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Deutsche Stiftung Weltbevölkerung (DSW)/
Action 4 Health Uganda (A4HU)

BUDGET ANALYSIS STUDY

FY 2021/2022
Final report

Date of Submission: 25/04/2022
Consultant: Centre for Budget and Tax Policy

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TABLE OF CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS IV
ACKNOWLEDGMENT VI
EXECUTIVE SUMMARY 1
Methodology 1
Findings of the study 1
Conclusion 3
Recommendations 4

1.0 BACKGROUND 6
1.1 Objectives of Study 6

2.0 STUDY METHODOLOGY 6
2.1 Study area and study group 6
2.2 Study design overview 7
2.3 Sample size and sampling plan 7
2.4 Data collection tools and procedures 8
2.5 Data management and analysis 8
2.6 Ethical considerations 9
2.7 Study strengths and limitations 9
2.8 Structure of the report 9

3.0 CONTEXT ANALYSIS 10
3.1 Analysis of national policies and other legal instruments in relation to the study 10
3.2 Evaluating the implementation of existing family planning policies 11
3.3 Uganda's performance on financial commitments and investments for FP 18
3.3.1. FP2020 financial commitments 18

4.0 BUDGET ANALYSIS FINDINGS 21
4.2 Review and analysis of the health budget expenditure for FY 2020/21 at the national level 22
4.3 Review and analysis of family planning budget allocation trends and expenditure at the national level 23
4.4. Review and analysis of four selected district health and family planning budget allocation trends and expenditure 26
4.5 Selected District expenditure analysis FY 2020/21 26
4.5.1. Tororo District Local Government 26
4.5.2. Kamuli District Local Government 28
4.5.3. Mityana District Local Government 29
4.5.4. Mukono District Local Government 31

5.0 FAMILY PLANNING UTILIZATION 32
5.1 Benefits of FP 32
5.2 Perceived dangers of family planning and reasons for discontinued use of FP services 33

5.3 Challenges in accessing FP services 34
5.3.1 National level 34
5.3.2 Tororo district 35
5.3.3 Kamuli district 35
5.3.4 Mityana district 36
5.3.5 Mukono district 36
5.4 Recommendations to increase uptake of FP 37
5.4.1 National level 37
5.4.2 Tororo district 37
5.4.3 Kamuli district 38
5.4.4 Mityana district 38
5.4.5 Mukono district 38

6.0 GENERAL DISCUSSION 39

7.0 CONCLUSIONS 40

8.0 RECOMMENDATIONS 41
8.1 National level 41
8.2 Tororo district 42
8.3 Kamuli district 42
8.4 Mityana district 43
8.5 Mukono district 43

REFERENCES 44

LIST OF FIGURES

Figure 1: GoU allocations to RH supplies from FY 2017/18 to FY 2020/21 (Million USD) 19
Figure 2: Amounts raised from development partners for RH from 2017 to 2021, USD Million 19
Figure 3: Estimated costs and allocations for FP from FY 2017/18 to FY 2020/21 in USD Millions 20
Figure 4: Health Sector Budget trend FY 2019/20 - FY 2021/22 21
Figure 5: Health sub-program budget allocation trend FY 2019/20 - 2021/22 (UGX Bns) 22
Figure 6: National FP Budget allocation trend FY 2019/20 - 2021/22 (UGX '000) 24
Figure 7: FY 2020/21 FP expenditure Vs Mama Kits off the RHS budget (UGX) 25
Figure 8: Tororo DLG Health expenditure analysis by source of revenue FY 2020/21 27
Figure 9: FP Budget trends in Tororo DLG (000,000) 28
Figure 10: FP Budget trends in Kamuli DLG 29
Figure 11: FP Budget trends in Mityana DLG (UGX Billions) 30
Figure 12: FP Budget trends in Mukono DLG 31

LIST OF TABLES

Table 1: Scope of work 7
Table 2: List of Key Informant Interview respondents 8
Table 3: FP related policy instruments and their implementation status 12
Table 4: Expenditure analysis for FY 2020/21 against the approved budget, Billion UGX 22
Table 5: Estimated Budget allocations for FP programs under Vote 014 in UGX 24
Table 6: Table 5: National FP Budget allocation trend FY 2018/19 - 2021/22 (UGX '000) 24
Table 7: FP Commodities procured in FY 2020/21 (UGX) 25
Table 8: Tororo DLG allocation and expenditure performance of health department as at end of March 2021 FY 2020/21 (UGX '000) 27
Table 9: Kamuli DLG expenditure performance by department as at end of March 2021 FY 2020/21 ('000) 29
Table 10: Mityana DLG expenditure health department performance as at end of March 2021 FY 2020/21 ('000 UGX) 30
Table 11: Mukono DLG Expenditure performance by department FY 2020/21,'000 UGX 31
Table 12: FP Users per district FY 2021/22 32

LIST OF ACRONYMS AND ABBREVIATIONS

A4HU	Action 4 Health Uganda
BCC	Behavioural Change Communication
COVID 19	Corona Virus Disease 2019
CSO	Civil Society Organization
DCIP	Family Planning Costed Implementation Plan
DHO	District Health Officer
DLG	District Local Government
FP	Family Planning
FP CIP	Family Planning Costed Implementation Plan
FY	Financial Year
FGDs	Focus Group Discussions
GoU	Government of Uganda
HC	Health Centre
HCD	Human Capital Development
IFMS	Integrated Financial Management System
IEC	Information Education and Communication
KIIs	Key Informant Interviews
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MDAs	Ministries Departments and Agencies
mCPR	modern Contraceptive Prevalence Rate
NMS	National Medical Stores
MPS	Ministerial Policy Statement
PHC	Primary Health Care
PIAP	Programme Implementation Action Plan
PNFP	Private Not for Profit
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHs	Referral Hospitals
RMNCAH	Reproductive Maternal New-born Child and Adolescent Health

SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UDHS	Uganda Demographic and Health Survey
USD	United States Dollars
UGIFT	Uganda Intergovernmental Fiscal Transfers
URMCHIP	Uganda Reproductive Maternal and Child Health Improvement Project
VHTs	Village Health Teams
WRA	Women of Reproductive Age
DSW	Deutsche Stiftung Weltbevölkerung
GOU	Government Of Uganda
MOH	Ministry of Health

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Dr Bernard Tusiime
CEO
Action 4 Health Uganda

EXECUTIVE SUMMARY

Uganda is the third fastest-growing country globally, with a population of 45 million, and 48% of the people are under the age of 15years. On average, women bear approximately seven children, with nearly half of all pregnancies being unplanned. The ability of women and couples to decide when to have children, and how many to have is crucial for the productivity and well-being of the population.

Therefore, Family Planning (FP) is an essential practice in society as it provides knowledge and information that allows women and couples to decide when they are ready to have children based on their preparedness. FP has presented several benefits to the women, their families, and the community at large.

The Government of Uganda (GoU) recognises and has prioritised FP in broad development and health policies and strategies. At the Human Capital Development Programme and Ministry of Health level, relevant policy and planning frameworks exist to guide FP interventions.

With that said, previous research by Deutsche Stiftung Weltbevölkerung (DSW), Action 4 Health Uganda (A4HU) and other FP programming partners have shown that challenges in the implementation of FP related policies and investing in FP at both the national and sub-national level persist.

As with previous years, DSW and A4HU conducted a budget analysis study to document FP investment status and trends at both the national and sub-national levels. The study's findings aim to support evidence-based advocacy for increased investments in FP.

Methodology

The study was conducted at the national and district level in Mityana, Mukono, Tororo, and Kamuli. It examined allocations for FP in FY 2021/22 compared to those of FY 2020/21 and FY 2019/20 and the expenditures in FY 2020/21. Both quantitative and qualitive data were collected. Methods used to collect the data included reviewing FP-related policy and budget documents, Key Informant Interviews, and Focus Group Discussions. The quantitative allocations and expenditure data were analysed using an MS Excel Based tool. In contrast, the qualitative data was transcribed into MS Word and grouped into themes on FP uptake and access to various methods.

Findings of the study

Implementation status of FP-related policies

The study found poor dissemination and application of FP-related policies, standards, and guidelines at all levels of health care, with laxity in the provision of Youth/ Adolescent-friendly services and dissemination at service delivery points in both

the public and private sector. Additionally, providers had not been sensitised on the updated FP-related policies. Several national FP-related policy documents have been approved but not yet launched, while others are still in development. Through advocacy from the sub-national level and support from partners, the second National FP-CIP (FY 2021/22- FY 2025/26) will be launched and disseminated as the National Health Policy for Adolescents, and the Adolescent Health Strategy follow closely in the next year.

Financing to the Health Sector and FP interventions

The health sector budget in Uganda has since the FY 2019/20 increased to UGX 3,331.02 billion in FY 2021/22 from UGX 2,589.49 billion, with the Ministry of Health (MoH) taking the largest proportion of the health sector budget, followed by the Primary Health Care (PHC) Grant that is routed to the Local Governments for health service delivery. The National Medical Stores and the Referral Hospitals (cumulative) come third and fourth, respectively.

The study found a higher commitment from donors to fund FP commodities and interventions than the Government of Uganda (GOU). Donor funding to FP in Uganda had increased more than ten-fold since 2017 and gone beyond the USD 20 Million annual targets that GOU had made in the FP2020 commitments. The availability of these funds likely led to the laxity in GOU investments. As a result, donor-supported, implementing partner-driven and dominated interventions exist for several components of the FP program such as commodity security, service delivery, especially FP outreaches, Behavioural Change Communication (BCC) interventions, and adolescent health interventions.

The National Medical Stores (NMS) vote 116 saw a budget increase between the FY 2020/21 and FY 2021/22 from UGX 14.72 billion to UGX 20.46 billion. The UGX 5.74 billion budget increase, came when there were increased reports of conception among teenagers and couples in union to promote family planning. However, this increase did not necessarily translate into increased allocations for FP commodities and supplies, which, together with Maternal commodities and supplies are catered for under this vote.

The estimated allocations to FP programs under the Ministry of Health (MOH) vote 014 increased by approximately UGX 210 million from UGX 394.4 million in FY 2019/20 to UGX 604.3 million in FY 2020/21. These allocations were only estimates as FP interventions are integrated with other programs in the Reproductive and Infant Health Division's annual work plan.

The allocation for FP under the referral hospitals increased between FY 2020/21 and FY 2021/22 from UGX 209.754 million to UGX 229.974 million, with more resources allocated to FP commodities than services.

In FY 2020/21, all the FP commodities were procured with external support from the World Bank, United States Government (USG), and other development partners. Safe Delivery Kits (Maama Kits) were noted to consume over 90% of the Reproductive Health Supplies (RHS) output budget (UGX 14.72 billion); however, in the FY 2020/21 RHS output spend, Maama Kits accounted for only 56% (UGX 8.23 billion) of the budget.

The districts' allocation and expenditure for FP services are covered under the integrated outreaches for FP and other programs like immunisation and HIV/AIDS. We noted no explicit reference to the district Family Planning Costed Implementation Plan (FP-CIP) in the annual work plans for FP services. Development partners also heavily funded the National (2015-2020). The National FP-CIP did not have clear linkages with other strategic documents like the RMNCAH investment case. In the National FP-CIP II, there was an effort to harmonise it with the RMNCAH investment case II.

Despite the benefits of FP, the study established that there are still negative perceptions of FP hindering its use and uptake among community members in Mityana, Mukono, Tororo and Kamuli districts. This showed the need to increase investments in mindset change to alleviate the myths and misconceptions and contribute to the improvement of FP indicators.

Conclusion

There is continued reliance on external financing to implement interventions in the health sector, including FP. This shows the lack of ownership of FP programming by GOU and likely gives way to development and implementing partners to decide which projects and interventions to focus funding, which might not necessarily be the priorities aligned in the National and District FP-CIPs. Therefore, taking steps to transition from complete donor dependency towards domestic financing for national and sub-national levels is crucial.

Although the NMS - Reproductive Health Supplies budget increased from UGX 14.72 billion to UGX 20.46 billion in FY 2021/22, the split between Mama Kits and FP commodities remains skewed towards the former. This significantly impedes the strides that could be gained in the form of increased uptake for FP.
There is hardly any financing from GOU that is focused on improving FP outcomes for adolescents and young people, yet they constitute more than 50% of the country's population and are the key to helping the country to achieve the Demographic Dividend (DD).

In the management of COVID-19, government expenditure fell by 40% in the 2nd half of the FY 2020/21. This was justified by the need to divert resources to COVID-19 response measures. This caused gaps in service delivery and access to FP commodities that had already been procured. However, there was no budget cut to Vote 116 under

the RHS output due to COVID-19.

The programming for FP is majorly health-centred, and funding explicit to FP can only be explicitly traced in the health department. Even when the role of other departments is clear in dealing with teenage pregnancies, there is little effort in implementing a multi-sectoral approach to reducing teenage pregnancy and increasing the access to and right usage of contraception methods.

Individuals, couples, families, parents, communities, health workers, school leadership and teachers, FP champions, opinion, religious and cultural leaders also need to be accountable for their roles in improving FP use.

Recommendations

Given the ever-increasing population of Uganda, it is evident that GOU needs to be intentional about increasing allocations specific to FP at the national and sub-national levels. NMS should also increase the quantity of FP commodities provided and a wider method mix to enable clients to access methods of their choice easily.

To avoid reliance on external financing, which is unpredictable and unsustainable, GOU should take on alternative financing avenues at the national level. Districts should continue to invest in FP programming from their local revenue and advocate for all departments to contribute to this cause as the improvements in FP indicators affect the health, well-being and productivity of all people who ultimately contribute to the district's development.

The lack of evidence regarding GOU's performance on the FP2020 commitment to allocate 10% of the annual RMNCAH (GFF) budget to Adolescent Health calls for the need to increase investments in FP interventions for adolescents and young people.

Allocations specific to FP under NMS Vote 116 should increase their aggregation under RH commodities to include Safe Delivery Kits (Maama Kits), and FP does a disservice to the latter. Alternatively, CSOs should advocate for a 50% split between these two broad items so that when the overall vote budget is increased, FP commodities also gain from it.

The capacity of officers, especially at the sub-national level, should be built-in advocacy for increased investments in FP at the districts to take ownership of the program. This can be done using their District FPCIPs.

A multi-sectoral approach needs to be strengthened at both the national and sub-national levels as FP is not just a health issue but a developmental one that cuts across sectors, departments, religions, levels of leadership, communities, families, and individuals. This also speaks to increasing male involvement in FP related issues

through their sensitisation in settings where they are relaxed to show them the benefits of planning for their families.

Transparency and access to expenditure data at the national and subnational levels to inform advocacy efforts are vital in improving FP programming.

Investments should be made for the recruitment and training of Health Workers in providing FP information and services at all levels of care. Additionally, Village Health Teams (VHTs) should be trained to provide FP information and services and their stock replenished in a timely manner. They are the first line of call for most FP users in the community.

1.0 BACKGROUND

Action 4 Health Uganda (A4HU), in partnership with Deutsche Stiftung Weltbevölkerung (DSW) are implementing a budget advocacy project aimed at increasing Family Planning (FP) budget allocations at the national and sub-national level in Kenya, Tanzania, and Uganda to address the unmet need for FP.

A4HU in partnership with DSW seeks to extend successful approaches targeting the supply of FP funding whilst also applying demand pressure for increased allocations at national and sub-national/decentralised levels. Consequently, A4HU contracted a consultant to conduct an FP budget allocation analysis for FY 2021/2022 and track the actual FP budget allocations and expenditure for FY 2020/21 at the national sub-national levels. The findings are herewith presented in this report.

1.1 Objectives of Study

1. To track health and FP budget allocations at the national level and in four project districts of Kamuli, Tororo, Mityana, and Mukono for FY 2021/22 compared with FY 2020/21 and FY 2019/20.
2. To conduct an expenditure analysis for FY 2020/21 against the approved budget.
3. To identify and evaluate the implementation of existing family planning policies at the national and sub-national levels
4. To document the effect of COVID-19 on the allocation of resources and delivery of FP services.
5. To document community attitudes towards FP and barriers to access and use of FP services, particularly of women and men of reproductive age, religious leaders, influencers, and traditional leaders.
6. To provide a background on key FP indicators at the national and sub-national level, identifying bottlenecks/barriers to access and utilisation of FP services.
7. To provide recommendations that will inform evidence-based policy advocacy toward increasing FP financing at the national and district levels.

2.0 STUDY METHODOLOGY

2.1 Study area and study group

A4HU/DSW annually tracks family Planning budgets to ascertain whether there is an increased Government of Uganda (GOU) commitment to FP programs and commodities. This budget study sought to track FP allocation at the national and district level. Four districts, namely Kamuli, Tororo, Mityana and Mukono, where A4HU operates, were chosen to enable comparison across all the years of the study.

2.2 Study design overview

The study employed both quantitative and qualitative methods, which included a review of relevant documents (budgets, expenditure reports and policies), Key Informant Interviews (KIIs), and Focus Group Discussions (FGDs). The qualitative information was used to support the budget and expenditure analysis as it filled information gaps and captured stakeholders' perceptions.

The study collected sampled user feedback (through FGDs) on the barriers to access and utilisation of FP services, interacted with faOility in-charges and FP focal persons to identify FP access and utilisation gaps and solutions from the service providers' perspectives, reviewed the budget and policies that facilitate FP service delivery at district and national level.

2.3 Sample size and sampling plan

FP funding from government budgets and expenditure at the national level from the Ministry of Health (MOH), National Medical Stores (NMS), and Referral Hospitals from all the regions were considered.

In the four districts, the study covered selected government-supported health facilities with consideration of all hospitals, health center-IV and selected health centres IIIs and IIs.

Budget allocations for FY 2021/22 and expenditures for FY 2020/21 were analysed. Data from annual work plans, budget allocations, expenditure reports and other relevant information was collected and analysed using the FP budget and expenditure analysis tool in an MS Excel database.

Table 1: Scope of work

Level	Institutions	Data collection method/s
National	MOH	Document review & KIIs
	NMS	Document review & KIIs
	Mulago National Referral Hospital	Document review & KIIs
	17 Referral Hospitals[1]	Document review & KIIs
District	Kamuli	Document review, FGDs & KIIs (2 HC IVs, 9 HC IIIs, & 1 HC II)

1 These include: Arua, Entebbe, Fort Portal, Gulu, Hoima, Jinja, Kabale, Masaka, Mbale, Soroti, Lira, Mbarara, Mubende, Moroto, Naguru. Kawempe, Kiruddu

	Mityana	Document review, FGDs & KIIs (1 Hosp., 3 HC IVs, 10 HC IIIs, & 1 HC IIs).
	Mukono	Document review, FGDs & KIIs (1 Hosp, 1 HC IVs, 11 HC IIIs, & 1 HC II)
	Tororo	Document review, FGDs & KIIs (1 Hosp., 3 HC IVs & 10 HC IIIs).

2.4 Data collection tools and procedures

Document review: This involved collecting and reviewing all relevant documents at the national level (MOH, NMS, and referral hospitals) and district level (Kamuli, Tororo, Mityana and Mukono). These included: FP Costed Implementation Plan end term assessment report; approved Annual Work Plans, approved Annual Budgets; Q4 cumulative budget performance reports, RMNCAH sharpened plan I performance assessment. The Budgets and work plans covered FY 2019/20 to FY 2021/22.

Key Informant Interviews (KIIs): KIIs were conducted with relevant government officials at national and district levels, mainly to understand the processes of prioritisation and resource allocations for FP and validate and confirm the analysed information. The respondents for the KIIs are proposed as below.

Table 2: List of Key Informant Interview respondents

Level	Key Informant
National level	Assistant Commissioner Reproductive Health -MoH Chief Procurement Officer – NMS Referral Hospital Directors
District level	District Health Officers and health facility in-charges Chief Administrative Officers

Focus Group Discussions: FGDs were conducted in each district in numbers not exceeding 10 while maintaining COVID-19 SOPS. The participants were categorised by age and gender: male and female separate, age 15-24 years and then 25 years and above alone. The following categories were included in the FGDs.

2.5 Data management and analysis

The collected data was cleaned and organised using MS Excel. The quality of the results depended on the accuracy of the work plan/ budget and expenditure information obtained. Thus, precautions were taken to avoid double counting or misrepresenting the FP funding and spending through a validation exercise with government officials. Where FP activities were integrated into other budgets/ expenditure lines (i.e., for Reproductive Health), a 'subjective' percentage share of the FP component was

determined in consultation with the relevant health facility officials. The subjectivity was based on the proportion of planned total outputs to those specific to FP. The proportion was then applied to the output allocation and or expenditure.

2.6 Ethical considerations

The study was sanctioned by the director for clinical services at the MOH and all the District Health Officers (DHOs) in the participating districts. Consent was sought from all the participants of the Focus Group Discussions.

Well-trained research assistants collected all the data and therefore the quality of the data collected was good.

2.7 Study strengths and limitations

Since the study was sanctioned by the MOH, the response rate from the Referral Hospitals (RHs) was good through the Directorate of Clinical Services. Where data gaps were occasioned by the non-responsiveness of the respondents, the budget website (www.budget.go.ug) was used to access the relevant budget data.

The assignment was conducted when COVID-19 was still prevalent hence strict observation of Standard Operating Procedures (SOPs).

The National Medical Stores was also not forthcoming with information on the breakdown for FP expenditure from the Reproductive Health Supplies output. The data we needed was the monthly stock status reports from FY 2019/20 to FY 2020/21.

2.8 Structure of the report

This report is divided into eight parts, as outlined here. The first part gives the study's background, objectives, and methodology. Part two provides the study methodology while part three briefly analyses FP-related policies in Uganda. Part four provides a review and analysis of budget allocations and spending on FP. Part five includes information from the Focus Group Discussions on access to and utilisation of FP services in the four districts. Part six contains the general discussion of the study, while part seven outlines the conclusion. Part eight states recommendations based on the findings, while the references come last.

3.0 CONTEXT ANALYSIS

3.1 Analysis of national policies and other legal instruments in relation to the study

Uganda is the third fastest-growing country globally, with a population of 45 million. 48% of the population is under the age of 15 (The Republic of Uganda, 2019). On average, women will have approximately seven children (6.9) if contraceptive and fertility patterns do not change. Nearly half of all pregnancies in Uganda are unplanned, and that narrative needs to change if the country is set on averting a population explosion (The Republic of Uganda, 2019). If the mindset and behaviour of the populace do not change and investments in FP/SRH do not increase, the Maternal Mortality Rate (MMR) is likely to rise to a point where 435 women will die for every 100,000 live births, because of pregnancy-related causes. It is estimated that 8,200 Ugandan women die annually from pregnancy-related causes (Ensuring Access to Family Planning for All in Uganda, n.d.).

There are more than 6.5 million Ugandan Women of Reproductive Age (WRA) from 15-49 years. Among them, 39% use any method of contraception, and 31% use a modern, more effective method (09.08.21 Performance Review Report of Uganda's FP2020 Commitments, n.d.-a) The most used methods are contraceptive injectables (15.5%) and oral contraceptive pills (4.6%). An estimated 37% of Ugandan women want to prevent pregnancy but do not use modern contraception—this is the unmet need. Of those women with unmet need, 57% desire to wait at least two years before having a child (or another child), and 43% want to stop childbearing altogether.[2] Despite government actions to increase coverage, two out of every three Ugandan women who want family planning do not have access to modern methods of contraception. (Ensuring Access to Family Planning for All in Uganda, n.d.)

A review of the performance of some RH indicators further amplifies the need for adequate public financing for Reproductive Health, and in particular, Family Planning. The Maternal Mortality Rate (MMR) averaged 429 per 100,000 live births between 2001 and 2016.[2] This rate increased from 418 to 438 per 100,000 live births between 2006 and 2011 before reducing to 336 per 100,000 live births in 2016. 28% of currently married women and 32% of sexually active unmarried women had an unmet need for family planning. However, this is not a significant change in relation to the unmet need of 29% of married women recorded in the 1995 UDHS. This could be due to changes in the computation for unmet need over the years and many other reasons that need further interrogation, funding being one of them. The modern Contraceptive Prevalence Rate (mCPR) is increasing. Still, Uganda did not reach its target of 50% by 2020 (30.4%[3] as at the end of 2020) as was set in the Family Planning Costed

2 Uganda Demographic Health Surveys; 2001 - 2016
3 National Family Planning Costed Implementation Plan 2020/21 - 2024/25

Implementation Plan (FPCIP).

3.2 Evaluating the implementation of existing family planning policies

Uganda has put in place several policies and other instruments that promote family planning, and their implementation status is discussed in Table 3 below.

Table 3: FP related policy instruments and their implementation status

Policy or other instruments	Implementation status
Uganda's National Population Policy (2020). The policy's strategic actions are to accelerate fertility and mortality decline for a more favourable population age structure and a lower dependency burden by increasing and expanding access to family planning (FP) and increasing demand for family planning.	The TFR is 6.9 children per woman, and MMR is 336 women per 100,000 live births. The population age structure is mainly young people, with 74.7% aged 30 and below. The dependency burden is high as young people form much of the non-working age population. Access to modern FP methods is at 39%, while the unmet need for FP is 17% for all women.
The National Development Plan III (NDP) 2020/21 – 2024/25: has 18 programmes, including Human Capital Development. Among the Human Capital Interventions is to reduce the unmet need for family planning from 28% to 10% and increase the Contraceptive prevalence rate (CPR) from 35% to 50% by FY2024/25.	MDAs and districts are implementing interventions that contribute to harnessing the Demographic Dividend (DD) and achieving the Vision 2040. GOU allocates budgets per FY to mainly the health, education, social development, water & environment, and agriculture sectors at the national and sub-national levels. Reliance on external financing for RH/FP interventions is a significant issue at both the national and sub-national levels. Knowledge gaps also exist in implementing DD interventions, coupled with low absorption rates.
Human Capital Development Programme Implementation Action Plan (HCD PIAP) 2020/21-2024/25): Objective four of PIAP is to improve population health, safety, and management through increasing access to Sexual Reproductive Health (SRH) and Rights with a particular focus to family planning services and harmonised information.	SRHR services are predominantly financed by development partners, with the major investment being through the Uganda Reproductive Maternal and Child Health Improvement Project (URMCHIP). Additionally, SRH information was the least funded DD intervention in the health sector at 4% in FY 2018/19 and is projected to be 2% in FY 2022/23.

Policy or other instruments	Implementation status
Investment Case for Reproductive, Maternal, New-born, Child, and Adolescent Health Sharpened Plan in Uganda, 2015/16 - 2019/20 (RMNCAH Sharpened plan) The implementation of the sharpened plan is based on the five strategic shifts: Focus Geographically; High Burden Populations; High Impact Solutions; Education, Empowerment, Economy, Environment; and Mutual Accountability. Regarding RH, the shifts aimed at prioritising budgets and committing to action plans to end preventable deaths, scaling up access for the underserved population groups, delivering integrated service packages, targeting delivery and PNC as the biggest opportunities for impact, and empowering women to make decisions. The plan had five impact indicators: maternal mortality rate, stillbirth rate, infant mortality rate, under-five mortality rate, and teenage pregnancy.	Although mCPR increased to 39% and unmet reduced to 17%, both were short of targets. Teenage pregnancy rate remains high at 25%. Granular data on RMNCAH/N expenditure was not timely, especially at the district level. Dependence on external financing persists.

Policy or other instruments	Implementation status
National FP CIP (2015-2020) Its overall goals were to reduce the unmet need for family planning to 10% and increase the modern contraceptive prevalence rate amongst married women and women in the union to 50% by 2020. The plan was hinged on six thematic areas: Stewardship, Management and Accountability, Financing, Commodity Security, Policy and Enabling Environment, Service Delivery, and Demand Creation.	In 2020, the FP CIP was evaluated to assess performance and identify gaps and lessons learned. End-line evaluation of FP CIP found poor multi-sectoral collaboration, and the implementation of FP interventions was left mainly to the health sector and was not emphasised as a development issue. Access to FP methods was mainly in the public sector, contributing to the unmet need of 17% by 2020, while the mCPR was 39%. The FP CIP was not well disseminated at the subnational level (regional and district), and as such, implementation at those levels was not optimal. Additionally, the differences in regional demographics and FP needs were not considered and as such, their issues were not addressed, and indicators did not improve.

Policy or other instruments	Implementation status
National FP CIP II (2021- 2025) Evaluation of the first National FPCIP informed the development of the second National FP CIP to ensure continuity of the gains from the first FP CIP and use the lessons learned to continue the journey to achieve set goals. It envisions improved quality of life of Ugandans by enhancing their productivity through three technical strategies, namely: the shift from health sector dependent to multi-sectoral collaboration for socio-economic development; a shift from predominantly public to a Total Market Approach for universal health coverage and sustainability; and the shift from nationally driven to sub-regional focus to address inequities. The FPCIP II will also change the focus of its goals from just the married women and those in the union, to all women. Therefore, the goals are to increase mCPR from 30.4% in 2020 to 39.6% by 2025 and reduce the unmet need for contraception from 17% to 10% for all women and reduce teenage pregnancy from 25% to 14% by 2025.	It has been developed but is yet to be launched and disseminated.
National Family Planning Advocacy Strategy & Costed Implementation Plan 2020/21 – 2024/25. This strategy aims for all women, men, and young people to actively seek and have ready access to accurate and comprehensive FP information, be provided with high-quality, affordable, and equitable FP services, and utilise the FP programmes and resources available.	Although the country seems to be saturated with information about FP, gaps still exist in the actual uptake of FP services. Only 52% of demand is satisfied by modern contraceptive methods.

Policy or other instruments	Implementation status
Adolescent Health Policy (2021-2025) The 4th edition of this policy aims at promoting an adolescent responsive health care system that provides quality information and services to all adolescents, including hard to reach and those in humanitarian and fragile settings. This policy envisioned that all adolescents are alive, healthy, and thriving through increasing availability and accessibility of appropriate, acceptable, affordable, and quality information and health services to all adolescents regardless of gender, socio-economic status, disability, and location.	It has been under development since 2016. The draft underwent several reviews to meet the current RH/FP needs of young people in Uganda and the alignment with the Regulatory Impact Assessment (RIA) and other policies. The MOH SMT approved the final draft, and the policy awaits presentation to higher management.
The SRHR policy itemises numerous national documents (policies, guidelines, standards, etc.) that speak to the issue of teenage pregnancy. The 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."	TFR and teenage pregnancy rates are higher in Uganda than in other East African countries and some of the highest globally, at 6.9 children per woman and 25%, respectively. Increased cases of Sexual and gender-based violence and teenage pregnancies during the COVID-19 pandemic remain to be dealt with.
National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2012) They provide direction and focus on the provision of reproductive health services and guide the implementation of a coherent and coordinated reproductive health programme. The roles of MDAs, Development Partners, communities, and other stakeholders involved in planning, implementation, service provision, monitoring and evaluation are also defined.	General hospitals and Health Centre IVs offer comprehensive FP services and integrated RH services, while Health Centre IIIs and IIs offer basic FP services. IEC material development and dissemination and Behavioural Change Communication are primarily supported by implementing partners.

Policy or other instruments	Implementation status
National Comprehensive Condom Programming Strategy & Implementation (2020 - 2025)	Uganda has enough stock of condoms in the pipeline to cover public sector condom needs until the end of 2022. This is due to supplies and projections from various development partners in HIV and FP programming. The lack of reliable logistics and service delivery data was a challenge in forecasting and supply planning. Uganda now utilises the global UNAIDS/UNFPA condom estimation tool. Challenges still exist in the attitudes and belief that condoms are associated with promiscuity, limited availability and access at the community level, and poor condom use amongst people with a low socio-economic status.
District Tororo District Family Planning Costed Implementation Plan (DCIP) Mityana District Family Planning Costed Implementation Plan Kamuli District Family Planning Costed Implementation Plan Mukono District Family Planning Costed Implementation Plan	Three districts of Mityana, Kamuli and Tororo have developed FP CIPs that are supporting the district as resource mobilisation tools. While the plans are in place, funding the activities is still a dream. It is also clear that civil societies push these plans as opposed to local governments authorities. Their implementations are challenged by limited budgets and many competing priorities.

Despite all these policies in place, there is poor dissemination and application of FP/SRH policies, standards, and guidelines at all levels of health care. At the service delivery points, there is a general lack of relevant SOPs on the provision of Youth/Adolescent-friendly services. This is because SOPs on the provision of Youth/Adolescent-friendly services have not been disseminated to service delivery points in the public and private sectors.

3.3 Uganda's performance on financial commitments and investments for FP

3.3.1. FP2020 financial commitments

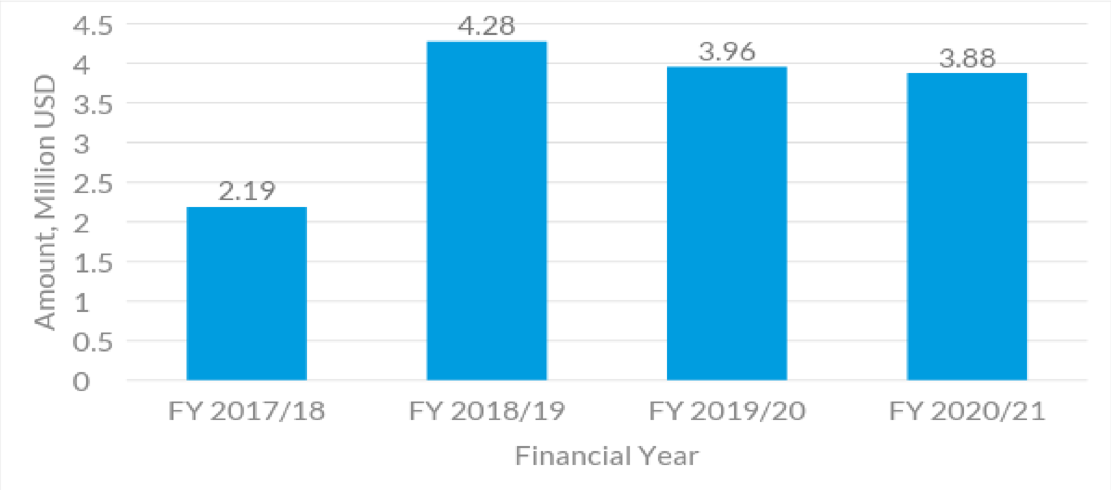
As committed at the FP2020 London summit, and subsequently recommitted in 2017, the Government of Uganda (GOU) was to allocate $5 million annually from domestic resources for procurement and distribution of a range of FP supplies and RH commodities up to the health facility level. The annual financial allocations show that this commitment was only met in FY 2013/14 and 2014/15. In FY 2017/18, the allocation was for the procurement, storage and distribution of Medroxyprogesterone and Safe Delivery Kits (Maama Kits).

From FY 2017/18 to FY 2020/21, allocations fell short of the FP2020 commitment of USD 5 Million leaving funding gaps of USD 2.81, 0.72, 1.04 and 1.12 million, respectively. Notably, in the FY 2020/21, 56% of the annual allocation under the National Medical Stores (NMS) Vote 116 under the RHS output went to Mama Kits, while GOU spent nothing on FP commodities.

This highlights the fact that without an exclusive budget line for FP commodities, the GOU expenditure will always be reprioritised since FP commodities are heavily externally supported. The USD 5 Million commitment of FP expenditure made in 2012 and renewed in 2017 was never met. An in-depth review of the RHS output under NMS, as highlighted later in this report, reveals this.

The GOU allocations for RH commodities and supplies from FY 2017/18 to FY 2019/20 are displayed in the figure below.

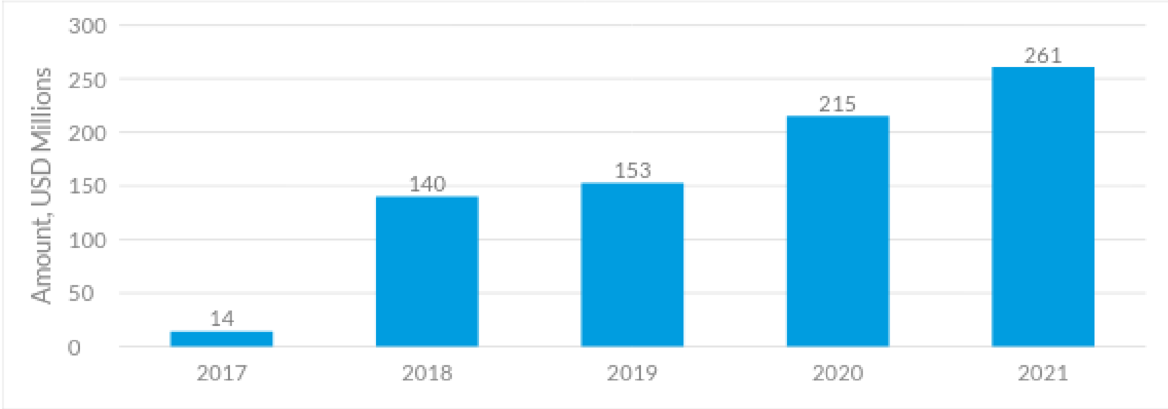
Figure 1: GoU allocations to RH supplies from FY 2017/18 to FY 2020/21 (Million USD)



Source: Consolidated Ministerial Policy Statements, Vote 116 NMS performance reports

The financial data shows a higher commitment of donors relative to the GOU on procurement of FP commodities, as shown by the Family Planning/ Reproductive Health Commodity Security (FP/RHCS) working group quarterly reports. This is further emphasised by the FP2020 commitment to raise $20 Million annually through continued partnership with development agencies and the private sector. The annual amounts raised for RH from development partners from 2017 to date are displayed in the figure below.

Figure 2: Amounts raised from development partners for RH from 2017 to 2021, USD Million



Sources: RMNCAH Resource mapping reports, Development partner websites

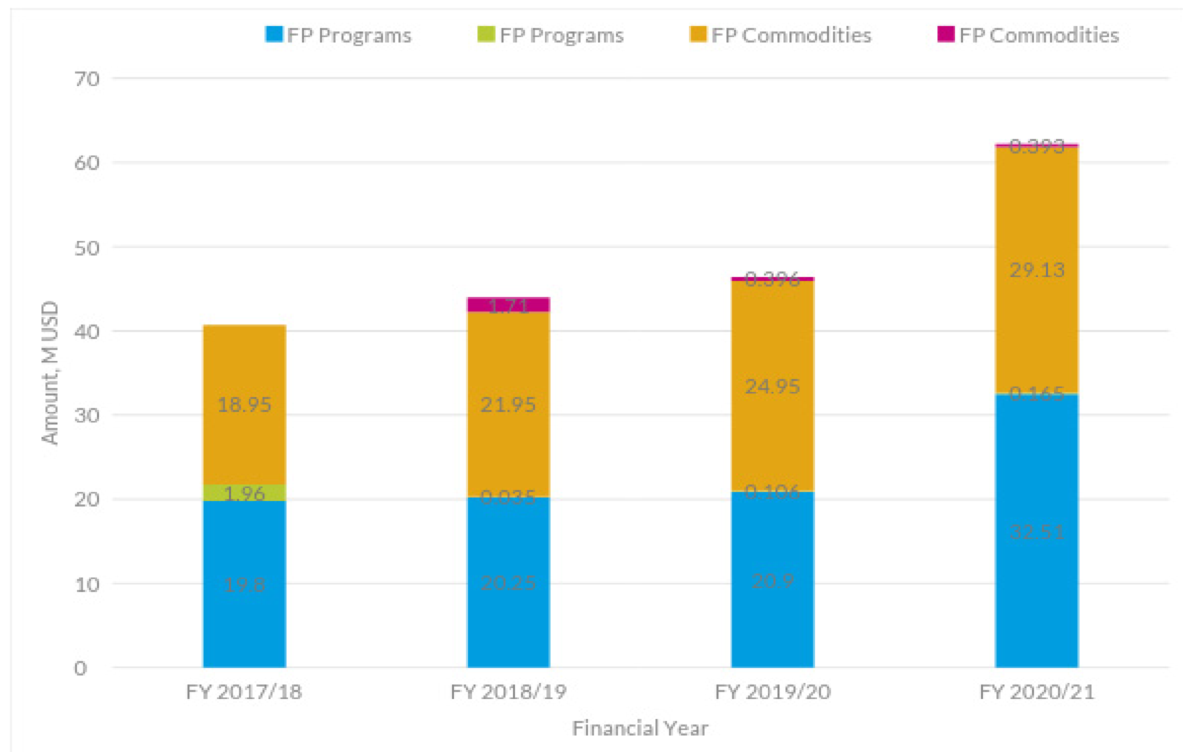
Donors and implementing partners support several components of the FP program such as commodity security, service delivery, especially FP outreaches, Behavioural Change Communication (BCC) interventions, and adolescent health interventions. The amounts raised from donors have increased more than ten-fold since 2017 and exceeded the USD 20 Million annual target. The availability of these funds has led

to laxity in GOU investments and, as a result, caused a sustainability risk. Countries like India and Rwanda intend to move from donor to public-funded FP commodity security, demonstrating greater sustainability of the FP program and a growing mCPR. Therefore, taking steps to transition from complete donor dependency towards domestic financing for national and sub-national levels is crucial.

3.3.2. Financial performance of the National FP CIP (2015 - 2020)

The development of the first National FPCIP was informed by the investment case for the RMNCAH sharpened plan. The estimated overall cost of implementing the FP-CIP over the five years was USD 235.1 Million. FP CIP stipulated the costs of implementing interventions under the six thematic areas of Stewardship, Management and Accountability, Financing, Contraceptive (Commodity) Security, Policy and Enabling Environment, Service Delivery, and Demand Creation. It further divided Contraceptive security costs into commodities and contraceptive programs. The RH/FP allocations are divided into the FP programs (Stewardship, Management and Accountability, Financing, Contraceptive programmes, Policy and Enabling Environment, Service Delivery, Demand Creation) and FP commodities and supplies. Figure 3 below compares the cost estimates for the implementation of FP programming with the allocations from FY 2017/18 to FY 2020/21.

Figure 3: Estimated costs and allocations for FP from FY 2017/18 to FY 2020/21 in USD Millions



Sources: FP CIP I, FP CIP II, Reproductive & Infant Health Division work plans, MOH commodities Stock Status Reports

*100% allocation went to Safe Delivery Kits (Maama Kits) as NMS had leftover stock of FP commodities from the previous years.

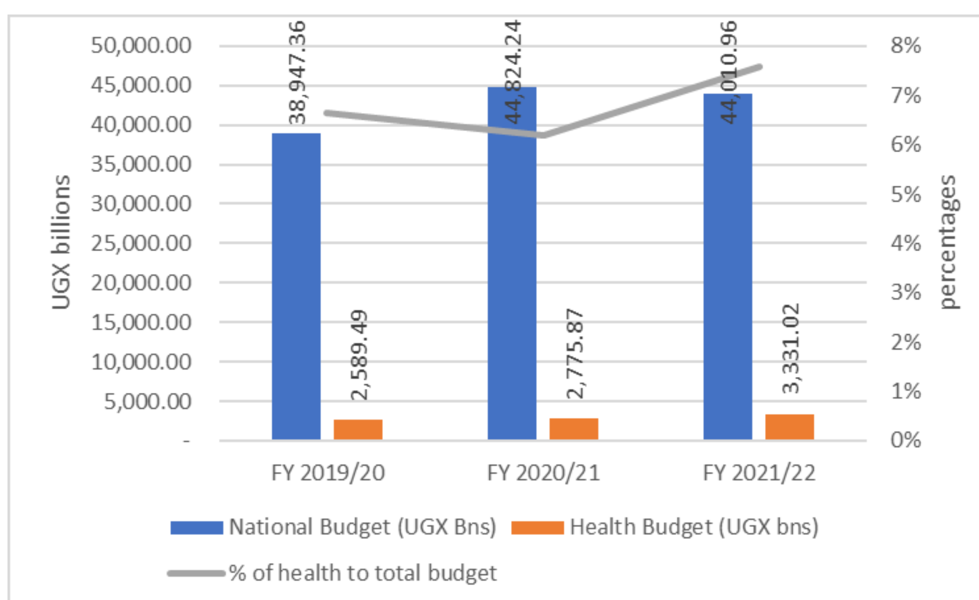
Domestic budgets per FY were significantly below the estimated costs (allocations between 0.2% and 1% for FP programs) and (1% and 8% for FP commodities) thereby contributing to the gaps in the implementation of FP interventions, especially in Stewardship, Management and Accountability, Policy, and Enabling Environment, as well as Demand Creation. Development partners supported the implementation of these areas through partnerships with GOU and projects based on their interests.

4.0 BUDGET ANALYSIS FINDINGS

This section presents annual budget allocation trends for the national level and selected districts. This section also covers an in-depth analysis of the FY 2020/21 for the health sector and particularly Family Planning.

4.1 Review and analysis of health budget allocation trends at the national level
The government of Uganda approved a national budget of **UGX 44,010.96 billion** in the FY 2021/22, of which 3,331.02(8%) was allocated to the health sub-program, an increase from UGX 2,775.87 billion in FY 2020/21. For the period under review, the Ministry of Health (MOH) took the largest proportion of the health sub-program budget, followed by the Primary Health Care (PHC) Grant that is routed to the Local Governments for health service delivery. The National Medical Stores and the Referral Hospitals (cumulative) come third and fourth, respectively.

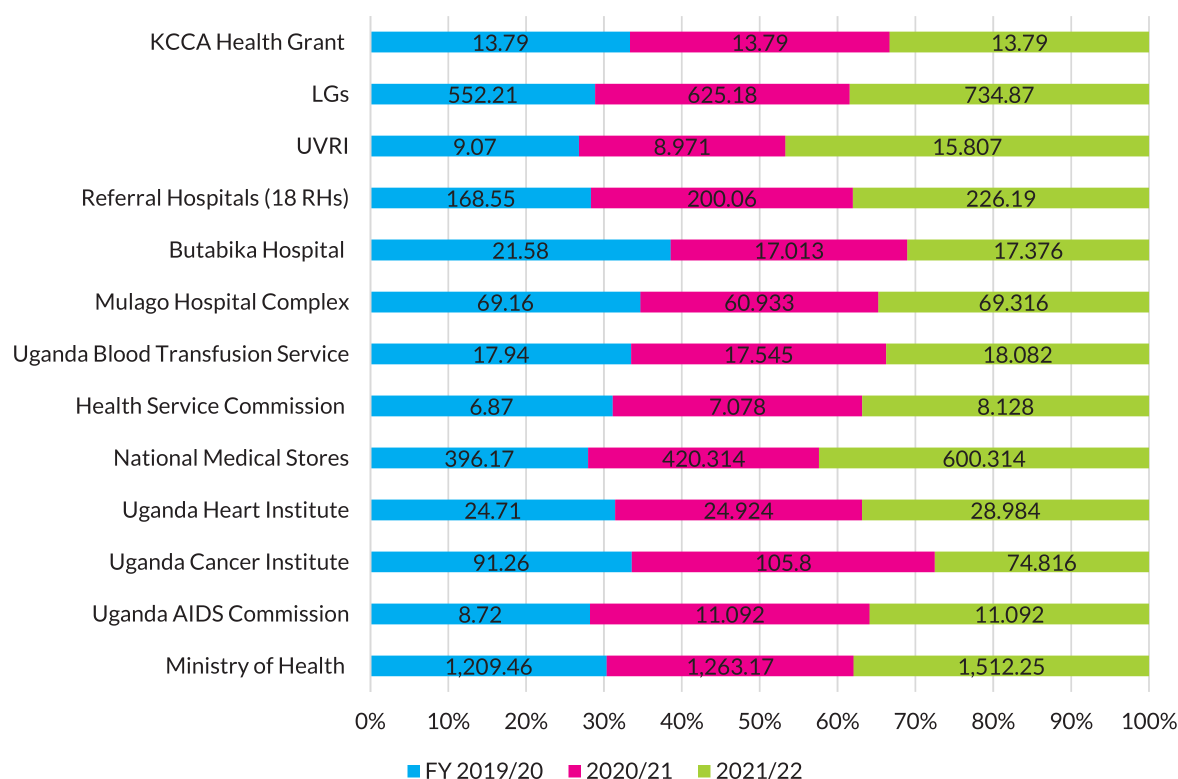
Figure 4: Health Sector Budget trend FY 2019/20 - FY 2021/22



Source: A4HUs computations and calculations

The health sub-program budget is further divided among 13 MDAs and LGs as indicated in Figure 5 below. The Ministry of Health and the National Medical Stores are taking the biggest share of the budget.

Figure 5: Health sub-program budget allocation trend FY 2019/20 - 2021/22 (UGX Bns)



Source: Approved budget estimates FY 2019/20 – FY 2021/22

4.2 Review and analysis of the health budget expenditure for FY 2020/21 at the national level

This section highlights the allocation and expenditure analysis for the FY 2020/21 for national and district budgets.

Table 4: Expenditure analysis for FY 2020/21 against the approved budget, Billion UGX

	Approved Budget (bns)	Release	Expenditure	Expenditure performance	Release Performance
Ministry of Health	1,263.17	992.1	177.34	18%	79%
Uganda AIDS Commission	11.092	11.092	10.974	99%	100%

	Approved Budget (bns)	Release	Expenditure	Expenditure performance	Release Performance
Uganda Cancer Institute	105.8	40.996	40.901	100%	39%
Uganda Heart Institute	24.924	24.998	24.76	99%	100%
National Medical Stores	420.31	456.57	453.79	99%	109%
Health Service Commission	7.078	7.119	5.806	82%	101%
Uganda Blood Transfusion Service	17.545	17.434	17.209	99%	99%
Mulago Hospital Complex	60.933	63.603	59.423	93%	104%
Butabika Hospital	17.013	17.023	16.552	97%	100%
Referral Hospitals (18 RHs)	200.06	151.626	136.636	90%	76%
UVRI	8.971	6.153	4.739	77%	69%
LGs	625.18				0%
KCCA Health Grant	13.79	13.796	12.98	94%	100%
Total	2,775.87	1,802.51	961.11	53%	65%

*As at end of March 2021; **data for Kiruddu covers cumulatively up to the end of Q2. No data from the Mulago Women's Specialised hospital; ***data for Entebbe and Kawempe RHs covers cumulatively up to Q3*

4.3 Review and analysis of family planning budget allocation trends and expenditure at the national level

In tracking budgets for FP, the two components that are considered are FP programs and FP commodities. The budget allocation for Family Planning at the national level has been taken, for this study to cover allocations in the National Medical Stores under the Reproductive Health Supplies, the estimated amount budgeted for FP-related activities in the Ministry of Health Reproductive and Infant Health (R& IH) Division annual work plan and the proportion of funds in RHs that are allocated and spent on FP to deliver on the "number new and old FP users" indicator.

While the FP commodities are catered for under vote 116, FP programs, including Service Delivery and Access, Financing, Stewardship, Management and Accountability, Policy and Enabling Environment and Demand Creation, are under vote 014 (Ministry of Health) and the Referral Hospitals. The R&IH Division of the Ministry of Health has no budget line specific for FP. As such, estimates of the allocations for FP programs were derived from integrated activities in the annual work plans of the R&IH Division.

Table 5: Estimated Budget allocations for FP programs under Vote 014 in UGX

Financial Year	2018/19	2019/20	2020/21
FP programs	130,767,000	394,400,000	604,332,000

Source: MOH Integrated Annual work plans for Reproductive, Maternal and Child Health Department FY 2018/19, FY 2019/20, FY 2020/21.

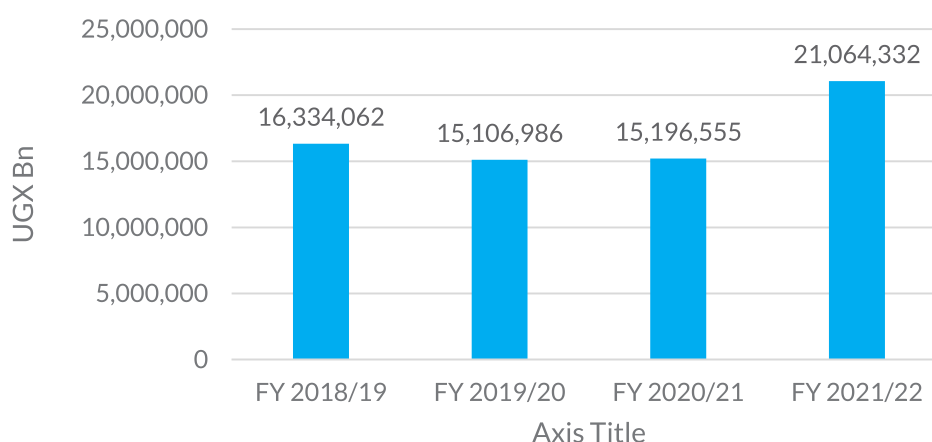
The work plans were reviewed for activities such as policy reviews, coordination meetings, sensitisation sessions, review, pre-test and update of supervision and mentorship tools, on-job supervision, mentorship and coaching for service providers in selected districts on the integration of FP into other services, quarterly FP meetings, commodity security meetings, supporting the development of district FP-CIPs, commemorating International FP day, supporting the roll-out of DPMA-SC (Depo Provera) and tracking implementation of FP procurement plan. Where FP activities were integrated with others in the division work plan, a proportion attributable to FP was taken based on the advice of officials in the division.

Table 6: Table 5: National FP Budget allocation trend FY 2018/19 - 2021/22 (UGX '000)

	Category	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
National Medical Stores (RH supplies)	Commodities	16,000,000	14,720,028	14,720,000	20,460,000
RHs	Service Delivery	233,089	386,885	394,418	229,974
MoH	FP programs	100,973	73	82,137	604,332
Total		16,334,062	15,106,986	15,196,555	21,064,332

Source: Approved Budget Estimates, Ministerial Policy Statement and FP Budget Analysis Report FY 2020/21

Figure 6: National FP Budget allocation trend FY 2019/20 - 2021/22 (UGX '000)



Source: Approved Budget Estimates, Ministerial Policy Statement and FP Budget Analysis Report FY 2020/21

The allocation for FP under the referral hospitals increased between FY 2020/21 and FY 2021/22 from UGX 209.754 million to UGX 229.974 million, with more resources allocated to commodities than services. The National Medical Stores saw a budget increase between FY 2020/21 and FY 2021/22 from UGX 14.72 billion to UGX 20.46 billion. The UGX 5.74 billion budget increase came when there were increased reports of conception among teenagers and couples in the union to promote family planning.

To further understand the allocation under the RH budget line in the NMS, we reviewed the Ministry of Health monthly stock reports that revealed all the procured commodities were not funded by GOU funds, as highlighted below.

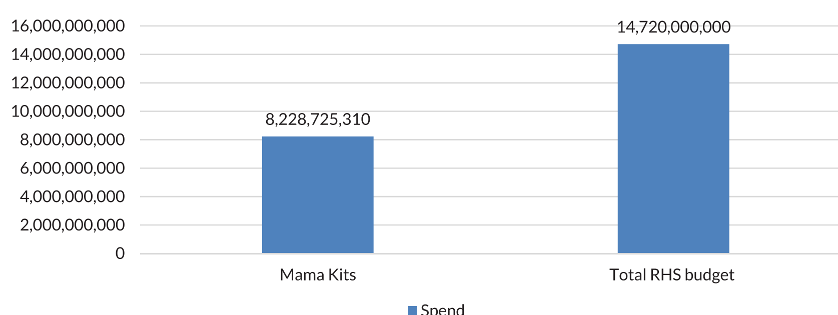
Table 7: FP Commodities procured in FY 2020/21 (UGX)

FP Commodity	Annual Spent	Source of Funding
Ethinylestradiol 0.03+Levonorgestrel 0 .15mg 3 cycles	952,585,198	External
Medroxyprogesterone Acetate. 150mg/Ml Inj with Syringe	3,107,313,456	External
IUD-Copper Containing Device Tcu380a	177,183,199	External
Levonorgestrel 1.5mg Tabs	125,889,757	External
Levonorgestrel 2 x 75 Mg, Implant (Jadelle)	2,332,477,826	External
Etonogestrel 68mg Implant (Implanon)	8,066,154,338	External
Levonorgestrel 0.03mg Tab 3 Cycles	51,769,520	External
Sayana Press 104 mg/Ml 200 x 0.65	3,603,994,193	External
Levonorgestrel 0.75mg Tabs	19,690	External

Source: MoH monthly stock status reports

From the table above, all the FP commodities were procured with external support, either from the US-Government (USG) or Donations (TPT). From the literature reviewed, Mama Kits were noted to consume over 90% of the RHS output budget (UGX 14.72 billion). With the FY 2020/21 RHS output spend review, Safe Delivery Kits (Maama Kits) accounted for only 56% (UGX 8.23 billion) of the budget.[4]

Figure 7: FY 2020/21 FP expenditure Vs Mama Kits off the RHS budget (UGX)



Source: Monthly MoH Stock reports FY 2020/21

4 Monthly MoH Stock Reports FY 2020/21

4.4. Review and analysis of four selected district health and family planning budget allocation trends and expenditure

Districts receive medicines from the national medical stores against a health facility's budget for the essential drugs. The health budget at the district level is funded through grants from the central government through the DHO's office and directly to the Health Facilities. Upon quarterly requests, funds are released to the districts. Family Planning at the district level is funded through the integrated outreaches and through the commodities delivered by the National Medical Stores. This study sampled four districts of Kamuli, Mityana, Tororo and Mukono, and their allocations trended from FY 2019/20 to FY 2021/22. All the districts under review had increasing health department budgets between FY 2020/21 and FY 2021/22 except for Tororo DLG. The health department budget for Tororo was reduced from UGX 12.877 billion to 12.048 billion between FY 2020/21 and FY 2021/22.

The allocation for FP in the districts is explicitly situated in the health facility budgets under the reproductive and maternal health sub-programme. The explicit GOU activity tagged to FP is integrated facilitation for outreaches that are central to demand creation and providing services (counselling and dispensation of commodities) to underserved populations in the communities.

4.5 Selected District expenditure analysis FY 2020/21

4.5.1. Tororo District Local Government

By the end of Quarter Four (Q4), the district had a budget release of UGX 54.61 billion against an annual budget of UGX 64.69 billion (84% budget performance).

By the end of Q4, the district's actual local revenue collection stood at UGX 938.88 million, only 40% of the annual target. The poor local revenue collection was witnessed during the quarter because markets which contribute a big portion of the district's local revenue were still closed due to the COVID-19 pandemic. The district had realised UGX 709,248,000 from external financing against an annual budget of UGX 1.38 billion being 51% budget performance by the end of Q4. 43% of external financing sources were not committed to and performed at 0%.

All the funds received had been disbursed to the respective departments by the end of Q4. Water, Administration, Education and Roads realised the highest budget outturn of 100%, 99%, 98%, and 98% respectively while Natural Resources and Production and marketing realised the least with 43% and 40% respectively.

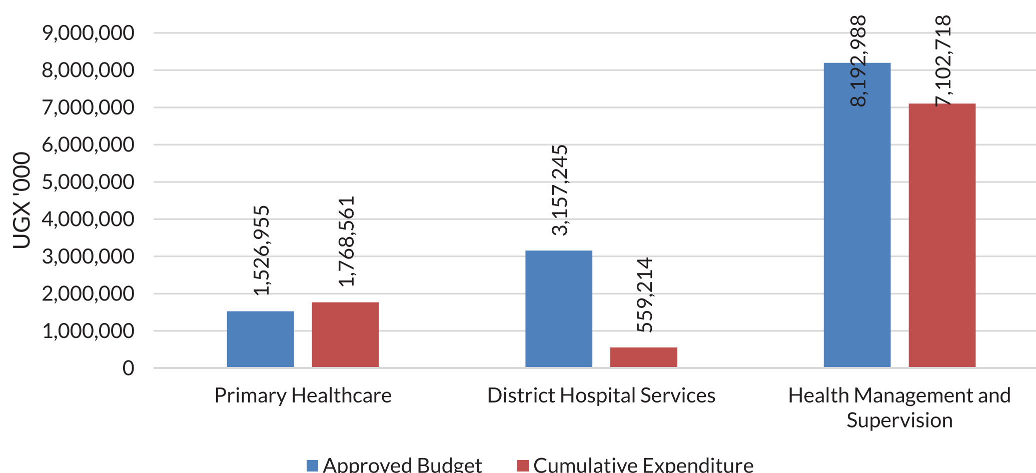
Table 8: Tororo DLG allocation and expenditure performance of health department as at end of March 2021 FY 2020/21 (UGX '000)

Depart-ment	Approved Budget	Cumulative Releases	Cumulative Expenditure	% Budget Released	% Bud-get Spent	% Releases Spent
Health	12,877,188	10,075,345	9,430,494	78%	73%	94%
Grand Total	64,693,616	54,606,029	50,809,500	84%	79%	93%

Source: Q4 cumulative budget performance report Tororo DLG FY 2020/21

The total allocation to the health budget was 20% of the entire district budget. By the end of Q4 for FY 2020/2021, the health department had received a total of UGX 10.08 billion against an annual budget of UGX 12.9 billion, representing 78%. By the end of Q4, the health department had cumulatively spent UGX 9.43 billion against an annual planned expenditure of UGX 12.88 billion representing 73 % performance.

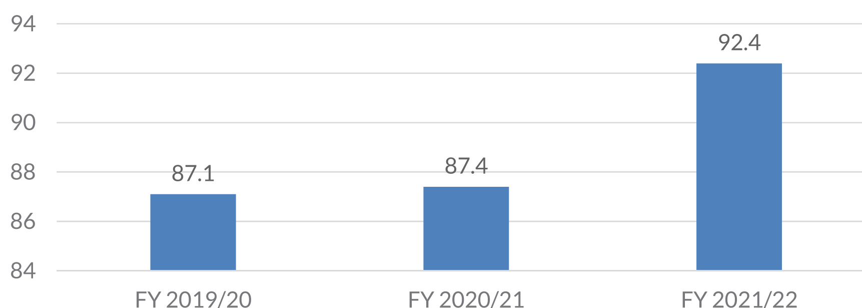
Figure 8: Tororo DLG Health expenditure analysis by source of revenue FY 2020/21



Source: Tororo DLG Q4 cumulative expenditure report FY 2020/21

By the end of Q4 for FY 2020/21, the department had cumulatively spent UGX 6.82 billion as wages against an annual planned wage expenditure of UGX 7.24 billion, representing 94 % performance. The department also spent UGX 1.69 billion on wages during the quarter against a quarterly planned expenditure of UGX 1.81 billion representing a quarterly expenditure performance of 94% cumulatively spent UGX 120.8 million as external financing against an annual budget of UGX 820 million representing a 15 % performance by the end of the reporting quarter. Of the Health sub-programmee budget, UGX 42.898 million could be traced and tagged as Family Planning expenditure.

Figure 9: FP Budget trends in Tororo DLG (000,000)



As illustrated in table 8, the budget allocation for FP in the FY 2021/22 increased from UGX 87.4 million to UGX 92.4 million. The district health office allocated the highest funds (UGX 23.16 million) to FP in FY 2021/22. This was followed by Nagongera and Mulanda HC Vs, which allocated UGX 7.29 million and UGX 3 million respectively.

4.5.2. Kamuli District Local Government

Kamuli District Local Government had an annual budget of UGX 46.38 billion for FY 2020/21. By the end of Q3, UGX 34.52 billion had been received, giving a revenue performance of 74%. The underperformance was due to low donor funding commitments and other government transfers. The cumulative expenditure was UGX 28.05 billion which is 81% of the total budget release of which UGX 19,134,530,000 was wage, UGX 6,585,895,000 was non-wage, UGX 1,745,655,000 was development and UGX 588,886,000 was donor.

The total unspent balance was UGX 6.43 billion which is detailed as follows: Wages had an unspent balance of UGX 1.55 billion which was due to non-recruitment of staff, especially in Education (UGX 701m), Administration (UGX 289m), Health (UGX 255m) and Production (UGX 161m). In addition, several staff retired and had not yet been replaced because of no functional District Service Commission (DSC). UGX 1.78 billion was unspent for non-wages mainly due to pension/gratuity, UGX 375m not paid because of delayed processing on the IPPS, UGX 666m for education which was for UPE/USE not yet paid to schools, and Roads UGX 549m for tarmacking of Kiroba road. All these projects were not implemented on schedule due to delayed procurement. The balance of UGX 65m on external financing was for Health and Child protection. UNICEF supported activities that were yet to be implemented by the end of the quarter.

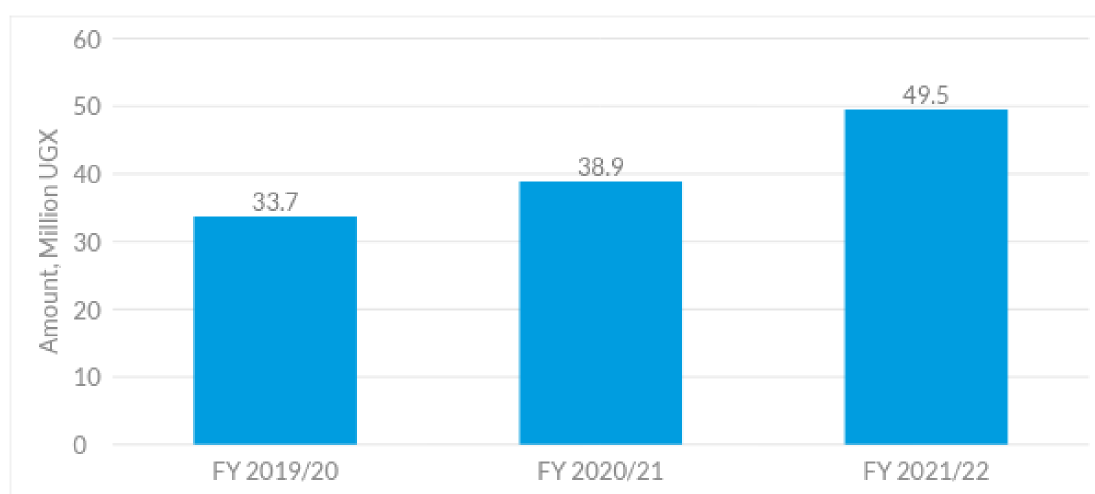
Table 9: Kamuli DLG expenditure performance by department as at end of March 2021 FY 2020/21 (‘000)

Department	Approved Budget	Cumulative Releases	Cumulative Exp	% Budget Released	% Budget Spent	% Releases Spent
Health	9,769,288	7,329,703	6,295,136	75%	64%	86%
Grand Total	**46,384,732**	**34,484,346**	**28,054,966**	**74%**	**60%**	**81%**

Source: Q3 Cumulative performance report FY 2020/21

The health department had a projected annual budget of UGX 9.77 billion, out of which UGX 7.34 billion had been realised by the end of Q3 giving a revenue performance of 75%. The total expenditure was UGX 6.30 billion, of which UGX 4.76 billion was wages, UGX 1.08 billion was non-wage, UGX 284.47 million was development and UGX 167.44 million was external financing.

Figure 10: FP Budget trends in Kamuli DLG



Source: Health Facility Work plans FY 2020/21 and literature review

In FY 2021/22, the budget allocation for FP in Kamuli increased from UGX 38.9 million to UGX 49.5 million. Of this allocation, 60% was PHC, and the rest was from RBF and partners. Some facilities with the highest allocations for FP in FY 2021/22 included Bugulumbya HC III with UGX 5.5 million, Nankandulo HC V with UGX 11.4 million and Balawoli HC III with UGX 6.139 million.

4.5.3. Mityana District Local Government

By the end of quarter three, cumulatively, UGX 22.89 billion out of the total district budget of UGX 31.13 billion had been realised, making 74% of the budget. This is 1% less than the expected overall performance due to several sources performing below expectation. Locally raised revenues at only 17%, owing to non-disbursements by Ministry of Finance Planning and Economic Development citing inadequate remittances on the part of the district. Other Government transfers were also noted

to have dismally performed i.e., 24% of the Uganda Road Fund (URF) was not released as per the funds flow requests in the budget; external financing was at only 33% narrowed by low commitment from the funding sources.

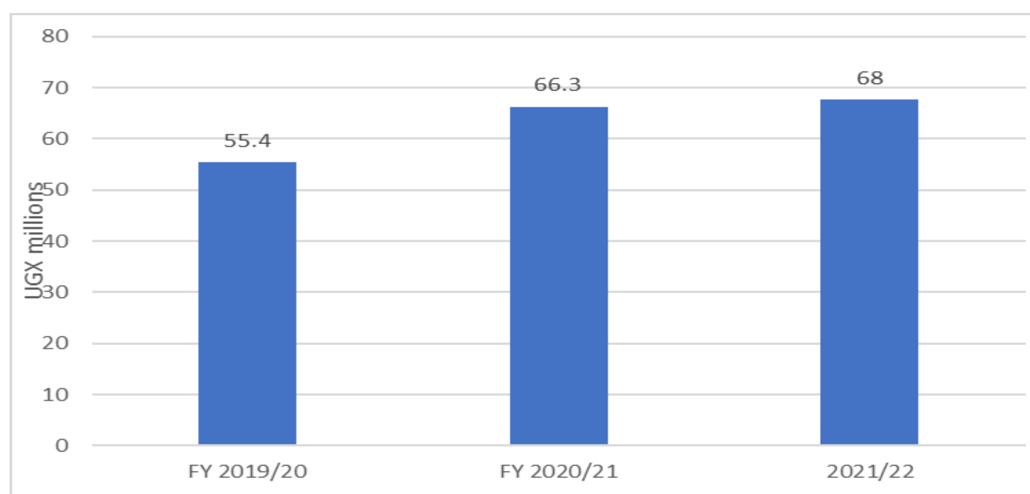
Table 10: Mityana DLG expenditure health department performance as at end of March 2021 FY 2020/21 ('000 UGX)

Department	Approved Budget	Cumulative Releases	Cumulative Expenditure	% Budget Released	% Budget Spent	% Releases Spent
Health	8,285,028	6,278,593	4,676,707	76%	56%	74%
Grand Total	**31,125,351**	**22,890,396**	**16,748,857**	**74%**	**54%**	**73%**

Source: Q3 Cumulative performance report FY 2020/21

The health departmental cumulative budget performance was UGX 6.28 billion against the annual budget of UGX 8.29 billion, giving a 76% cumulative outturn percentage. The recurrent revenue in the quarter was 97%, and development revenue was 102%. Expenditure in the Quarter was UGX 1.7 billion overall, representing 56% of the planned budget for the Quarter of UGX 2.07 billion.

Figure 11: FP Budget trends in Mityana DLG (UGX Billions)



Source: Health Facility Work Plans FY 2020/21 and literature review

The allocation for FP in Mityana district marginally increased in the FY 2021/22 from UGX 66.3 million to UGX 68 million only. The facilities that had high FP allocations included Maanyi HC III with UGX 4.336 million, Mityana Hospital with UGX 4.68 million and Magala HC III with UGX 5 million. The DHOs office in Mityana district had a total budget for FP engagement that was as high as UGX 155 million the proportion that was tagged to domestic resources was UGX 12.2 million and was factored into the total budget of UGX 68 million for the FY 2021/22.

4.5.4. Mukono District Local Government

By the end of Q4 FY 20/21, the district had received UGX 46.53 billion against the planned UGX 48.47 billion, translating to 96% budget performance, which is slightly below expected. The low performance was due to the locally raised revenue, other Government Transfers and external financing performing below 100%. However, Conditional Government Transfers performed above 100%.

On departmental expenditure, UGX 46.02 billion representing 99% of the budget was utilised to achieve departmental outputs leaving an unspent balance of 1% at the end of Q4 for FY 2020/21, mainly for the construction of the seed school in Kimenyedde Sub-County. Wages accounted for 60.3% of the overall total expenditure, and 31.2% supported non-wage related expenditure. Domestic Development and Donor development respectively accounted for 8.4% and 0.1% of the overall expenditure of the district by the end of Q4 in FY 20/21.

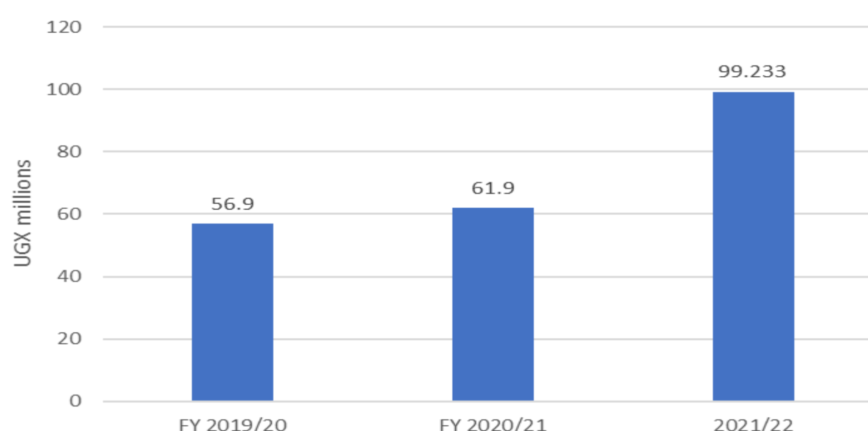
Table 11: Mukono DLG Expenditure performance by department FY 2020/21,'000 UGX

Department	Approved Budget	Cumulative Releases	Cumulative Expenditure	% Budget Released	% Budget Spent	% Releases Spent
Health	6,834,743	6,480,912	6,446,626	95%	94%	99%
Grand Total	**48,467,985**	**46,533,562**	**46,017,578**	**96%**	**95%**	**99%**

Source: Q4 Cumulative performance report FY 2020/21

Sector Conditional Grant Non-Wage had performed at 109% by the end of Q4. Revenue and expenditure stood at 95% and 138% on quarterly outturn, respectively. Revenue performance was below the expected because of the non-receipt of locally raised revenue in Q4 for the department. Wage consumed 63.4% of the total expenditure, non-Wage related activities consumed 24.7%, and 11.9% was used for development and donor-related expenditures. The absorption capacity of the department for the receipts was 97% at the end of Q4.

Figure 12: FP Budget trends in Mukono DLG



Source: Health Facility work plans FY 2021/22 and literature review

The largest proportion of the health expenditure in Mukono is towards PHC. Up to 94% of the total health budget was spent during the reporting period, with the district hospital services spending 100% of its budget.

The budget allocated to FP in Mukono district increased from UGX 61.9 million to UGX 99.233 million between FY 2020/21 and FY 2021/22. Out of this allocated budget, only 14% (UGX 13.5 million) was attributed to PH. The facilities with the highest PHC allocations *in* the FY 2021/22 included Goma HC III with UGX 2.196 million and Seeta Namagunga HC III with UGX 8.4 million.

5.0 FAMILY PLANNING UTILIZATION

The ability of women and couples to decide when to have children is crucial for the population's well-being. Family planning has been viewed as an essential practice in society. It provides women with the ability to have children when they are ready. This has presented several benefits to the women, their families, and the community at large. The community members' access to and utilisation of FP services was examined through FGDs conducted in Kamuli, Mukono, Tororo and Mityana districts.

Table 12: FP Users per district FY 2021/22

	Male	Female	Total
Kamuli	4,600	40,320	
Mityana	1,857	20,232	
Mukono	2,608	30,595	
Tororo	5,158	20,947	

5.1 Benefits of FP

Enabling child spacing and promoting education and career growth: With FP, women and couples are presented with the opportunity to have children at their convenience, which allows the opportunity to prepare well for them, with a minimum spacing of 2 years. This creates time for the woman to pursue other personal development avenues, including further studies and career growth. In addition, women are allowed to fully heal from the effects of childbirth of one child before embarking on the next one.

"Family planning is important because it has helped many families live a happy life so that they have managed to construct beautiful houses and buy other properties like land from their savings and because of few children." **Female adult at Namwenda HC IV**

Reduces diseases like Sexually Transmitted Infections (STIs): The use of family planning methods like condoms has contributed to the reduction of STIs, including the

Human Immune Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS), especially among the youth, both male and female.

Improves women's health: With the planned child spacing, a mother is allowed to heal from the previous pregnancy fully. The body is given the opportunity to regain its state before pregnancy before embarking on another. This improves the mother's health, especially with the resizing of the uterus.

"A woman who produces every year weakens her body. However, if you space your child well, it makes the body fine, and you look beautiful," one of the female adult respondents from Nakifuma HC III.

Reduces unwanted pregnancies, especially among young girls: Family planning has supported so many teenagers to stay in school, as many youths can access and use family planning which enables them to study and have control of when to give birth.

Reduces unnecessary expenditures: With a family supported through family planning, couples can space and plan better for their children, reducing the risk of high expenditures on children, especially school-going children.

Increase parental care for each child: Parents can provide quality care for their children with family planning as they prepare better for them and secure their well-being with increased attention to their health.

5.2 Perceived dangers of family planning and reasons for discontinued use of FP services

The participants expressed their opinions on the dangers they might face or those they have experienced, which led to their discontinued use or discouragement from taking up FP. These experiences and perceptions are outlined below.

- **Side effects in use dependent on the method of family planning used:** Family planning methods like the coil, injectables and implants disrupt one's menstrual periods where some women are unable to get their period while others experience over bleeding, back pain, nausea, and dizziness, which require medical attention many times.
- **Unreliable** in some instances, especially where the woman ends up getting pregnant, even when on family planning.
- **Irreversible effects:** Long term methods like vasectomy (male sterilisation) and Tubal Ligation (female sterilisation) can have irreversible effects which some people might be unaware of.
- **Promoted sexual immorality among women and girls:** The increased promotion of family planning has exposed girls, especially the youth, to sexual

encounters before the appropriate age. These are more concerned about using family planning methods that do not get them pregnant, ignoring the exposure to HIV/AIDS.

- **Misinformation about causing barrenness and infertility:** The high perceptions about family planning have discouraged its uptake in several communities as women and girls are biased to use family planning methods with the understanding that they will get barren and infertile, which is false.
- **Incites and facilitates Gender-Based Violence:** From the FGDs, some men are against the use of FP services by and with their wives due to a negative attitude to its use. These influence their spouses against using FP services. This has limited the use of FP services and fuelled GBV in families and communities, especially when both spouses are on opposing sides on the use of FP.
- **Leads to the reproduction of abnormal/deformed children:** There is an increased perception that family planning breeds abnormal/ deformed children, increasing its limited use, especially among female adults.
- **Religious and traditional beliefs:** The religious faith and some traditional cultures are against family planning practices as they believe it limits the opportunity to bring life to the world. Family planning is viewed as a practice that limits childbearing and is therefore preached against among the churches, especially the Catholic faith.

5.3 Challenges in accessing FP services

5.3.1 National level

At the national level, some of the key issues faced in accessing FP services are outlined as follows;

- Understaffing at health facilities leads to FP service provision not being prioritised.
- Stock-out of FP commodities at service provider levels leads to inconsistencies in accessing FP methods and sometimes quitting.
- Lack of capacity and facilitation of VHTs in providing FP services to communities.
- The lack of fully trained staff in FP service provision and counselling means that client's access to services is limited.
- Long distances to especially the higher-level health facilities which was compounded by the restrictions in movement during the COVID 19 lockdowns.
- Inadequate knowledge of FP services and benefits among communities.
- Low male involvement in FP is a significant impediment to women accessing FP services.

5.3.2 Tororo district

The participants in the FGDs for Tororo district listed the challenges faced in accessing FP as follows;

- **Failure to access the FP method of choice** from the health facilities due to stock-outs. The FP method that participants mentioned as being out-of-stock were injectables. In the absence of injectables, some women would go without FP as they were not open to switching to another method like contraceptive pills.
- **Understaffing** of health workers which led to their being overwhelmed by the number of FP clients. As a result, clients would have to wait long to receive FP services, and others would end up leaving without them if they had to attend to other activities.
- **The negative attitude of men towards family planning.** Very few men supported family planning in the area, which meant that women needed to find a way to access the health facilities without their husbands' knowledge. On days when they could not "escape" they would not be able to access the services. Additionally, the lack of support from some men meant that they would not provide transport for their partners to go to the health facilities for FP services.
- **Long distances to higher level health facilities.** Many women had to walk long distances to access a variety of FP services as the lower-level health centres (Health Centre IIs) did not have all the FP methods they were interested in.
- **Language barrier:** Respondents mentioned that some health workers did not speak the local language, which made it difficult for clients to get the information they needed and the services they preferred.
- **The negative attitude of some health workers:** Some participants noted that some health workers, particularly midwives, were rude to clients, which led to difficulty in accessing services and eventual discouragement.

5.3.3 Kamuli district

The participants in the FGDs for Kamuli district listed the challenges they faced in accessing FP as;

- **Commodity stock-outs** led to failure to access the preferred FP method or service. Many health centres would have stock-outs of injectables, pills and sometimes condoms.
- **Limited health workers** to attend to FP clients and provide the services. In some cases, one midwife or nurse would have to attend to mothers giving birth and provide FP services. This also means long waits and sometimes not getting the services.
- **Limited training of staff to provide FP services.** Some of the medical personnel are not well-versed with the variety of FP methods, which makes it difficult to access and recommend the most effective method.

- **Travelling long distances to health facilities.** During the COVID-19 lockdowns, clients had to walk long distances to access the FP services. This discouraged many from making use of the services.
- **Expired FP commodities** such as condoms at health facilities meant that clients would be deprived of the service.
- **Rude health workers** discouraged some clients from accessing family planning services.

5.3.4 Mityana district

The participants in the FGDs for Mityana district listed the challenges they faced in accessing FP as follows;

- **Lack of information** about family planning. This means that many potential clients do not know what services they can get and sometimes where to get them from, especially those who live in forests where megaphones do not reach. Additionally, some health workers do not counsel clients before providing the FP methods, leading to misinformation.
- **The negative attitude of some health workers.** Some participants noted that some health workers, particularly midwives, were rude to clients, which led to difficulty in accessing services and eventual discouragement.
- **Long-distance to health facilities.** This hinders some clients' access to FP services, and some end up waiting for the services to be brought nearer through partner outreaches that might not be regular.
- **Men are not fully sensitised on FP.** This has led to little support for their partners accessing FP services.

5.3.5 Mukono district

In Mukono district, the participants in the FGDs raised the following as the challenges they face in accessing FP services:

- **Long distances to health facilities.** Many women had to walk long distances to access various FP services.
- **Lack of information** on family planning. Some people did not know about FP and the services they can get, while others were unaware of where to get the services.
- **Understaffing** health workers led to clients waiting too long to receive FP services. Some clients would leave without getting services as they got tired of waiting.
- **Failure to access the FP method of choice** from the health facilities due to stock-outs. The FP method participants mentioned as out-of-stock were pills, injectables, and condoms.
- **The negative attitude of some health workers.** Some participants noted that some health workers, particularly midwives, were rude to clients, which led to difficulty in accessing services and eventual discouragement.

- **Lack of counselling on FP.** Some health workers do not counsel clients before providing the FP methods, which leads to misinformation or getting methods that they wouldn't have.
- **Lack of active youth-friendly corners.** This led to some young people being uncomfortable accessing FP services for fear of bumping into their parents and relatives.

5.4 Recommendations to increase uptake of FP

5.4.1 National level

The recommendations made at the national level to increase the uptake of and access to FP services were.

- **Recruitment of more staff** to provide FP services. These should also be motivated to provide better services.
- **The National Medical Stores should increase the quantity of FP commodities** provided, adhere to the preferences of specific health facilities and do it on schedule.
- **Training VHTs** to offer FP services to the communities and educate people on FP.
- **Train staff** to provide quality FP services, with adequate knowledge on counselling, as well as the different methods of FP.
- **FP outreaches, especially by health facilities**, should be increased to reduce the long-distance travel of clients.
- **Strengthen sensitisation of communities** on family planning, strongly emphasising its benefits.
- **Promotion of male involvement in FP** even during health facility visits.

5.4.2 Tororo district

To address the challenges faced in access to and uptake of FP services, respondents in the FGDs recommended that;

- Through the National Medical Stores, the government increases the quantity of FP commodities provided with specific attention to the more preferred methods per health facility.
- Health facilities should organise regular outreaches in the communities to overcome the challenge of long distances.
- Men and the community are sensitised to increase their support for the use of FP.
- Government should recruit more staff to ensure that they are not overwhelmed with clients.
- Health workers should be trained in the local language or translators hired to help.

5.4.3 Kamuli district

Respondents in the Kamuli FGDs made the following recommendations to address the challenges.

- The government should supply all health facilities with FP commodities in a timely manner and with various methods.
- All health workers should be trained in providing FP services such that they do not limit the clients' options.
- Government should recruit more staff to ensure that they are not overwhelmed with clients.
- Train community health workers to help provide FP services closer to the people.
- Government should recall expired commodities such as condoms.

5.4.4 Mityana district

To address the challenges faced in access to and uptake of FP services, respondents in the FGDs recommended that;

- Government should provide IEC materials and mass media messages to inform people about FP.
- Health facilities should organise regular outreaches in the communities to overcome the challenge of long distances.
- Health workers should always give counselling services enough time so that FP clients can make informed decisions.
- Men and the community should be sensitised to increase their support for the use of FP.

5.4.5 Mukono district

Respondents in the Mukono FGDs made the following recommendations to address the challenges.

- VHTs should be facilitated to increase access to commodities at the community level. Without transport and commodities, it is hard for them to support FP service delivery and save clients from the issue of long distances to health centres.
- Sensitisation of communities on FP information and services.
- Government should recruit more staff to ensure that they are not overwhelmed with clients.
- The government should increase the quantity of FP commodities provided at all levels of health facilities.
- Government should train all health workers in counselling for FP services at all levels of care.
- Youth-friendly corners should be equipped to encourage young people to receive services without bias and judgement.

6.0 GENERAL DISCUSSION

The ability of women and couples to decide when to have children is crucial for the population's well-being. Family planning has been viewed as an essential practice in society. It provides women with the ability to have children when ready. This has presented several benefits to the women, their families, and the community at large. Participants shared this view in the Focus Group Discussions and Key Informant Interviews. Despite the benefits of family planning, the study established that a certain section of the participants had negative perceptions of FP, hindering its use and uptake. This showed the need to increase investments in mindset change to alleviate the myths and misconceptions and contribute to the improvement of FP indicators.

The influence of religious and cultural beliefs on the use of modern FP methods is an aspect that should not be ignored as it has far-reaching implications on the choice to use FP by sections of the population. The findings did not identify specific funding to sensitise religious and cultural leaders on FP such that they may, in turn, pass on positive messages to their followers.

The side effects experienced from using FP were mentioned as another significant reason for stopping use of modern FP and hesitation of some non-users in adopting them. This is an indication for the need to invest in training and mentoring health workers in managing side effects at all levels of care.

There was a perception among the community members that FP promoted sexual immorality among young people and adolescents. There were also concerns that some young women and girls were more focused on methods that prevent pregnancy while ignoring the exposure to HIV/AIDS. This calls for increased investments in developing and disseminating IEC materials at both the national and sub-national level, BCC, and providing FP/SRH information to adolescents and young people.

Gender-Based Violence came up as another unintended outcome arising from men disagreeing with their partner's use of FP. Due to the lockdowns in the COVID-19 pandemic, cases of GBV have gone up due to several reasons, some of which might be FP related. This calls for multi-sectoral coordination and investment in FP between MOH and the Ministry of Gender, Labour, and Social Development and between the District Health and Community Development departments.

Several challenges in accessing FP services and information were identified through the FGDs. Among these was the failure to access the preferred FP method from the health care providers due to stock-outs and a limited variety of commodities. This could be related to GOU allocating no more than 10% of the Vote 116 to FP commodities and being complacent that external funding will cover them.

There were significant challenges in service delivery, such as understaffing and lack of training in providing FP information at services. The inadequacy in numbers meant that possible users of FP might miss out on getting services if the health workers are swamped with other work that takes precedence over FP. A related challenge was the lack of training of Village Health Teams (VHTs), who would help fill human resource gaps at the community level.

The existence of communities that could not readily access FP services due to long distances and poor road networks requires more investments in outreaches to avail FP information and services to people living in hard-to-reach areas.

Despite Uganda's being a signatory to global and regional initiatives that support RH/FP and the existence of several policies and other instruments for FP programming, there are gaps in disseminating these instruments and sensitisation in their use at the sub-national level. This creates a gap in the application of these instruments as a guide for the district leadership and health workers as they implement FP programs.

There is also a mismatch between Uganda's population age structure (50% young people) and the priorities in allocating funds to provide information and services specific to their needs. This was partly evidenced by GOU failure to progress on the FP2020 commitment to allocate 10% of the RMNCAH budget to adolescents. If this trend continues, any strides achieved in FP will likely be minimal at best.

7.0 CONCLUSIONS

There is continued reliance on external financing to implement interventions in the health sector, including family planning. This shows the lack of ownership of FP programming by GOU and likely gives way to development and implementing partners dictating which projects and interventions to focus funds on, which might not necessarily be the priorities aligned in the National and District FP-CIPs.

Although the NMS - Reproductive Health Supplies budget increased from UGX 14.72 billion to UGX 20.46 billion in FY 2021/22, the split between Mama Kits and FP commodities remains skewed towards the former. This significantly impedes the strides that could be gained in increased uptake for FP.

A major challenge that persists is the lack of full disclosure of the expenditure breakdown for the Reproductive Health commodities output in Vote 116. The lack of transparency significantly affects budget tracking efforts especially at the national level, thereby taking away what would be evidence to identify gaps, and challenges and ultimately inform budget advocacy efforts. Although budgets for FP at the districts

have also progressively increased, emphasis needs to be placed on a multi-sectoral approach to planning, resource mobilisation and implementation of FP interventions.

There is hardly any financing from GOU that is focused on improving FP outcomes for adolescents and young people, yet they constitute more than 50% of the country's population. Development partners continue to support programs right from policy development level to service delivery. Demand creation for this section of the population has great potential to help the country achieve the Demographic Dividend.

In the management of COVID-19, government expenditure fell by 40% in the 2nd half of the FY 2020/21. This was justified by the need to divert resources to COVID-19 response measures. This caused gaps in service delivery and access to FP commodities that had already been procured.

The Government of Uganda GOU recognises and has prioritised family planning in broad development and health policies and strategies. At the sector and MOH level, relevant policy and planning frameworks exist to guide FP interventions. However, the challenge is in the dissemination and use of these policies at the district and Health Facility levels.

The FP2030 commitments were launched, and the FP CIP II will soon follow, but to achieve the goal of increasing the mCPR from 30.4% to 39.5% and reducing the unmet need from 17% to 15% for all women, all stakeholders should be mindful of their roles, and be held accountable in the political, financial, programmatic realms. Individuals, couples, families, parents, communities, health workers, school leadership and teachers, FP champions, opinion, religious and cultural leaders also need to be accountable for their roles in improving FP.

8.0 RECOMMENDATIONS

Based on the findings of the study, our recommendations at the national and sub-national levels are;

8.1 National level

- Given the ever-increasing population of Uganda, it is evident that GOU needs to be intentional about increasing allocations specific to FP.
- NMS should also increase the quantity of FP commodities provided and a wider method mix to enable clients to easily access methods of their choice.
- To avoid reliance on external financing, which is unpredictable and unsustainable, GOU should take on alternative financing avenues at the national level.
- The lack of evidence regarding GOU performance on the FP2020 commitment

to allocate 10% of the annual RMNCAH (GFF) budget to Adolescent Health calls for the need to increase investments in FP interventions for adolescents and young people.

- Allocations specific to FP under NMS vote 116 should be increased as their aggregation under RH commodities to include Safe Delivery Kits (Maama Kits) and FP does a disservice to the latter. Alternatively, CSOs should advocate for a 50% split between these two broad items so that when the overall vote budget is increased, FP commodities also gain from it.
- A multi-sectoral approach needs to be strengthened as FP is not just a health issue but a developmental one that cuts across sectors, departments, religions, levels of leadership, communities, families, and individuals.
- Transparency and access to budget data, including expenditures at the national level, to identify gaps and inform advocacy is key to improving FP programming.
- Government should invest in the recruitment and training of Health Workers in providing FP information and services at all levels of care. Additionally, VHTs should be trained in providing FP information and services and their stock replenished in a timely manner as they are the first line of call for most FP users in the community.

8.2 Tororo district

- Increasing allocations specific to FP by both the central government and the district through local revenue and alternative funding sources. to contribute to increased health, well-being, and productivity.
- National Medical Stores should increase the quantity of FP commodities provided and a wider method mix to enable clients to easily access methods of their choice.
- The capacity of district stakeholders should be built-in advocacy for increased investments in FP through their DCIP.
- A multi-sectoral approach needs to be strengthened as FP is not just a health issue but a developmental one that cuts across sectors, departments, religions, levels of leadership, communities, families, and individuals.
- Transparency and access to expenditure data to inform advocacy efforts is critical to improving FP programming.
- Training of Health providers, including VHTs in the provision of FP information and services at all levels of care.

8.3 Kamuli district

- The central government and the district should increase allocations to FP. This could be through local revenue and alternative sources of funding.
- National Medical Stores should increase the frequency of delivery and the quantity and variety of FP commodities provided.
- The capacity of district stakeholders should be built-in advocacy for increased investments in FP through their DCIP.

- The district needs to strengthen the multi-sectoral coordination in FP programming as FP is a cross-cutting issue.
- Transparency and access to expenditure data to inform advocacy efforts is vital.
- Health workers and VHTs should be trained in providing FP information and services.

8.4 Mityana district

- Increasing allocations specific to FP by both the central government and the district through local revenue and alternative funding sources. to contribute to increased health, well-being, and productivity.
- National Medical Stores should increase the quantity of FP commodities provided and a wider method mix to enable clients to easily access methods of their choice.
- The capacity of district stakeholders should be built-in advocacy for increased investments in FP through their DCIP.
- A multi-sectoral approach needs to be strengthened as FP is not just a health issue but a developmental one that cuts across sectors, departments, religions, levels of leadership, communities, families, and individuals.
- Transparency and access to expenditure data to inform advocacy efforts is key to improving FP programming.
- Training of Health providers, including VHTs in the provision of FP information and services at all levels of care.

8.5 Mukono district

- The central government and the district should increase allocations to FP. This could be through local revenue and alternative sources of funding.
- National Medical Stores should increase the frequency of delivery and the quantity and variety of FP commodities provided.
- The capacity of district stakeholders should be built-in advocacy for increased investments in FP.
- The district needs to strengthen the multi-sectoral coordination in FP programming as FP is a cross-cutting issue.
- Transparency and access to expenditure data to inform advocacy efforts is vital.
- Health workers and VHTs should be trained in providing FP information and services.

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