesfoundation.org/Media-Center/Press-Releases/2012/07/Landmark-Summit-Puts-Women-at-Heart-of-Global-Health-Agenda

8 Cohen. S.A (2012). London Summit Puts Family Planning Back on the Agenda, Offers New Lease on Life for Millions of Women and Girls. Guttmacher Policy Review Summer 2012 | Volume 15 | Number 3

During the summit, the global community agreed to advance women's rights with higher impetus, calling for creative interventions and dedicated public-private partnerships to achieve the goals set. The summit called for political commitment and resources that would enable an additional 120 million women access contraceptive services. Uganda joined this cause and President Museveni made political, financial, program and service delivery commitments to reduce unmet need for family planning from the current 40% to 10% by 2022.[9]

This study sought to assess progress on the GOU FP2020 commitments, the facilitating factors and barriers to achieving the set targets, including the implications of the reinstatement of the Mexico City Policy Uganda's leading health development partner, the US Government. This study was conducted a part of the Health Systems Advocacy Partnership (HSAP) project, implemented by Amref Health Africa in partnership with African Center for Health and Social Transformation (ACHEST), Coalition for Health Promotion and Social Development (HEPS) in collaboration with Health Action International (HAI), and Center for Health, Human Rights and Development (CEHURD), among other partners, with funding from the Ministry of Foreign Affairs of the Netherlands.

1.2 Situation analysis

Women and girls are unable to realize their right to the highest attainable standard of health. Worldwide, too many women, children and adolescents still have little or no access to essential good quality health services; experience violence, discrimination and disempowerment; and encounter other barriers to realizing their rights.[10] Globally, the targets for Millennium Development Goals for reducing maternal deaths were never met, even though significant progress was registered. The global under-five mortality rate fell by 53% between 1990 and 2015, short of the target of two thirds reduction. Global maternal mortality ratio (MMR) declined by 44%, which was also short of the targeted 75%.[11]

More than one third of the global burden of premature mortality is accounted for by deaths among pregnant women, children and adolescents, majority of which are preventable.[8] The majority of these deaths occur in developing countries. Maternal mortality rates are 19 times higher in developing countries compared to the developed world.[9] The probability of children dying before the age of five in developing countries is eight times more than it is in developed countries.[12] By the end of the MDGs in 2015, Uganda's MMR was estimated 360 deaths per 100,000 live births, short of the target of 131 deaths per 100,000 live births.[13] The current MMR is estimated at 336 deaths per 100,000 live births.[14]

The total fertility rate (TFR) has declined from 7.4 children per woman in 1988-1989 to 5.4 children per woman in 2016, this rate remains too high.[15] Teenage pregnancy is a major problem, with too many girls starting to have children too early in life. By the age of 15-19, 25% of the adolescents have started having children, 19% have given birth and 5% are pregnant. Child bearing among adolescents rises rapidly with age. By the age of 15, 3% have had children. This percentage rises rapidly to 22% by the age of 17 years, and to 54% by the age of 19 years.[16]

9 FP 2020 commitments for Uganda available at HTTP://WWW.FAMILYPLANNING2020.ORG/UGANDA
10 Every woman, Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).
11 The Millennium Development Goals Report 2015, United Nations.
12 United Nations: Millennium Develop Goals' Report 2015.
13 Trends in Maternal Mortality: 1990-2-13 Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division
14 Uganda Demographic and Health Survey 2016
15 Uganda Demographic and Health Survey 2016
16 Uganda Demographic and Health Survey 2016

The use of modern family planning remains low. Modern contraceptive prevalence among married women is 35%; prevalence of traditional methods among the same group is 4%, giving a total of 39%. Contraceptive prevalence among sexually active unmarried women is 51% (47% modern methods; 4% traditional methods). The unmet need for family planning among married women is 28% and demand for family planning among the same group is 67%. The unmet need among sexually active unmarried women stands at 32%.

The unmet need for family planning in Uganda is still high while contraceptive prevalence in Uganda is still low. Under the Family Planning 2020 (FP2020) commitments, Uganda made formal pledges to expand access to voluntary rights-based family planning.[17] President Museveni, on behalf of the Government of Uganda (GOU) made political, financial, program and service delivery commitments to reduce unmet need for family planning from the current 40% to 10% by 2022.

However, half way the period, the key indicators show slow progress. The unmet need for family planning among married women and women in union has reduced by only 12 percentage points to 28%, while among unmarried sexually active women it is estimated even higher, at 32%. There is therefore need to assess progress on the commitments made during the London Family Planning Summit of 2012 and to identify the factors that may be slowing down progress, in order to inform advocacy for faster progress.

17 Family Planning 2020 Commitments

1.3 Uganda's Family Planning 2020 commitments

During the 2012 and 2017 London Summits on Family Planning, GOU made the following commitments to improve family planning funding, policy environment, political commitment, system strengthening and service delivery by the indicated timeframes in order to reduce the unmet need from 40% to 10% by 2022.

a) *Commitment during the 2012 summit*

COMMITMENT	TIMEFRAME
Policy and political commitments	
Develop and implement an integrated family planning campaign	2012-2020
Create an enabling policy environment for family planning	2012-2020
Increase financial investment into health human resources development	2012-2020
Strengthen the delivery of health services	2012-2020
Conduct half yearly RH/FP reviews by the Ministry of Health	2012-2020
Ensure timely completion of the Annual Household Panel Surveys by Uganda Bureau of Statistics to ascertain progress on heath, including FP, service delivery	2012-2020
Carry out a robust evaluation of all FP investments in Uganda	2012-2020
Accelerate passage of the National Population Council Bill into law	2012-2020
Make inter-ministerial structure functional and appropriating the necessary budget support	2012-2020
Review the current post-shipment testing policy on male and female condoms in line with current international standards to reduce delays in release of vital RH supplies, including FP supplies	2012-2020
Financial commitments	
Increase annual budget allocation for FP supplies from US$3.3 million to US$5 million for the next five years	2012-2017
Mobilize an additional US$5 million a year through donor financing	2012-2020
Design a plan to reorganize health financing and develop a health insurance plan for the country	By 2020
Promote voucher programs as a form of demand-side financing to increase use of FP and safe motherhood services among the poor	2012-2020
Program and service delivery commitments	
Partner with appropriate private sector bodies and institutions for the integration of MH/RH/FP and HIV&AIDS information and services for their employees and families	2012-2020
Strengthen institutional capacity of public and community-based service delivery points to increase choice and quality of care at all levels (through staff recruitment, train motivation and equipment)	2012-2020
Support the development and professionalization of midwifery through skills training, good employment practices, and the involvement of midwives in policy dialogue and health management	2012-2020
Investing in midwifery career promotion and the bonded midwifery scholarship programs	2012-2020
A road-map to finance, train, recruit, retain, and manage performance of skilled human resources for health will be developed	2012-2020
Roll out youth friendly services in all Government Health Center IVs and district hospitals	2012-2020

Strengthen the technical and institutional functionality of Uganda Health Marketing Group and National Medical Stores in a dual public-private RH supplies distribution system	2012-2020
Continuing to support the public-private arrangement for increased access to FP services	2012-2020
Scale-up partnerships with CSOs and private sector entities for FP outreach and community-based services to target hard-to-reach communities, and to invest in social marketing and social franchising approaches to ensure access to FP	2012-2020

b) *Commitments during the 2017 summit*

It is important to note that amidst these commitments, during the London summit, in July 2017, Uganda made five further commitments[18] in a bid to ensure that it meets the unmet need for family planning. Uganda committed to:

1) Allocate $5million annually from domestic funding to expand the choice of methods,
2) Work closely with development partners to raise US$20 million annually for family planning,
3) Support a robust communication strategy to increase demand and linkage to family planning services ensuring a cross sectoral approach that addresses broader issues such as child marriage and girls' education,
4) Reduce the unmet need amongst adolescents from 30.4% in 2016 to 25% in 2021 through operationalizing the National Adolescent Health Policy and the National Sexuality Education Framework, and
5) By increasing the deployment of critical health cadres in hard-to-reach areas and by task shifting where appropriate, to expand the provision of services to include long-acting and reversible and permanent methods

18 http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/07/FP_Summit_2017_Commitment_Summary_Update-V17-FINAL-CLEAN.pdf

1.4 Rationale of the study

Uganda has one of the youngest populations in the world; more than half of the country's population (50.3%) is aged 15 years and below.[19] This reflects a high population growth rate, a high fertility rate and a high dependency ratio. Overall, the country's age dependency ratio is estimated at 103, implying that for every 100 economically active persons, there are 103 dependents.[20] As noted in the 2008 National Population Policy and Vision 2040, the high child-dependency ratio is a major barrier to social transformation and development in Uganda.

Uganda's unfavorable population dynamics can be turned into a "demographic dividend"[21] only with investments in family planning, education, and economic policy.[22] The country will have to undergo steady fertility decline to achieve an age structure concentrated in the working ages. Access to family planning information and services is critical to achieving declining fertility and childbearing, thereby shaping a country's demographic path while simultaneously improving health and increasing savings across development sectors.[23] Fulfilment of Uganda's aspirations for socioeconomic transformation and transition into an upper-middle income country by 2040 can be enhanced considerably if the country prioritizes policies that will facilitate citizens to have smaller families.[24] Addressing the unmet need for family planning calls for reducing barriers to demand, access, and use of family planning through, among others sustaining a high level of government investment in family planning.[25]

Family planning is not only a development issue but also a health and human rights issue. Among the internationally agreed human rights central to human well-being is the right to sexual and reproductive health (SRH).[26] This right was endorsed by 179 governments in the 1994 Program of Action of the International Conference on Population and Development (ICPD). The ICPD Program of Action stated that individual rights and dignity – including the equal rights of girls and women, and universal access to sexual and reproductive health and rights (SRHR) – are necessary for the achievement of sustainable development. Access to family planning services is a foundational element, not just of reproductive health, but of social and economic equality, since unintended pregnancy constrains opportunities that women would otherwise have for education, civic participation and economic advancement.[27]

19 UBOS, 2016. National Population and Housing Census 2014
20 UBOS, 2016. National Population and Housing Census 2014
21 "Demographic dividend" refers to the economic benefit a society enjoys when fertility and mortality rates decline rapidly and the ratio of working-age adults significantly increases relative to young dependents.
22 National Planning Authority, 2014. Harnessing the Demographic Dividend: Accelerating Socioeconomic Transformation in Uganda
23 National Planning Authority, 2014. Harnessing the Demographic Dividend
24 National Planning Authority, 2014. Harnessing the Demographic Dividend
25 National Planning Authority, 2014. Harnessing the Demographic Dividend
26 UNFPA, 2017. Worlds apart: Reproductive health and rights in an age of inequality. *State of the world population 2017.* https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2017_EN_SWOP.pdf
27 UNFPA, 2017. Worlds apart: Reproductive health and rights in an age of inequality. State of the world population 2017.

There have been important gains in recent decades in realizing the SRHR of girls and women, including in addressing unmet need for family planning, increasing contraceptive prevalence, and preventing unintended pregnancies. However, the pace of these gains has gradually slowed and has been short of national and international targets.[28] The London Family Planning Summit of 2012 came at a time when the international community and many low-income countries were reflecting on the gaps responsible for slowing progress since the ICPD (1994) and the Millennium Summit (2000), and at a time ideas were being floated for the post-Millennium Development Goals (MDGs) agenda.[29] Hence, FP2020, which culminated from the summit, was based on the principle that all women, no matter where they live, have a right to access contraceptives.[30]

Delegates at the FP2020 summit, including Uganda, pledged to expand access to rights-based family planning through a set of ambitious financial, political, program and service delivery interventions. Reporting on the progress towards implementing the interventions pledged and its effectiveness in achieving the overall target of reducing the unmet need for family planning from 40% in 2012 to 10% has not been systematic and consistent. Work done by partners so far in tracking progress on the FP2020 has suggested that by December 2015, all the financial commitments had been achieved, while the policy and service delivery commitments are yet to be achieved, but are on track. However, an official update report on progress in achieving GOU Family Planning 2020 commitments for the period 2015-2016 shows that even the financial commitment of investing US45 million per annum in family planning supplies are yet to be achieved; revealing that the country continued to invest US$3.3 million in domestic resources into family planning.

National family planning indicators suggest that overall progress on achieving the target of target of reducing the unmet need for family planning from 40% to 10% by 2022 is slow. The unmet need for family planning is still 28% and 32% among married women (including women in union) and sexually active unmarried women[31], respectively. In view of the inconsistent reporting and slow progress on the key target indicators, it was necessary for the civil society to undertake this rapid assessment of interventions implemented to achieve GOU FP2020 commitments, to identify to identify facilitating factors and barriers that can be highlighted in advocacy efforts for accelerated progress.

1.5 Objectives of the study

1) To assess the progress on the FP 2020 country commitments,

2) To determine factors that are facilitating progress and barriers to achieving FP2020 targets, including the Mexico City Policy and its implications for SRHR services in Uganda,

3) To analyze the national budget for family planning for the last five years and determine the funding sources, including government and funding trends,

4) To identify key advocacy issues for next steps.

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28 Darroch JE and Singh S. 2013. Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: An analysis of national surveys. *Lancet* 2013; 381: 1756-62

29 The Lancet, 2014. Meeting demand for family planning within a generation: The post-2015 agenda. Comment, *The Lancet.* http://dx.doi.org/10.1016/ S0140-6736(14)61055-2

30 The Lancet, 2014. Meeting demand for family planning within a generation: The post-2015 agenda. Comment, *The Lancet*

31 Uganda Demographic and Health survey (UDHS) 2016

2. METHODOLOGY

2.1 Study design

This study used qualitative methods to assess the country's progress on implementation of interventions GOU made under the FP2020 commitments. The data were collected at national and district levels. In addition, collation of existing relevant data was done, including from work done by different stakeholders and partners.

2.2 Sampling and study setting

This study was conducted at both national and district levels. At the national level, key informant interviews were held with representatives of the Reproductive Health Division and the Pharmacy Division of Ministry of Health, as well as with key civil society SRHR advocacy organizations.

At the district level, data were collected from program managers, health facility in-charges and service providers in Kabale and Soroti districts. The study was restricted to two districts due to time and budget constraints, under the assumption that what is happening in two districts could be happening in other parts of the country. Kabale and Soroti districts were selected because they are part of the HSAP project implementation districts, and have a broad scope of the health system structure, ranging from HC IIs to regional referral hospitals.

Kabale district lies in the Southwest of Uganda. It borders the districts of Kisoro to the West, Rukungiri to the North, Ntungamo to the East and the Republic of Rwanda to the South. The total population is estimated at 534,160 and about 86% live in rural areas.[32] The district has a total of 117 health facilities, including two hospitals (one public, one private-not-for-profit, PNFP), seven HC IVs, 23 HC IIIs (16 public, seen PNFP) and 85 HC IIs (65 public, 20 PNFP).[33]

On the other hand, Soroti district is found in the eastern part of the country. It is bordered by districts of Amuria to the North, Katakwi to the East, Ngora to the southeast, Serere to the South, and Kaberamaido to the West. The population is estimated at 297,157 and about 83% of these live in rural areas. The district has 29 health facilities, including three HC IIs, 14 HC IIIs, three HC IVs and one hospital. In addition, it has six private and PNFP dispensaries, one HC III, one hospital and a regional referral hospital.[34]

2.3 Data sources

Data was obtained through an online literature search, a desk review of reports from government, development partners and advocacy organizations and groups, as well as from personal interviews with key informants. Secondary data was obtained from government and partner reports and documents. Data on progress on FP2020 was obtained from the online partners' reproductive health commitments tracking portal (http://www.ugandarhpromises.org/), used by partners under the Reproductive Health Supplies Coalition (RHSC) to track progress on three sets of commitments, including FP2020, using an agreed "Commitments Compendium" of indicators.

Primary data was obtained through interviews with program managers at national and district levels, as well as with service providers at health center III, IV and hospital levels in Kabale and Soroti districts. In Kabale, the study team held interviews with the acting district health officer (DHO); the in-charge of maternal and child health as well as the nursing officer in charge of family planning of Kabale regional referral hospital; the in-charges and family planning service providers at one HC III and two HC IVs.

32 Uganda Bureau of Statistics, 2016. National Population and Housing Census 2014.
33 Kabale District Local Government 2012. Kabale District Local Government Statistical Abstract 2012.
34 Uganda Travel Directory accessed from http://www.ugandatravelguide.com/soroti-district.html on 15/08/2017

In Soroti, the study tam held interviews with the assistant DHO; the in-charge of one HC III, two HC IVs (one public, one PNFP); and with the principal nursing officer and the administrator of Soroti regional referral hospital.

The preliminary findings were presented at a validation meeting attended by representatives of Ministry of Health, district local governments of Kabale, Soroti, Kisoro, Serere, Dokolo and Lira, service providers, media and the civil society. The inputs from the validation meeting were incorporated into this report.

2.4 Data management and analysis

Interviews were transcribed verbatim and saved in electronic form as word documents. An initial coding frame was developed which will be tested on a few transcripts. The coding frame was then iteratively refined to ensure that it provides a suitable structure for organizing the data into smaller more manageable analytical units. Two researchers who are part of the study coded the rest of the transcripts and the coded data were compared. The coded data were then analyzed using thematic content analysis.

2.5 Ethical Consideration

Ethical approval for the study was sought and obtained from Uganda National Council for Science and Technology (UNCST) and Makerere University College of Health Sciences Higher Degrees Ethics Committee. Informed consent was obtained from all the respondents.

2.6 Limitation of the study

The sample of the study was limited to only two districts, and hence its findings can only be generalized by deduction. This study was unable to secure interview appointments with all the target respondents due to a combination of busy schedules of key informants, and limited timeframe allocated to data collection. While the desk review was comprehensive, it can hardly be considered to have been exhaustive.

3. PROGRESS ON FP2020 COMMITMENTS

Following a series of reproductive health-related commitments that Uganda made at the international level, including under FP2020, stakeholders under the Reproductive Health Supplies Coalition (RHSC) agreed a "commitments condominium", which deconstructs all explicit and implicit commitment statements for FP2020 and other reproductive health-related commitments made by Government of Uganda (GOU) into implementable activities and indicators that the coalition monitors. The coalition monitors progress on the basis of the agreed indicators and posts results on an online "motion tracker" portal.[35] This section assesses progress on FP2020 commitments as reported on the RHSC portal vis-à-vis findings from other sources reached in this study, including official records/reports and key informants at national, district and service provision levels.

Summary of progress

COMMITMENT	ACTIONS	PROGRESS
Financial		
Increase funding for FP from USD 3.3 million to USD 5 million per year for 5 years	GOU has allocated Ushs8 billion per annum between FY2012/13-2016/17 to reproductive health items under Budget Vote 116	No progress
Mobilize an additional USD 5 million from donors	Development partners have contributed approx. US$25.5m over 5-year period from 2013/14 Additional US$7m from World Back/GFF for FP supplies 2017-2021	Achieved
Reorganize health financing and develop a health insurance plan for the country, and to establish voucher programs as a form of demand-side financing	• Debate on the National Health Insurance Bill has stalled • MSI Uganda contracted to manage the voucher program for maternal health and family planning	Limited progress
Policy		
Create an enabling policy environment for FP, increasing financial investment into health human resources development, and strengthening the delivery of health services	• Developed the Investment case for reproductive, maternal, newborn, child and adolescent health: Sharpened plan for Uganda 2016/17-2019/20. Published 2016 • Developed and published Uganda Family Planning Costed Implementation Plan (2015-2020) • MOH stayed the Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (S&Gs) after they were published in April 2015 • Gender Ministry banned CSE in 2016 • MOH stayed the revised National Guidelines and Standards for Sexual and Reproductive Health & Rights in 2017	Limited progress

35 http://www.ugandarhpromises.org/

Implementation/service delivery		
Develop and implement an integrated family planning campaign	• Uganda held first National Family Planning Conference in 2014 • Demographic Dividend report emphasizing family planning launched in 2014 • Second national family planning conference held September 2017	Partially achieved
Conduct half yearly RH/FP reviews; ensure timely completion of the Annual Household Panel Surveys to ascertain progress on heath, including FP, service delivery	• Performance Monitoring and Accountability 2020 (PMA2020)[1] started collecting data on key family planning indicators in Uganda every six months since May 2014 • First annual household panel survey conducted 2016	On track
Carry out a robust evaluation of all FP investments in Uganda	*Data not available to measure progress*	
Accelerate passage of the National Population Council Bill into law, immediately making the inter-ministerial structure functional and appropriating the necessary budget support	Established a National Population Council by an act of Parliament to oversee population and RH programs including FP	Partially achieved
Review the current post-shipment testing policy on male and female condoms in line with current international standards to reduce delays in release of FP supplies	*Data not available to measure progress*	
Support a robust communication strategy to increase demand and linkage to family planning services ensuring a cross sectoral approach that addresses broader issues such as child marriage and girls' education	*Data not available to measure progress*	
Reduce FP unmet need amongst adolescents from 30.4% in 2016 to 25% in 2021 through operationalizing the National Adolescent Health Policy and the National Sexuality Education Framework	MoH with support from UNFPA, Amref and WHO held meetings to assess gaps in the CME service guidelines and align them to WHO standards Ministry of Gender banned CSE in October 2016	Retrogressed
Develop and professionalize midwifery through skills training, good employment practices, and the involvement of midwives in policy dialogue and health management	Midwifery curriculum reviewed; more tutors have been trained; and more midwives have been recruited. Midwives association formed Implementing partners providing training in long-term methods, but on limited scale	On track
By increasing the deployment of critical health cadres in hard-to-reach areas and by task shifting where appropriate, to expand the provision of services to include long-acting and reversible and permanent methods	A task sharing advisory committee co-chaired by MoH and PPD ARO has been established. PPD ARO has also engaged parliamentarians through advocacy ensuring visibility of task sharing at the highest level. MoH incorporated task sharing within the FP guidelines	On track

3.1 Progress on financial commitments

The key GOU financial commitment was to increase the annual budget allocation for family planning supplies from US $3.3 million to US $5 million per annum for the next five years (2012-2016); and to mobilize an additional US $5 million per year from development partners. The other financial commitments were: to reorganize health financing and develop a health insurance plan for the country; and to initiate voucher programs as a form of demand-side financing to increase use of family planning and safe motherhood services among the poor – in both cases, by 2020.

3.1.1 Domestic funding for family planning

Available data on GOU allocations to family planning commodities show that the commitment to allocate US$5 million from domestic resources to family planning supplies has not been achieved yet. A sub-count within the National Health Accounts (NHA) was created for reproductive health items on the budget vote for NMS (Vote 116) to track and ring-fence government investments in SRHR supplies. For the five-year period FY2012/13-2016/17, this account has been allocated Ushs8 billion per annum (US$2.2 million), reflecting an allocation of 44% of the commitment sum.

This amount (Ushs 8 billion), which is equivalent to about US$ 2.2 million[36], is not only far below the commitment of US$ 5 million per year, but has remained constant over the five year period. In addition, the constant amount has been spread to a bigger number of items. For the three years FY2012/13-2014/15, the amount was used to buy only Depo Provera; from FY2015/16, mama kits were added; and in the following year FY2016/17, Misoprostol for the prevention and management of postpartum hemorrhage, was added – with the total allocation remained constant.

The lack of progress on the financial commitments is corroborated with information from the official country FP2020 Annual Commitment Update for 2016, which reveals that GOU maintained its allocation of USD $3.3 million (Ushs 11.9 billion) – equivalent to 66% of the amount it pledged – which was the baseline allocation at the time the commitments were made in 2012.

3.1.2 Donor funding for family planning

GOU has been more successful in mobilizing additional resources from donors as pledged. As of end of FY2014/15, USAID had committed USD 8 million towards contraceptives including condoms; UNFPA USD 7.5m for contraceptives; DFID USD 10m for commodities; and IPPF USD 40,000 worth of contraceptives, among other donations – giving a total of US$ 25.54 million.

In July 2016, Uganda submitted an investment case, totaling US$140 million, which has since been approved by the World Bank. Of this figure, US$110 million is financed by an International Development Agency (IDA) credit and US$30 million is a grant from the Global Financing Facility (GFF) Trust Fund. The goal of the investment case is to improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts; and scale-up birth and death registration services (CRVS).

The GFF process was informed by the Family Planning Costed Implementation Plan 2015-2020, which estimates a total cost of interventions to achieve the FP2020 commitments of Ushs 622 billion (or US$235 million), of which nearly half (US$ 115 million) is budgeted for commodities, including contraceptives and consumables.

36 At the current exchange rate of US$1=Ushs 3,600

The GFF allocation of US$ 7,037,386 for procurement of reproductive health commodities set criteria for prioritization to include: priority commodities that have a funding gap; long acting reverse family planning methods; commodities with no current donor backing; and commodities with expressed need in the public sector. Under these criteria, the prioritized commodities for this funding stream in the next five years include cycle beads, IUDs, oral pills (COCs), 1-rod implants (3 years) and pregnancy test kits. The equipment for family planning include implant insertion/ removal kits and IUD insertion/ removal kits.

GFF commodity indicative budget

Request	unit	Unit cost ($)	2017 ($)	2018 ($)	2019 ($)	2020 ($)	2021 ($)	Total req. (#units)	Total cost ($)
Cycle beads	1	1.48	25,727	27,162	28,574	30,889	33,318	145,671	215,592
IUDs	1	0.63	22,016	23,722				45,738	28,815
Pills (COCc)	cycles	0.27	1,215,617	1,283,402				2,499,019	674,735
1-rod implants (3yr)	1	8.50	119,383	119,383				238,766	2,029,511
Implant insert/ removal kits	Pack of 25	25.50	14,731	15,932	17,194	18,330	19,551	85,737	2,186,292
IUD insert/ removal kits	Pack of 25	241.23	1,354	1,459	1,570	1,688	1,815	7,886	1,902,441

The indicative budget shows that the bulk of the GFF funds (US$4,215,803 or 60%) for family planning commodities will go to the procurement of implants and the kit for their insertion/removal.

3.1.3 Reform of the family planning funding mechanisms

On the commitments to reorganize health financing and develop a health insurance plan for the country, and to establish voucher programs as a form of demand-side financing to increase use of family planning and safe motherhood services among the poor – in both cases, by 2020 – progress has been limited. The National Health Insurance Bill has dragged for years, with its very necessity of a national health insurance scheme still being a subject of public debate. The Bill was considered by Cabinet but has never come up for debate in parliament. The National Population Council reports that it is in the process of engaging members of parliament on the importance of family planning so as to have it included as one of the packages in the national health insurance scheme.

On establishing a voucher program, GOU reports that it has hired Marie Stopes International-Uganda (MSI Uganda) to manage the voucher program to increase use of family planning and safe motherhood services among the poor under the Uganda Reproductive Health Improvement project. MSI Uganda will implement the voucher system for both maternal health and family planning. A contract has been signed and will cover four years.

3.2 Progress on policy commitments

The key GOU policy-related FP2020 commitments are: Create an enabling policy environment for family planning; increase financial investment into health human resources development; pass the National Population Council Bill into law, and make the inter-ministerial structure functional and provide the necessary budget support; operationalize the National Adolescent Health Policy and the National Sexuality Education Framework; and review the current post-shipment testing policy on condoms in line with current international standards to reduce delays.

3.2.1 Improvements in FP policy and legal framework

The major family planning-related policy developments since the commitments were made in 2012 include the development of the Family Planning Costed Implementation Plan 2015-2020; the RMNCAH Investment Case in 2016; as well as the Guidelines for Alternative Distribution Strategy. The country has also since upgraded the Population Secretariat to National Population Council (NPC), with an Act of Parliament, to oversee population and reproductive health programs in Uganda including family planning. A task-sharing advisory committee co-chaired by Ministry of Health and Partners in Population and Development Africa Regional Office (PPD ARO) was set up and helped the Ministry of Health Reproductive Health Division to incorporate task-sharing into the family planning guidelines.

In addition, Performance Monitoring and Accountability 2020 (PMA2020) started collecting data on key family planning indicators in Uganda every six months since May 2014, and has so far collected seven rounds of data and published reports. PMA2020 is implemented by Ministry of Health, Uganda Bureau of Statistics (UBOS) and Makerere University School of Public Health (MUSPH) to monitor key family planning indicators on a bi-annual basis.

The Tax Act has been amended to provide exemption for reproductive health supplies; while declassification of contraceptives including injectables is reportedly being addressed in tandem with ongoing task-sharing efforts.

3.2.2 Setbacks in the policy and legal framework

There have been negative policy developments and inaction on some of the policy-related commitments. There have been three major policy setbacks in the recent years: 1) Ministry of Health stayed the Standard and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda (S&Gs) after they were published in April 2015; 2) The ban on comprehensive sexuality education (CSE) "everywhere on the Ugandan soil [in] school or non-school environment" in October 2016 by Ministry of Gender, Labor and Social Development, following a parliamentary resolution; and Ministry of Health's stay of the revised National Guidelines and Standards for Sexual and Reproductive Health and Rights in 2017 following controversy over a provision supporting provision of contraceptives to adolescents.

The S&Gs, among others, prescribed the minimum acceptable standards and guidelines for ensuring full access to high-quality, affordable, acceptable and sustainable contraception and family planning for all women who desire it regardless of age as one of the interventions for the primary prevention of unintended and risky pregnancies and unsafe abortion. However, Ministry of Health stayed the implementation of the S&Gs shortly after they were launched due to strong opposition from religious circles that viewed them as promoting abortion. The problematic provision was the guidance on dealing with survivors of sexual violence, which advised health providers that reporting the case to police should not be a requirement for the survivor to access safe abortion services. Respondents from Ministry of Health report that they are in the process of revising the language to make it acceptable to all stakeholders.

With regard to CSE, the commitment to operationalize the National Sexuality Education Framework is yet to be achieved following the 2016 ban. According to UNFPA, comprehensive sexuality education enables young people to protect their health, well-being and dignity, and helps advance gender equality and SRH rights and empowerment of young people.[37] But the statement from Minister of Gender claimed comprehensive sexuality education "poisons the minds of our young people". This was a setback due to the well-known value of comprehensive sexuality education in empowering young people to make informed decisions on uptake of family planning information and services, and is obviously counter-productive to the FP2020 commitment to reduce the unmet need for family planning amongst adolescents from 30.4% in 2016 to 25% in 2021. Respondents from Ministry of Health reported that the Ministry had finalized consultations with stakeholders and that that the CSE framework was being reviewed.

Further, this study did not find evidence of action on some of the policy-related commitments, such as on the pledge to review the current post-shipment testing policy on male and female condoms in line with current international standards to reduce delays in release of vital reproductive health supplies, including family planning supplies.

Some policy commitments are stated in such broad and vague terms that it is not clear what actions are needed to meet them. For instance, the commitment to "support a robust communication strategy to increase demand and linkage to family planning services ensuring a cross sectoral approach that addresses broader issues such as child marriage and girls' education". Activities to fulfill this commitment have not been clarified, even under the RHSC commitments condominium framework.

37 UNFPA. Comprehensive sexuality education: Overview. http://www.unfpa.org/comprehensive-sexuality-education

3.3 Progress on programming and service delivery commitments

The family planning service implementation-related commitments were: Develop and implement an integrated family planning campaign; increase financial investment into health human resources development; strengthen the delivery of health services; invest in midwifery career promotion and the bonded midwifery scholarship programs; roll out youth friendly services in all GOU HC IVs and general hospitals; and scale-up partnerships with CSOs and private sector entities for family planning outreach and community-based services to target hard-to-reach communities, and to invest in social marketing and social franchising approaches to ensure access to family planning.

3.3.1 Family planning campaign

Following the FP2020 summit, Ministry of Health, UNFPA, PPD ARO, Reproductive Health Supplies Coalition (RHSC), Uganda Family Planning Consortium and other stakeholders and advocates took steps to capitalize on the new optimism and political support to push for momentum in family planning. Policy interventions to facilitate access to quality family planning information and services were initiated; a reproductive health subaccount was established to track reproductive health resource flows and improve the NMS' capability to distribute reproductive health supplies and commodities; and Guidelines for Alternative Distribution Strategy have been developed and Uganda Health Marketing Group (UHMG) is reported to be managing inventory of over 76 facilities. Innovations that have so far come with the campaign include task sharing for contraceptive procedures and provision of contraceptive injectables (Sayana press) by village health teams, and postpartum availability of IUDs through voucher programs. Two national family planning conferences have so far been held to review progress, and presentations and proceedings in the latest conference, held in September 2017, indicate progress in access to family planning.

Each of the facilities reached by the study team in Kabale and Soroti districts reported to be providing family planning services, some on a daily basis. Data obtained from service providers indicates that there has been progress in involving non-state implementing partners, including PACE, Marie Stopes, Baylor, TASO and others in the provision of family planning services, especially on an outreach basis. Other partners that have supported the effort in Kabale and Soroti districts include JHPIEGO, Katuna MARPS, World Vision, AGHA, USAID Rights, EGPAF, Mama's Club and others. The outreaches are provided at health facilities, and the partners usually come with their own commodities and service providers, and involve one or two staff from the facility, who they appreciate with a refreshment or a token allowance (Ushs 5,000-20,000 per day). VHTs are engaged for mobilization. A few facilities reported to be entirely dependent on these partners for provision of long-term methods.

All service providers and program managers reached in this study reported an improvement in the uptake of family planning services. They attributed the trend to increased awareness, improvement in attitudes of both women and men toward family planning, improvement in choice of methods especially long term methods, and the fact that many men do not take responsibility for their families, leaving the burden to women.

> "***Uptake improving but it is very slowly. Women are increasing taking family planning because many are the ones looking their families and they are realizing whatever number of children they produce it is their burden; men are not taking responsibility***" – Service provider, Kamukira HC IV, Kabale

These findings are consistent with results from the national demographic and health surveys, which show that the proportion of married women and women in union currently using a modern contraceptive method improved from 26% in the 2011 UDHS to 35% in the 2016 UDHS.

Service providers reported that women continue to mostly prefer the three-month injectable Depo Provera because of its convenience (once in three months) and especially because they can conceal it from their partners. Service providers also report an improvement in uptake of long-term methods, due to their improved availability.

Indeed, service providers report an overall improvement in availability of commodities. None of the facilities reached in this study reported experiencing a stock out of all commodities at ago, with Depo Provera reported to be always available and in at least one case, to be in excess of need. The facilities reached receive commodities from National Medical Stores (NMS), as well as from PACE, Marie Stopes. NMS supplies mostly Depo Provera, pills and male condoms. The implementing partners supply mostly long-term methods.

3.3.2 Promotion of the midwifery profession

On the promotion of the midwifery profession, official reports show that in 2015, Uganda finalized the review of the midwifery curriculum to make it competency based.[38] The curriculum emphasizes more practical time than theory and includes a module on family planning. Some 160 midwifery tutors and clinical Instructors were given skills in mentoring and coaching of students to improve the quality of training for midwives. The aim is to produce competent midwives to offer quality maternal and child health services including family planning. Four clinical instructors in charge of midwifery skills labs were trained on how to use the equipment that had been supplied by UNFPA. Forty newly recruited midwives have been oriented on maternal health and family planning services. Ninety midwives have been recruited to serve in the hard-to-reach areas.

In addition, midwives have been supported to establish a midwives' association that will spearhead policy dialogues; 40 young midwives' leaders have been equipped with skills in leadership and advocacy for improved maternal health and family planning services; while a nursing and midwifery policy has been developed and presented to the senior management of Ministry of Health for approval.

3.3.3 Promotion of youth-friendly services

On youth friendly services, Ministry of Health, with support from UNFPA, conducted a national assessment on the knowledge, briefs, practices, needs of young people (10-24 years), and on access, appropriateness, and effectiveness of sexual and reproductive services. In 2015, UNFPA supported seen districts to provide youth-friendly services according to national standards in 100% and 86% of the hospitals and HC IVs, respectively. Furthermore, 15 health centers were supported to establish youth-friendly services in the target districts through faith-based organizations (FBOs).

There is a rising appreciation of the special SRH needs of adolescents and young people. Each of the facilities reached in this study reported an effort to give special attention to adolescents and young people. There have been efforts to set up a "youth corner" at each facility, a private room or to dedicate a day every week to provide SRH services to adolescents and youth people. The services range from health education, provision of condoms, antenatal care, family planning and others. Where youth corners have been set up, service providers have reported an improvement in uptake of ARH services by young people. Partners have been supportive in a few cases.

38 2016 FP2020 Annual Commitment Update Questionnaire Response – Uganda. http://www.familyplanning2020.org/uganda

For instance, at Princess Diana HC IV in Soroti district, AGHA and Baylor have improved the youth corner, a separate room, by donating indoor games, a TV set and music system. The corner has two dedicated staff: one general, the other specific for HIV. None of them has been trained in provision of ARH information and services to young people but they have reportedly been mentored. The two staff undertake outreaches to schools in the neighborhood, and use a peer-peer approach to reach out to young people. The facility has dedicated Wednesday afternoons to attend to the SRH needs of young people, and they consider their services to be youth friendly.

However, feedback from stakeholders attending the validation meeting indicates that the thinking is shifting away from the concept of youth corners because they mostly benefit boys, and that parents are unwilling to let their daughters to go and hang out in places dominated by boys. The new strategy is to promote youth friendly services through training of service providers so that they avoid being discriminatory and judgmental.

3.4 Factors affecting achievement of FP2020 commitments

3.4.1 Limited awareness of FP2020 commitments

Service providers are generally not aware of FP2020, its objectives and the commitments therein. FP2020 has remained at the policy and programming level, and has not been scaled to the operational and implementation level. None of the service providers interviewed in this study demonstrated any level of knowledge of the commitments.

3.4.2 Limited funding and high dependency on foreign aid

Uganda's health sector is generally under-funded, and depends too heavily on foreign funding. The 2017/2018 Health Sector budget declined by 37.5% over the 2016/2017, and the proportion of the budget for health has steadily declined from 9.6% in 2009/2010 to 8.7% in 2013/2014 and further to 7% in 2017/2018. In 2012, GOU pledged to increase the budget for family planning commodities from US$3.3 million to US$5 million, but to date NMS receives only Ushs8 billion (about US$2.2 million) per year, with the bulk of the funding coming from USAID, UKAID/DFID, UNFPA, and other donors. GOU contributes a paltry 7% to the national HIV response, with the rest coming from PEPFAR (62%), Global Fund (28%) and other sources (3%). GOU financing for EMHS stood at UGX 219 billion in 2013/14, translating into a public per capita medicine expenditure of about US$2.4, far below the donor contribution of US$6 per capita.[39]

3.4.3 Persistent commodity stock-outs

In spite of the reported improvement in commodity supplies, the problem of stock-outs persists, limiting choice of options. NMS has concentrated on the provision of Depo Provera, apparently because it is the most popular method, to the detriment of other options. Other options are supplied either in insufficient quantities, intermittently, or not at all. Facilities report to have not been supplied with some options for years, and to depend on alternative sources for long-term methods. All facilities reached reported to be out of stock for oral pills, including COCs that are essential for managing complications related to continuous bleeding. Respondents indicated that NMS stopped supplying oral pills due to low uptake, which was leading to their expiry at service points. The low demand for pills is attributed to their high side effect profile, but service providers reported that they need them to correct hormonal imbalances that are often responsible for prolonged bleeding.

> ***"There are irregularities in deliveries of commodities; sometimes the value delivered is less when some items are missing. When you order medicines you don't get what you want"*** – service provider, Kamukira HC IV, Kabale.

None of the facilities reached reported to have emergency contraceptive pills or female condoms. All they say is that "NMS does not supply those". One respondent reported that the provision of female condoms was abandoned due to lack of demand for them. There was also a shortage of five-year implants, also reportedly due to shortage of demand for them.

Service providers also reported a shortage of equipment for insertion and removal of IUDs and implants. The district health office in Kabale reported that each facility had received a donation of one set of equipment from JHPIEGO, an international health organization affiliated with Johns Hopkins University. However, some of the facilities reported that they only improvise. They further reported a challenge with clients of implementing partners, particularly Marie Stopes, which reportedly inserts implants and IUDs for free during outreach camps, but charges a fee of Ushs 20,000 for removal, prompting women who no longer wish to have them to go to public health facilities where the capacity to remove them is largely inadequate.

39 Ministry of Health, 2015. National Medicines Policy

The findings on stock-outs are consistent with those of the PMA2020 process, which in its 5th Round of data collection found that the most commonly out-of-stock method at public facilities continues to be pills (24.5% at public facilities and 12.6% at private). Male condoms were stocked out at 14.7% of private facilities. The results from the 2017 survey (7th Round) suggest that there is slow progress on the stock-out issue in Uganda, especially for pills at both public and private facilities. The survey found a limited number of private facilities that offer Sayana Press, with 95.8% of private facilities not offering this method. The public sector has 20.5% offering the method.[40]

3.4.4 Limited staff and staff capacities

Each of the facilities reached in this survey reported to have at least a couple of service providers for family planning, almost all of them report that they have inadequate staff and are constrained in provision of family planning counselling for lack of adequate time. None of the facilities had a member of staff dedicated to the provision of family planning services; family planning services are almost entirely provided by midwives and nurses who are engaged in MCH and out-patient duties. None of the facilities reached reported to have received an additional health worker for provision of family planning since 2012 when FP2020 commitments were made. Kabale district office reports an overall staffing level of 66%, but has a critical shortage of midwives and health educators at HC IVs. Only about 60 staff can offer long term methods and provide quality counselling in the entire district.

The findings further show a lack of systematic training of service providers. Most of the training in the provision of long-term methods is being conducted by implementing partners, but their capacity to train all service providers regularly seems limited. Only Maziba HC IV in Kabale reported to have had their family planning service providers trained in 2017, by Marie Stopes. Most of the service providers reached in this study report that they have not received any training in the last two years. Some service providers report to have last received training in 2012, and that they have not been practicing ever since they were trained due to lack of equipment for insertion and removal of long-term methods, particularly IUDs and implants. A few service providers expressed doubt whether they can ably remember what they were taught so many years ago due to lack of practice.

> "***One midwife and one nurse have been trained in long term methods – insertion of IUDs and implants. But they are not practicing due to lack of equipment. They are worried that they might forget what they were taught***" – respondent at Kamukira HC IV

3.4.5 Limited capacity to reach young people

While reaching adolescents is a specific FP2020 commitment of the Government of Uganda and findings show that there is a growing appreciation of the need to reach this age group, progress on ensuring that service points are youth friendly is slow. Facilities report a critical shortage of infrastructure that they are unable to dedicate a separate room for a youth corner. Most facilities that have established a youth corner of any standard have found challenges in dedicating staff to it due to understaffing. None of the facilities reached reported to have any staff trained in the provision of SRH information and services to young people, and at least one respondent reported, "we do it our way". There is a heavy dependence on third party implementing partners in efforts to make service points friendly to young people, and the challenge is that these partners have limited capacity to invest in expanding physical infrastructure. Hence, the commitment to make all health center IVs and hospitals youth friendly has not been achieved and progress to slow.

40 PMA2020 Round 7 - https://pma2020.org/sites/default/files/PMAUG-R5-HighlightsDraft-v2-2017.08.15_mmep_clean_0.pdf

3.5 The US Mexico City Policy and its implications for achievement of FP2020 commitments

USAID is one of the major funders for health including family planning over the years.[41] As the leading donor of international family planning assistance, the United States plays a major role in saving mothers' and children's lives. Its FY 2016/2017 contribution of $607.5 million prevented a range of adverse outcomes.[42] The 'Mexico City Policy' or the 'Global Gag rule' is a course of action that imposes anti-abortion restrictions against the use of global health assistance. It bars the US Government and non-US government agencies from providing support to organizations providing abortion services, counseling or making referrals for abortion, or advocating for abortion law reform, even if done with its own, non-U.S. funds.[43]

The expanded Trump GGR requires that any non-US NGO that wishes to receive US bilateral global health assistance from the US government certify their willingness to comply with the policy. It obliges them to refrain from any abortion-related activities paid for with their own, privately raised, non-US government funds as a condition for receiving U.S. bilateral global health assistance.[44]

Although not a change from previous GGR iterations, one of the criteria that foreign NGOs must meet in order to retain eligibility for U.S. government funds has the potential to take on significantly greater importance with the application of the GGR to all of global health assistance, as opposed to just FP/RH programs in the past.[45] Specifically, the eligibility criteria that requires that a foreign NGO certify that not only does it not itself engage in abortion-related activity, but also does not "provide financial support to any other foreign non-governmental organization that conducts such activities."[46] Depending on how the second condition is interpreted, a foreign NGO with a broad development and health portfolio could be disqualified from receiving U.S. global health assistance for providing funding to a foreign NGO partner for an education project, for example, if the other NGO is engaged in abortion-related activities, perhaps supported by its own government or another bilateral donor.[47]

Such an expansive interpretation would require the expenditure of exponentially larger amounts of human and financial resources by the U.S. government, U.S. NGOs, and the foreign NGOs themselves to monitor GGR compliance among a much broader universe of NGOs.[48] There is likely to be a miniscule return on this investment if done in the service of achieving the purported objective of the Trump GGR—rooting out and ending even indirect U.S. subsidies for abortion overseas.

Trump Administration's policy extends restrictions to an estimated $8.8 billion in US global health assistance[49], including funding support for family planning and reproductive health, maternal and child health, nutrition, HIV/AIDS – including The President's Plan for Emergency Relief for AIDS (PEPFAR).[50] This compares to just $575 million in bilateral family planning and reproductive

41 Kaiser Family Foundation. The US Government engagement in global health: a primer. Jan 27, 2017. http://kff.org/global-health-policy/report/the-u-s-government-engagement-in-global-health-a-primer/(accessed Jan 30, 2017).

42 SnehaBarot, 2017 The Benefits of Investing in International Family Planning—and the Price of Slashing Funding. Guttmacher Institute.

43 The White House.*Presidential Memorandum Regarding the Mexico City Policy*. Jan 23, 2017. https://white-house.gov/the-press- office/2017/01/23/presidential-memorandum-regarding- mexico-city-policy(accessed 19th August 2017).

44 Washington Memo, 2017.Everything but the Kitchen Sink. PAI

45 Ibid

46 Washington Memo, 2017.

47 Ibid

48 Sneha Barot, 2017. When Antiabortion Ideology Turns into Foreign Policy: How the Global Gag Rule Erodes Health, Ethics and Democracy, Guttmacher Institute.

49 The 1973 "Helms Amendment" to the Foreign Assistance Act prohibits the use of US funds from paying "for the performance of abortion as a method of family planning."

50 The President's Plan for Emergency Relief for AIDS (PEPFAR) is the US government's initiative on HIV/AIDS,

health funding, the only type of health assistance subjected to the GGR in its previous iterations during earlier Republican administrations. This represents a 15-fold increase in the amount of US Government funding implicated under the expanded GGR.

Without funding, several organizations especially in sub-Saharan Africa including Uganda will be unable to provide integrated maternal health care with contraceptive services, among many other services, leaving communities and entire health systems devastated. In some countries and communities, local NGOs who are unwilling or unable to certify GGR compliance may be the only ones left to provide services and not readily replaceable with other organizations who can effectively utilize the withheld, reprogrammed funds. This implies a complete scale down of family planning services available especially to women, or an increase in the prices for contraception thereby limiting access by women especially in the hard to reach areas, which may have huge negative results for family planning. There are organizations that are already experiencing this scale-backing service provision as a direct effect of the non-certification of compliance to the GGR[51].

One example are organizations that were rolling out to mostly rural and economically marginalized communities the use of the Sayana Press. The Sayana Press is a family planning device that that holds a three-month dose of the contraceptive progestin and is thatched to a short needle which is easy to use, disposable, effective and is very effective for women in rural areas because of its suitability for self-dosing. The pilot project under which the Sayana press has been rolled out in different parts of Uganda including very rural and hard to reach areas like Gulu, Kabale, Mbale, Fort Portal and Mbarara. This program which has been funded using USAID funds provided through the International Family Planning Foundation could be severely affected by the re-instatement of the Global Gag Rule in Uganda.

Most organizations, district health facilities and the MoH rely on foreign funding to bridge the gaps in the health care system. The Global Gag Rule's potential negative impact on programs like the Sayana Press initiative is particularly troubling. Sayana Press prevents unwanted pregnancies which would otherwise end in abortion. Limiting women's family planning options in a country where abortions have for years been legal only under the most extraordinary of circumstances, is likely to get a higher number of abortion cases and more maternal deaths because women are hesitant to nurture fetuses they do not need, or give birth to children they are not ready to take care of.

The WHO initiated studies to ascertain whether a relationship exists between the reinstatement of the Mexico City policy and a reduction in the rate of induced abortions. While relying on data from Demographic Health Surveys (DHS) of 20 Sub-Saharan countries between 1994 and 2008, it was found that during the Bush Administration, the abortion rate increased from 10.4 per 10,000 women-years to 14.5 per 10,000 women-years.[52] The report indicated timing of the rise being consistent with the reinstatement of the gag rule in early 2001. The rate was stable between 1994 and 2001 during the Clinton administration and then steadily rose from 2002 to 2008. The reinstatement of the Mexico City policy by the Trump administration will limit women's family planning options in Uganda, which is more likely to translate into a high number of abortion cases and more maternal deaths.

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and is the largest component of the President's Global Health Initiative.

51 https://qz.com/1051605/trumps-anti-abortion-global-gag-rule-and-its-impact-in-uganda/

52 Michelle Goldberg, 2017. Trump Didn't Just Reinstate the Global Gag Rule. He Massively Expanded It. Slate. http://www.slate.com/articles/news_and_politics/politics/2017/01/trump_s_global_gag_rule_is_even_worse_than_it_seemed.html (accessed 22nd August 2017).

4. RECOMMENDATIONS

- **Enhance awareness of FP2020 commitments**: The FP2020 commitments need to be popularized not only among program managers but also among service providers and service consumers, to achieve ownership and collective action
- **Resolve the impasse on comprehensive sexuality education**: Ministry of Health should convene stakeholder dialogue to find a way forward on comprehensive sexuality education and the contentious issue of provision of family planning to adolescents, to ensure that the current ban does not affect the provision of family planning and other SRHR information and services to young people or impede the operationalization of the National Sexuality Education Framework
- **Define and clarify actions needed to achieve each of the commitment.** The RHSC and its member institutions should expand its "commitments compendium" to define activities needed to achieve all FP2020 commitments, including those that were made during the 2017 family planning summit.
- **Ensure commodity security**: Partners should agree a standard minimum range of commodities that have to be supplied to service points and resolve supply chain hurdles to ensure clients have choice at all times.
- **Recruit and train more service providers**; Ministry of Health should mainstream the training of family planning service providers and increase the numbers service providers.
- **Improve the capacity to reach young people**: Ministry of Health should engage relevant departments of GOU and development partners to invest in the health system's capacity to reach young people, including physical infrastructure, recruitment and training of youth-dedicated staff, equipping youth centers, and publicizing services.
- **Community mobilization and empowerment**: The family planning campaign should be more aggressive in meeting the unmet need for family planning and in cultivating demand through community mobilization and education. Ministry of Health should coordinate with the civil society and implementing partners to empower women and communities to appreciate family planning, disseminate information and mobilize communities for family planning services.

(Footnotes)

1 PMA2020 uses innovative mobile technology to support low-cost, rapid-turnaround surveys to monitor key indicators for family planning. PMA2020/Uganda is led by the Makerere University's School of Public Health (MUSPH), in collaboration with the Uganda Bureau of Statistics (UBoS) and the Ministry of Health

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