Family Planning in Uganda:

A Review of National and District Policies and Budgets

DSW

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Contents

Table of Figures

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
BFP	Budget Framework Paper
BOU	Bank of Uganda
CBDAs	Community Based Development Assistants
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee
DDHS	District Directors of Health Services
DDP	District Development Plan
DHO	District Health Officers
DSW	Deutsche Stiftung Weltbevoelkerung
EU	European Union
FY	Fiscal Year
GDP	Gross Domestic Product
GoU	Government of Uganda
HC(1,2,3)	Health Centre levels
HCT HIV	Counseling and Testing
HIV	Human Immunodeficiency Virus
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IDA	International Development Association
IEC	Information Education and Communication
LGA	Local Government Act
LGBFP	Local Government Budget Framework Paper
LLG	Lower Local Governments
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoLG	Ministry of Local Government
MTEF	Medium Term Expenditure Framework Paper
NAWMP	Network of African Women Ministers and Parliamentarians
NDP	National Development Plan
NGO	Non Governmental Organisation
NHP	National Health Policy
NMS	National Medical Stores
NTIHC	Naguru Teenage Information and Health Centre
ODA	Official Development Assistance
OECD	Organisation for Economic Organisation and Development
PAF	Poverty Alleviation Funds
PEAP	Poverty Eradication Action Fund
PHC	Primary Health Care
PopSec	Population Secretariat
PPDA	Public Procurement and Disposal Act
RH/FP	Reproductive Health/Family planning
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHU	Reproductive Health Uganda
SAA	Senior Account Assistants
SBFP	Sub County Budget Framework Paper
SHSSPP	Support to the Health Sector Strategic Plan Project
SIDA	Swedish International Development Assistance
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SWAP	Sector Wide Approach
TFR	Total Fertility Rate
UBTS	Uganda Blood Transfusion Services
UDHS	Uganda Demographic and Health Survey
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMCHP	Uganda National Minimum Health Care Package
WHO	World Health Organization

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Special thanks go to Anne Alan Sizomu who carried out the health facility assessment and policy analysis. Matthias Bucker who tirelessly read all the budget documents and Ministry of Health activity work-plans to compile the national budget, health budget, RH budget and family planning budgets. Rita Nalumansi, Robert Kiwanuka Joseph Waninda and Clyde Muhumuza who took part at the district level data collection. Moses Muwonge who carried out budget analysis section compiled the report.

This report would not have been a reality without the support of Mityana and Kamuli District Health Office, Ministry of Health, RH division, MOFDEP and NMS. We are grateful for their time and information.

Executive Summary

At the London Family Planning summit in 2013, the president of Uganda demonstrated political commitment to increasing access to family planning services by pledging to allocate $5 million for procurement of RH commodities over the next five years commencing FY 2013/14. In response to the UN Director General's strategy on Every Woman, Every Child and the UN Commission on Life Saving Medicines, Uganda has carried out a bottle neck analysis of the Reproductive Health, Maternal Health, Newborn Health and Child Health (RMNCH) and developed draft RMNCH catalytic plan. Further Uganda has demonstrated commitment to improve the reproductive health status of the country through establishment of the Reproductive health commodities Budget line, development of the Reproductive Health commodity security strategy, prioritizing reproductive health within policy documents including the National Development Plan, the Health sector strategic and Investment Plan, Vision 2040 and the enactment of the population policy in 2013. Significantly, maternal and newborn health is mentioned as priority areas within the MTEF FY 2010/11, 2011/12, 2012/13 and FY 2013/14.

Despite the strong political commitment to reproductive health, the Government of Uganda's expenditure on health as a percentage of total government budget which directly impacts on the resources available for reproductive health has averaged at approximately 9% less than the commitment Uganda made at the Abuja Declaration of increasing the percentage expenditure on health to at least 15% of the total budget. Over the last three years and the next three year projections do not show any sign of improvement. The per capita expenditure on health stands at $9 way below the WHO recommendation of 44%.

In addition, the allocations and expenditure on Reproductive health within the health sector does not reflect the political commitment. The budget allocations to RH within the Health budget stands at 2% over the last three years and has decreased to 1% in FY 2013/14. There is need for advocacy to ensure that this trend is averted for the future resource allocations. However, within the 2% allocation to reproductive health, there is clear indication on commitment to family planning. Over the last three years, the allocations to Family planning have increased from 49% in FY 2010/11 to 74% in FY 2013/14 (PPD ARO, 2013).

It is expected that the resources realized at national level would trickle down to the district and lower level health facilities where impact would be most felt. The district assessment of 10 health facilities indicated availability of contraceptives on the day of the visit and each of the facilities had a professional midwife. The adolescent health services were not universally available and there was inadequate infrastructure to allow for good waiting areas, counseling and treatment for family planning, maternal health, malaria and HIV/AIDS.

The following advocacy issues need to be addressed:

- The declining RH budget allocation as percentage of Health sector budget need to be addressed. This should be carried out in tandem with a push for realization of the Abuja declaration of 15%.
- At local government level, resources should be invested in decision makers to understand the importance of RH and its prioritization within the district budget and work-plans
- There is need to invest resource and time in providing Family planning information to clients at health facility and community level. This was found to be one main obstacle to access to family planning services through focus group discussions.

Key Findings

Policies: National Population policy, Vision 2040 and National Health Policy, NDP all reaffirm commitment of international and regional conventions like ICPD-PoA, MDGs and New Partnership donor African Development (NEPAD), the Continental Policy Framework for Sexual and Reproductive Health &Rights and Maputo Plan of Action 2007-2010. Uganda has an enabling policy environment for fostering developmental programs for reproductive health programming in the country.

National Health Budget: The total health expenditure as a percentage of total government budget stands at a low 9% over the last three years which is below the Abuja Declaration of 15%. The per capita expenditure for the last three years has been averaging $9 which way below the WHO recommendation of 44%.

Donor Support: External support to health has increased over time, with USD 114 million in 2005 and 132 million in 2011. However, over the same period, European donors have reduced their investments by 33%.

Reproductive Health Budget: The reproductive Health budget as a percentage of the total Health expenditure has consistently been at 2% from FY 2010/11 to FY2012/13.However, it is projected to decrease to 1% in FY 2013/14.

District assessment: Ten health facilities visited in two districts of Mityana and Kamuli had at least one midwifery professional, contraceptive commodities were in stock. However the provision of adolescent health services was limited to a few health facilities and the health facilities infrastructure was found wanting in the provision of seating areas, counseling and treatment rooms (with exception of Mityana District hospital) and signage showing services availability was limited.

Budgeting process: based on the document analysis, it is very difficult to figure out the activities prioritized through the maternal and family planning allocations. This ambiguity makes it difficult for advocates to track and follow up expenditure on maternal and family planning services. This is more pronounced at regional referral hospitals which have specific vote on account within the MTEF.

1.0 Introduction

A majority of women, men and youth in Uganda want to better plan their families. However, they do not always find the services they need. The unmet need for family planning remains as high at 34% (UDHS 2011). This report makes suggestions how to further improve family planning services in Uganda. It answers the following questions:

- Do Ugandan policies adequately cover family planning services?
- How much does the government of Uganda and its development partners invest into family planning at national level?
- How do community members assess the family planning services in the districts of Mityana and Kamuli and what are their demands?
- Do health facilities in Mityana and Kamuli provide family planning services according to government standards?
- How much do the districts invest into family planning?

It is intended as an advocacy tool for family planning advocates at all levels: in the Ministries of Health, Finance and Planning, in Parliament, in district authorities, in donor agencies and among civil society organizations. It also provides community members in Kamuli and Mityana with facts about the state of family planning in their districts.

The report is divided into seven chapters:

Chapter one provides an overview of main findings for family planning advocates.

Chapter two is a review of the main policies having a bearing on family planning in Uganda.

Chapter three assesses Uganda's national budget for family planning as well as the contributions of development partners. This chapter establishes that resources for family planning commodities have increased considerably. However, other areas of family planning are suffering from decreasing budgets. In Uganda many health services are provided at lower government levels. Through decentralisation district governments have a role to play in improving family planning. This report chooses to assess the situation in Mityana and Kamuli.

Chapter four gives a quick profile of the districts, describing key health indicators and facilities.

Chapter five shows community members' assessment of family planning services in their districts. It reveals that while policies are in place, and budgets for commodities are increasing, service standards are still lagging behind;

- Communities demand that services are brought closer to the patients through outreaches. It is important to find solutions to bridge the long distances people have to cover before reaching a health centre.
- Counseling and information before and after uptake of family planning methods is wanting. Therefore, communities ask the government to fill human resource gaps at facility level, expand training opportunities and better monitor standards.

Chapter six: Communities asked DSW to assess family planning services in 10 facilities of their choice. The results of these facility assessments are provided in chapter six. It shows that increased funds for family planning commodities have translated into increased availability of contraceptives at all health facilities. However, it also reveals that lower level facilities have little knowledge of family planning policies and efforts to popularize key policies need to be stepped up.

Chapter seven: analyses the two district budgets, understanding the health budgets in relation to the overall budget as well as reviewing family planning activities scheduled in the health district workplans.

2.0 Country Profile

Uganda Human Development Index ranking is 161 out of 187 countries, below the Sub-Saharan Africa average score. With one of the highest population growth rates in the world (3% per annum), and more than half of the population under the age of 15 years, the country faces major challenges providing quality health care to its people. This young and growing population creates a huge demand for maternal and child health, immunization, and adolescent services. As a result, health expenditures will continue to grow in line with population growth, which is estimated to have tripled to 95 million by 2050. Total expenditure on health is well below the average per capita total health expenditure in the WHO African Region (USD 76).[ii]

Uganda has registered very slow progress towards attainment of the MDG target of reducing maternal mortality (MDG5). The maternal mortality ratio was over 500 (per 100,000 births) in the 1990s and has recorded a slow decline from 524 in 2000/01 to 438 in 2011, a decline of only 16% in ten years. The use of modern methods of family planning (FP) in Uganda has consistently increased over the past decade, growing from 14 percent of currently married women in 2000-01(excluding LAM) to 26 percent in 2011.The government sector remains the major provider of contraceptive methods for nearly half of the users of modern contraceptive methods (47 percent). About one-third (34 percent) of currently married women have an unmet need for family planning services, with 21 percent in need of spacing and 14 percent in need of limiting [i].

3.0 Policy Analysis

This chapter assesses the extent to which family planning issues are prioritized in broad development and health policies and strategies. It wants to understand key policy and programme priorities and policy implementation challenges and responses that are considered critical for the achievement of the objectives of the policies; and to assess the extent to which key family planning issues identified by communities members are reflected in the policies.

Currently there is a global and national momentum to increase access to contraceptives through FP2020, removal of barriers to access through the UN Commission on Life Saving Commodities (UNCOLSC), and using the Global Partnerships on Reproductive Health Commodity Security (GPRHCS) that is supporting some countries to procure family planning commodities for Ministries of Health through UNFPA based on the overall requirements of the public and private sectors. A draft reproductive health, maternal health, Newborn health and Child health (RMNCH) catalytic plan has been developed after carrying out a bottle neck analysis on RMNCH. This year (2013) the government of Uganda passed the population bill that will see the establishment of population council.

3.1 Policy analysis Findings

The National Population policy highlights commitment to international and regional conventions such as ICPD Programme of Action, the Millennium Development Goals and the New Partnership African Development (NEPAD). HSSP will be implemented in the context that health is a fundamental human right. Health as a human right is enshrined in several legal instruments that Uganda has ratified. The instruments declare health as a fundamental human right to be enjoyed by all without discrimination and these include the WHO constitution; International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC), International Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the African Charter on People's Rights (ACHPR) and several others.

The Continental Policy Framework for Sexual and Reproductive Health &Rights and Maputo Plan of Action 2007-2010 are all some of the regional policy frameworks that recognize the need to provide Youth friendly services in order to improve reproductive health for young people

Policy environment for Adolescent-Friendly Services
The Adolescent Health Policy Guidelines and Services Standards are tools that will operationalise the National Adolescent Health Strategy.

Vision 2040 recognizes slow progress in health conditions and this is attributed mainly to current health service delivery system which is facility-based. During this Vision period, there will be a paradigm shift from facility-based to a household based health delivery system. Focus on preventive health system rather than curative. Vision calls for policy shift in the health delivery system from mainly public centered to public-private partnership arrangement. Key strategy being adoption of universal health insurance system.

The National Policy Guidelines and Service Standards for Sexual Reproductive Health and Rights of 2011 recognize the relevance of providing adolescent-friendly health Services as a way of increasing service coverage for Reproductive Health (RH) amongst adolescents. Sets standards for RH services, target and priority groups and have service policy guidelines and service standards. Spells out components for SRH.

The Health Sector Strategic Plan II (2010/11-2014/15) highlights the need for increased RH service provision for young people through environments that are supportive and conducive. Article 16 section c) of the African Youth Charter (2006) supports the provision of Youth Friendly reproductive health services including contraceptives, antenatal and post natal services. The Continental Policy Framework for Sexual and Reproductive Health &Rights and Maputo Plan of Action 2007-2010 are all some of the regional policy frameworks that recognize the need to provide Youth friendly services in order to improve reproductive health for young people.

Adolescent Health Policy Guidelines and Service Standards provides standards for provision of YFS and spells out roles of different actors. Recognizes that teenage pregnancy and abortion are key challenges adolescents face and emphasizes need to improve access to services and information to adolescents and training of providers.

National Population Policy and Social Transformation and Sustainable Development highlights the issue of population growth being faster standing at 3.2% between 1991 and 2000 (pg4). In addition unplanned pregnancies and high teenage pregnancies as well as unsafe abortions are highlighted as contributors to high morbidity, mortality and poor health situation. It is also noted this constrains provision of Health Services (Relates to issue of: Limited Access to FP services as result of distance and fewer health centres). The policy emphasize that couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children , and to have access to information and education in order to make an informed choice and the means to do so. In addition it recognizes

health as in particular RH as a basic human right (pg 6). It highlights that RH services remain inadequate and the health system is weak and vulnerable citing human resource shortage for health care provision (pg 9). Also points areas in health where government needs to focus more like skilled attendance at birth, functional referral, antenatal care, family planning, RH commodity security, adolescent reproductive.

Recommendation

The RH policies are very explicit and demonstrate government commitment to international regional and country needs. However local government which do implementation at district and health facility need to be supported to implement the policies at community level.

4.0 Health Financing

The government health budget is allocated between the central and local government levels, as well as to referral hospitals and other agencies. About 52 percent of the health sector budget is decentralized to the districts (HSPR 2010). At the central level, funds flow to MoH and other key entities such as National Medical Stores and the Uganda AIDS Commission.

The MoH is responsible for the core functions of policy and standards formulation, quality assurance, and resource mobilization. MoH also manages the national and regional hospitals. Ownership of public health facilities (health centers and general hospitals) and the responsibility for delivering health services are vested in the district local governments. The latter, however, are not allowed to raise funds through local taxes and rely on centrally provided budgets.

Government budgetary allocations to health are made out of public revenues and on-budget donor contributions. There are two levels of resource allocation: inter-sectoral allocation across the ministries (which is done by MoFPED), and intra-sectoral allocation, which is performed by the MoH for the health sector, based on resource allocation formulas Uganda has a National Development Plan which provides a national Medium-Term Planning and Expenditure Framework. A three-year rolling framework, MTEF is used to streamline and guide the budget process and set out planned outputs and associated expenditures in the medium term.
MoFPED allocates resources within the MTEF to all sectors based on the NDP, policy priorities, and macroeconomic frameworks. The budgeting processes at the local government level are guided by the NDP. Planning guidelines and budget earmarks provided by MoFPED to local governments generally limit the latter from addressing local needs

where these are different from the priorities set in the NDP. For example, about 52 percent of the public health sector budget was decentralized until 2009, when this fraction was reduced as drugs and supplies were recentralized (HSPR 2010).

In theory, the budgeting process is a bottom-up approach starting from the health facilities, through the districts, to the MoH. However, based on stakeholder interviews, the districts and health facilities perceive that the budgeting process is top-down and does not take into account their concerns, since budget ceilings are set at the central level and districts receive mostly conditional grants in amounts which are determined by MoFPED and MoH. A Fiscal Decentralization Strategy does exist, which allows districts to reallocate a certain percentage of the recurrent grant to priority areas in any sector.

The MoH-level technical appraisals, needs assessments, and perceived health care needs are used to allocate funds for health infrastructure development. The wage allocated is based on level of care, specialty, and the available number of health workers in a given district/facility/institution. There are guidelines for allocation of funds to hard-to-reach areas, disadvantaged nomadic populations, and for emergencies. These criteria for financial allocations were deemed appropriate and are effectively being applied. This does not necessary imply that districts and hospitals get all the funds they need. The sentiments expressed at the district and facility levels were that funding is often "too little too late."

MoH will start a new initiative to allocate funds within the health sector based on a new resource allocation formula. The formula takes into account health indicators such as mortality indicators, number of live births in the district, and population size, as a proxy for health need. A special and fixed wage allocation is made for hard-to-reach areas, and a basic amount is allocated to all districts for health service delivery. This new need-based resource allocation formula has been designed and piloted and is expected to be rolled out over the next fiscal year

Budgeting Process

The budget process is a cycle that runs through the entire financial year, and it is a very participatory process. It begins with the review and update of the Medium Tern Expenditure Framework (MTEF), and a country Portfolio Performance Review between July and August each year. This is followed by the first Budget consultative workshop that takes place between October and November. After this, all Sector Working Groups and Local governments starts preparing of Budget Framework Papers (BFPs) and this is followed by Sector BFP Ministerial Consultations, which lead to the preparation of the draft National BFP. Once the Cabinet approves the BFP, it is presented to all stakeholders in a national budget workshop called the Public Expenditure Review Meeting.

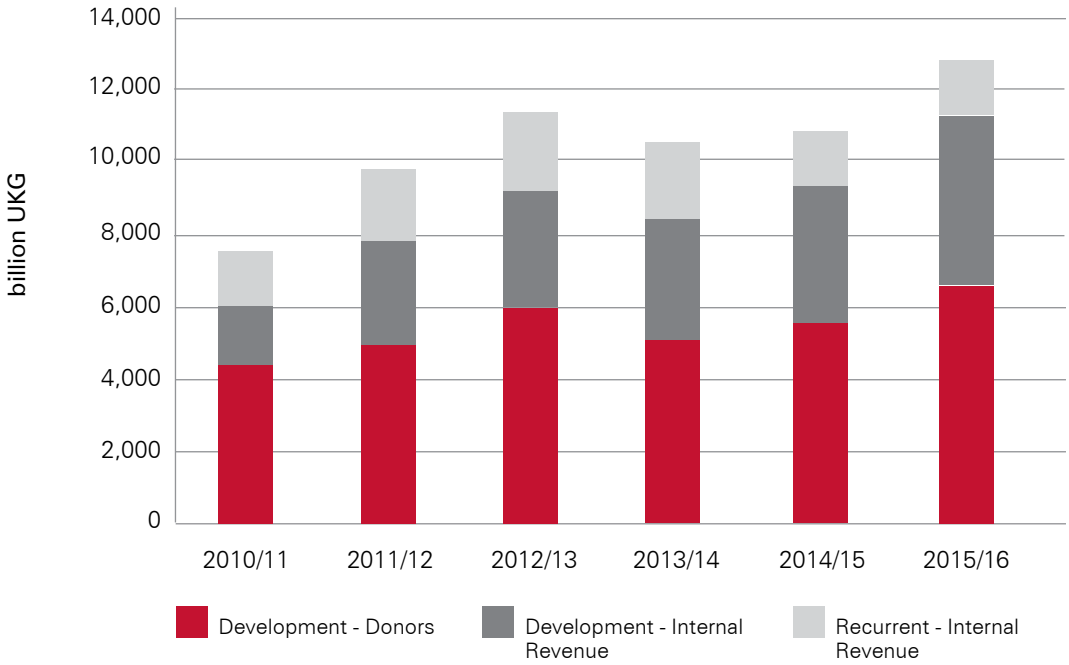
The final BFP is submitted to parliament by April 1, of each year. This is then followed by the development of the Background to the Budget and the detailed development of budget estimates by each Ministry and institution. The Ministry compiles these into the draft estimates of revenue and expenditure with consultation with the Parliamentary Budget Committee, and starts preparation of the Budget Speech, which must be presented, to Parliament by the 15th day of June of each year.

4.1 Budget Analysis Findings

4.1.1 Overall Budget trends

Over the years, Uganda's national budget has increased in nominal terms. The Budget increased from 6 trillion UGX (FY2010/11) to 9.1 trillion UGX FY 2012/13 in nominal terms. The external budget support remained relatively stable at about 18% of total national budget. In FY 2012/13, the budget support reduced to 17.8% and increased in FY 2013/14 to 21%. However, the actual expenditure in the financial year on donor support reduced due to the corruption scandal that unfolded in the Prime Minister's office. This forced donor countries to withdraw budget support in addition to asking for a refund from the Government of Uganda.

Figure 1: Nominal Uganda budget estimates

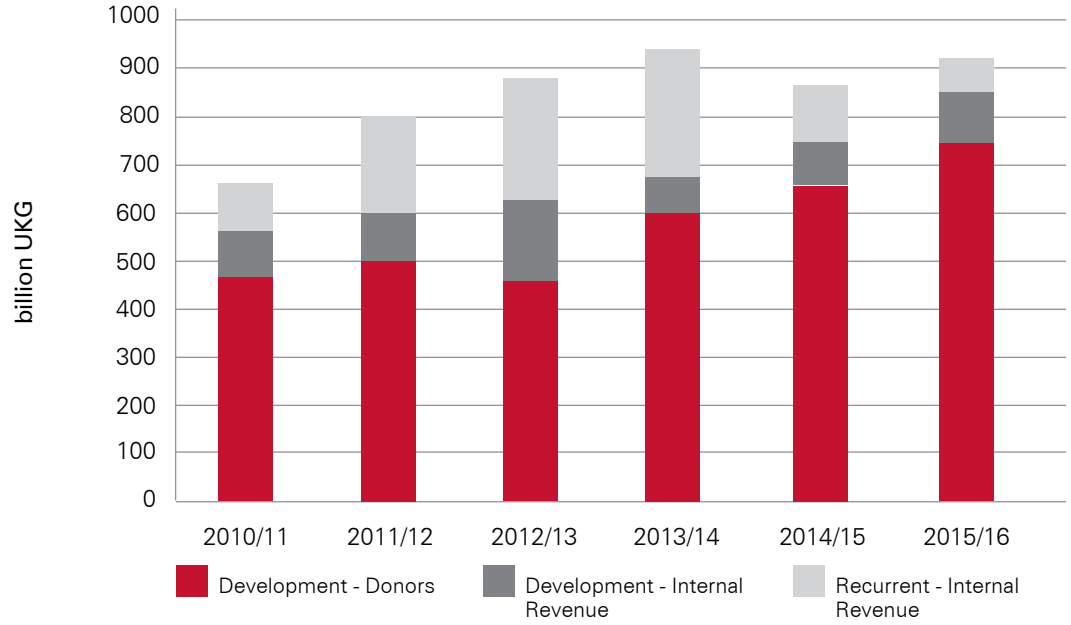


Sources: Approved Estimates of Revenue and Expenditure 2010/11, Volume 1 Central government votes p. 37 | Approved Estimates of Revenue and Expenditure 2011/12, Volume 1 Central government votes p. 31 | Approved Estimates of Revenue and Expenditure 2012/13, Volume 1 Central government votes p. 32 | Ministry of Finance, Planning and Economic Development, NATIONAL Budget framework paper, FY 2013/14 – FY 2017/2018

The same period of time, the health budget increased from 660 billion shilling in FY 2010/11 to 799 billion in 2011/12 shillings posting a 21% increase in funding for the health sector. It further increased to 853 billion in nominal terms but showed marked decrease in funding for the health sector in FY 2012/13 by 6.8%. In the FY 2013/14, the government allocated 932 billion shillings marking an increment of 9% from the previous financial year (2012/13). Overall the GOU health expenditure as a percentage of total government expenditure is below the Abuja declaration of 15%. The health expenditure against the total government budget was 8.9% (FY 2010/11), 8.3% (FY 2011/12), 7.6% (FY 2012/13) and 8.6% (FY 2013/14) respectively. The Government expenditure per capita on health in FY2010/11 was $9.4 (rate of 2209), increasing to $10.29 (exc rate 2443) FY2011/12, $9 (exch rate 2626) and projected per capita expenditure on health is estimated at $9 (exc rate 2813). The GOU per capita expenditure on health is way below the WHO region recommended rate of 44 USD

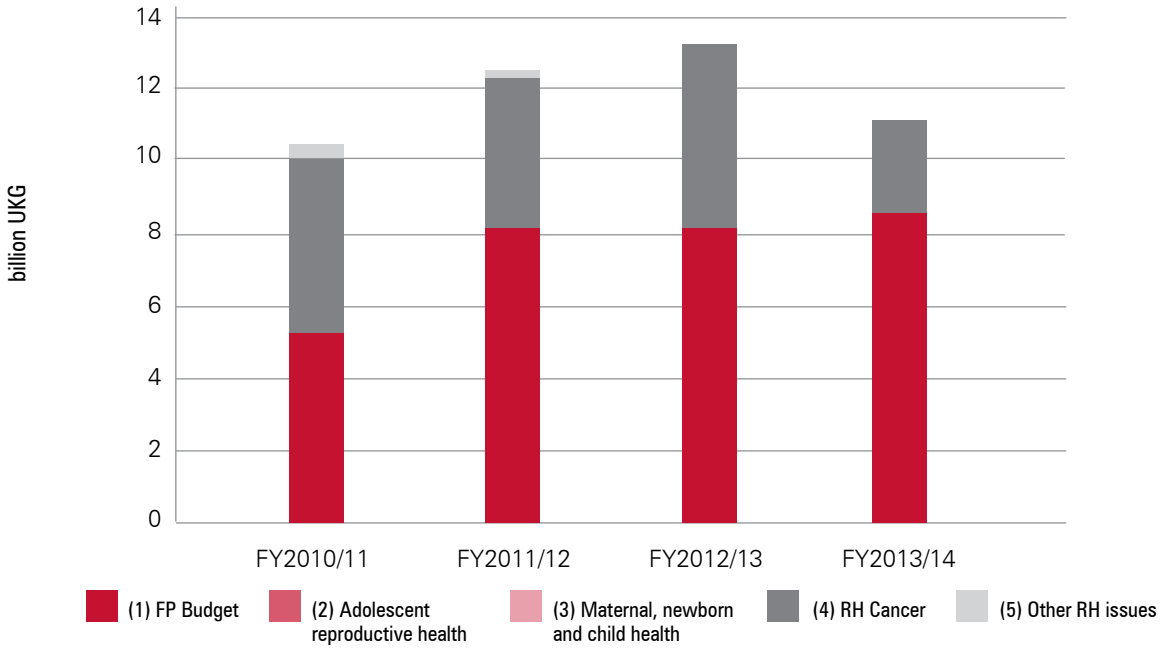
4.1.2 Health budget trends

Figure 2: Nominal Uganda Health Budget Estimates



Sources: Approved Estimates of Revenue and Expenditure 2010/11, Volume 1 Central government votes p. 37 | Approved Estimates of Revenue and Expenditure 2011/12, Volume 1 Central government votes p. 31 | Approved Estimates of Revenue and Expenditure 2012/13, Volume 1 Central government votes p. 32 | Ministry of Finance, Planning and Economic Development, NATIONAL Budget framework paper, FY 2013/14 – FY 2017/2018

Figure 3: Family Planning and Reproductive Health Budgets (Nominal)



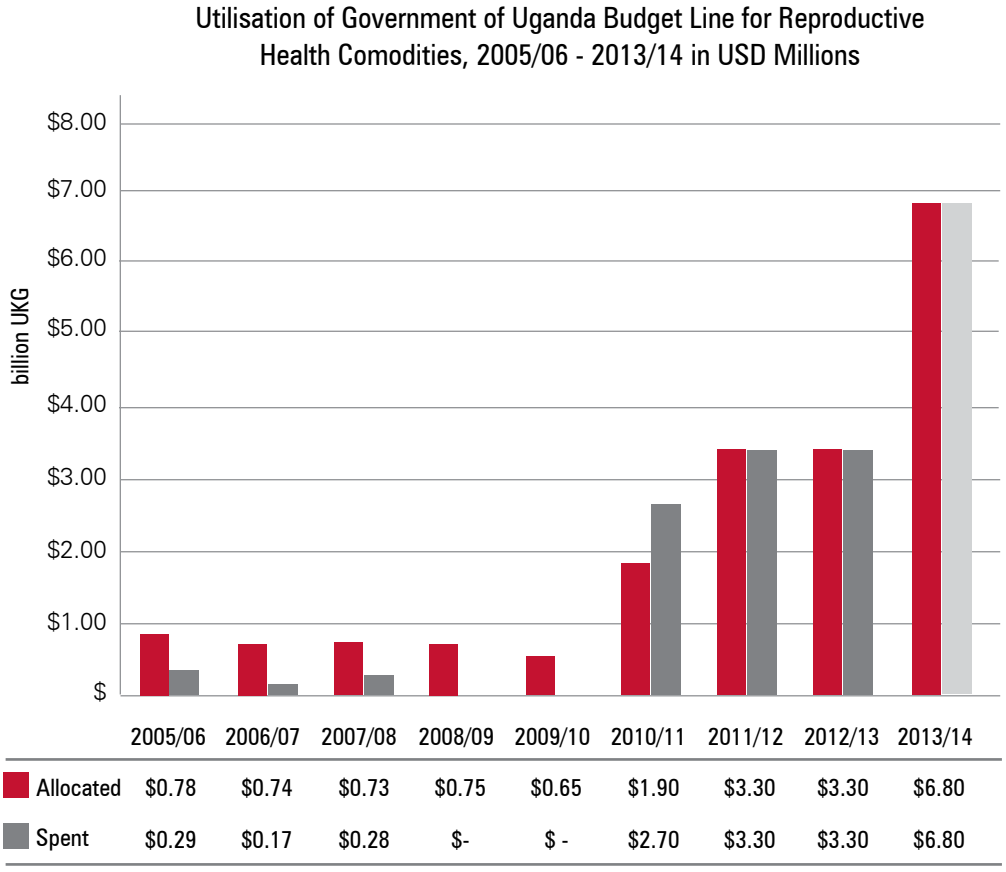
Sources: Ministry of Health, Activity work-plans 2010/11 – 2012/13 | Health Sector, Ministerial policy statement, FY 2010/11 – 2013/14

4.1.3 Family Planning and Reproductive Health Budget

The Reproductive Health (RH) Budget was determined by examining the Ministry of Health activity work-plans as well as ministerial policy statements. The RH budget covers family planning, adolescent reproductive health, maternal, newborn and child health and others. However the RH cancer was budgeted for in the FY 2012/13 only. Overall the budget allocation for RH increased from 10.3 Billion shillings in FY 2010/11 to 12.4 billion shillings posting a 19% increase in budget allocation to RH in FY 2011/12. The following FY 2012/13 posted a decrease in allocation by 5% and this continued to increase to 14% decrease in 2013/14. Because of the World Bank health system strengthening loan that amounts to 34 million US dollars over five year 2011/12 (project is in the 3rd year) for reproductive health, the government decreased it allocations to hospitals for supporting reproductive health. Within the 34 million USD, there is 13.5 million USD for procurement of RH commodities.

The RH commodities budget line established in FY 2005/06 contributes significantly to the overall RH budget. The table below shows the current funding for RH commodities in the public sector.

Figure 4: RH commodities Budget line



Source: Partners in Population and Development, Africa Regional Office (PPD ARO), 2013 report

The RH commodities budget was established to procure family planning commodities and a selected few RH commodities which include Deliver kits, Manual Vacuum Aspiration kits, Gynecological glover and Misoprostol for prevention and treatment of Post patterm hemorrhage (PPH).

Between FY 2005/06 to FY 2009/10, the expenditure on RH commodities was less than 30% of allocated funds. However, in FY 2010/11, the Government of Uganda changed policy of disbursement of funds for RH commodities to vote 116 at National Medical Stores (NMS). This policy shift meant that all funds for procurement of essential medicines and health supplies were sent directly to NMS through the Bank of Uganda. Previously, all the funds for procurement of RH commodities would first be requisitioned by the Ministry of Health from MOFPED and received in the MOH account (vote 009). Then NMS would requisition for the funds from MOH. The process was long and required efficiencies at the different levels. This led to poor absorption of funds and hence making it difficult to advocate for increased RH commodities funding. However from FY 2010/11, NMS has posted 100% expenditure on allocation which has given government impetus to increase the resource allocations.

For Uganda to attain social economic development it must invest in family planning to reduce on unwanted pregnancies in order to achieve a demographic dividend. For the last three years, Maternal and child health have been the health sector priority areas. However, the RH takes not more than 2% of the health budget. However, it worth noting that Family planning is prioritized based on the RH budget allocation of FP which has increased from 49% in 2010/11 to the current 76% allocated in FY 2013/14.

Table 1: Percentage share of health, Reproductive health and Family planning (from nominal figures)

Item	FY2010/11	FY2011/12	FY2012/13	FY2013/14	FY2014/15	FY2015/16
Health percentage of national budget	9%	8%	8%	9%	8%	7%
RH percentage of health budget	2%	2%	2%	1%	n/a	n/a
FP percentage of RH budget	49%	65%	62%	76%	n/a	n/a

4.1.4 Votes relevant to Family Planning

The Reproductive Health Division in the Ministry of Health finances its activities under Vote 014 - Programme 06 Community Health. Ministry of Health activity work-plans describe in detail activities planned by the RH division. In 2010/11 a total of 1.2 billion UGX was allocated for family planning. In 2011/12 this amount dropped to 0.228 billion UGX and in 2012/13 to 0.191 billion UGX. The consequence is that far less family planning activities are implemented.

(1) Other divisions implementing related activities are the following

a. The Integrated Curative Division has conducted activities to address obstetric fistula between 2010/11 and 2012/13.
b. The Nursing Division allocated funds to coordinate nursing and midwives activities
c. In 2012/13, the Child Health Division implemented an awareness creation activity on HPV, TT, malaria, child feeding and life skills.

Table 2: Other MOH divisions supporting RH and FP

	2010/11	2011/12	2012/13
07 Clinical services - Integrated Curative Division	10 million UGX	6.36 million UGX	4.21 million UGX
11 Nursing services - Nursing Division	57.88 million UGX	3.9 million UGX	30 million UGX
06 Community Health – Child health			9.141 million UGX

(2) The Ministry of Health is implementing a health systems development project (vote 014, function 08 02, project 1123).

a. Under Output 080201, this project caters for the procurement of RH supplies with an allocation of 5 billion UGX in 2010/11
b. In 2013/14, the same output caters for procurement of mama kits with an allocation of 0.7 billion UGX. And long term family planning supplies with an allocation of 0.5 billion UGX.

(3) National Medical Stores has a budget line for reproductive health supplies (Vote 116 National medical stores - function 0859 Pharmaceutical and medical supplies – 085915)

a. In 2011/12 this budget line was allocated 7.999 billion UGX
b. In 2012/13, 8 billion UGX
c. In 2013/14, 8 billion UGX.

(4) The regional referral hospitals have clear family planning output targets. These targets are lumped together with other services. The annual Health Sector Ministerial Policy statements show FP activities under the following outputs:

a. Function 0856 - Regional Referral Hospital Services - Output 085606 Prevention and Rehabilitation services. This output most systematically includes FP (all regional referral hospitals except Soroti and Kabale). It covers immunization of children and mothers, ANC, FP, PMTCT, sometimes VCT or even ART provision. Most of the time the output also includes physiotherapy, occupational therapy and orthopedic services.
b. Function 0856 - Regional Referral Hospital Services - Output 085602 Outpatient services. This output some times includes family planning targets. In those few cases, it also includes immunization, ANC, gynecology, PMTCT.
c. The analysis only captures those budgets which explicitly mention family planning.

It appears that referral hospitals' budget lines covering family planning services have remained constant until 2012/13. In 2013/14 those two budget lines have decreased considerably. The explanation got from key informant interviews revealed that the government is now focusing more on Emergency Obstetric and newborn care at regional referral hospitals.

Table 3: Allocations at regional referral hospitals for RH and FP

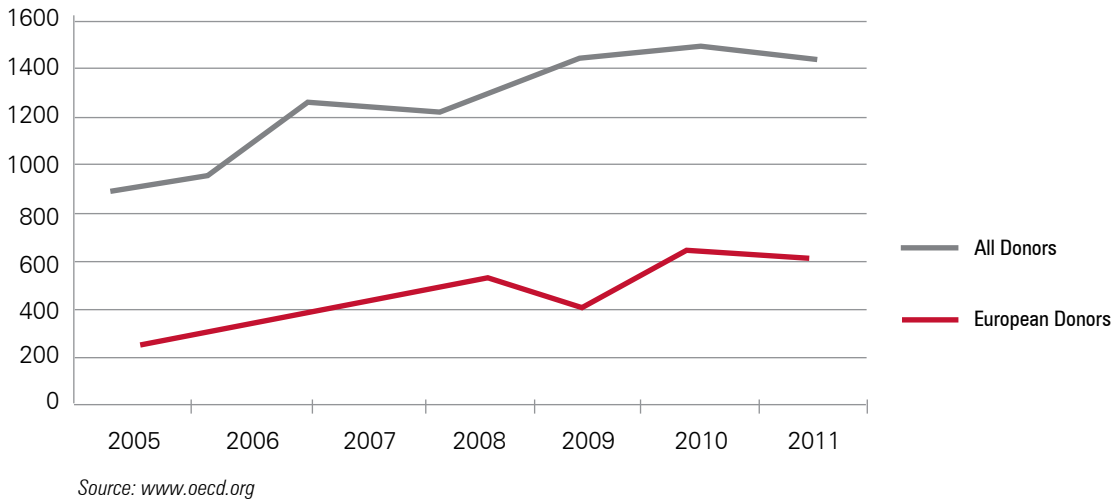
	2010/11	2011/12	2012/13	2013/14
Outpatient services	**1.92 billion UGX**	**1.5 billion UGX**	**2.45 billion UGX**	**0.51 billion UGX**
Prevention and Rehabilitation services	**2.19 billion UGX**	**2.68 billion UGX**	**2.42 billion UGX**	**1.48 billion UGX**
Total	**4.11 billion UGX**	**4.18 billion UGX**	**4.87 billion UGX**	**1.98 billion UGX**

5.0 External Funding for health, reproductive health and family planning

5.1 General development assistance

Development assistance to Uganda has steadily increased from US$ 880 million in 2005 to US$ 1.4 billion in 2011. In 2011 Uganda was the 17th largest recipient of aid." In 2005 European donors only provided a mere 28% of this amount. Yet they gained in importance as their share grew climbing to 43% in 2011.

Figure 5: Total official development assistance in Uganda, disbursements in million USD



Source: www.oecd.org

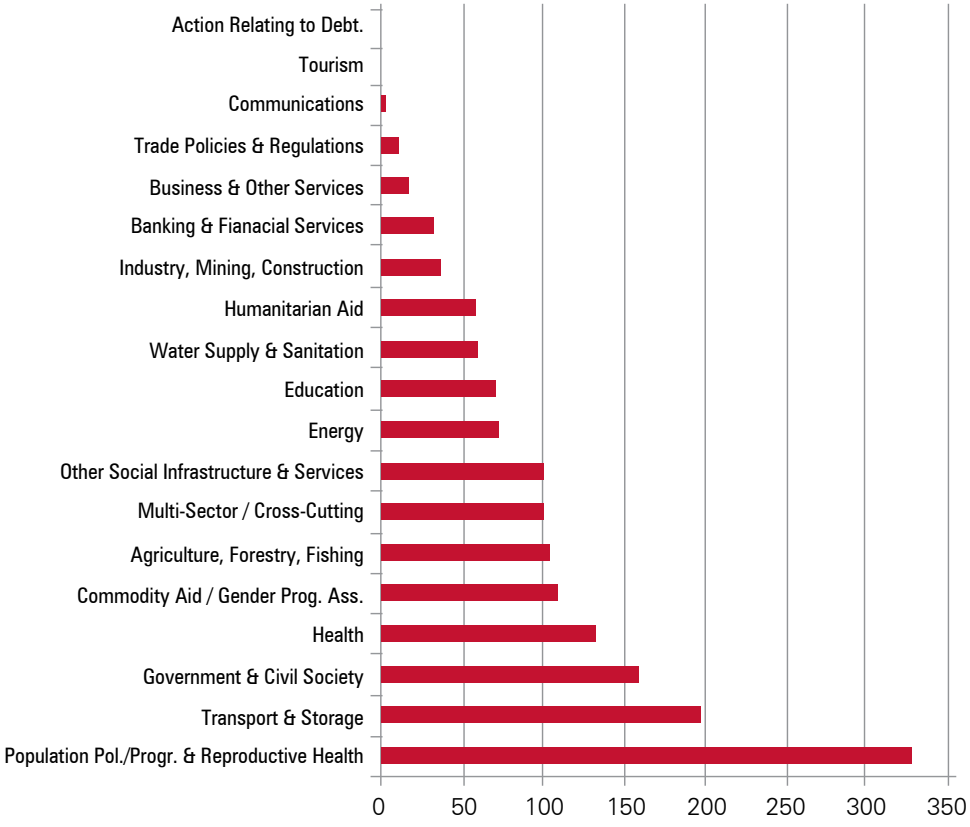
Between 2009 and 2011 the United States (US) was the largest donor providing US$996 million over the three years, followed by the United Kingdom (UK) with US$370 million and the European Union Institutions with US$370 million.

The Organisation for Economic Cooperation and Development's outlook for 2012 and beyond, shows that globally, "development aid fell by 4% in real terms in 2012, following a 2% fall in 2011. The continuing financial crisis and euro zone turmoil has led several governments to tighten their budgets, which has had a direct impact on development aid. There is also a noticeable shift in aid allocations away from the poorest countries such as Uganda and towards middle-income countries."

Sector spending

Of all sectors supported by external donors, population and reproductive health programmes received the largest share of funds, with 20% or US$ 328 million. This is due to a large HIV/AIDS programmes. The general health sector came fourth with 8% or 132 million USD.

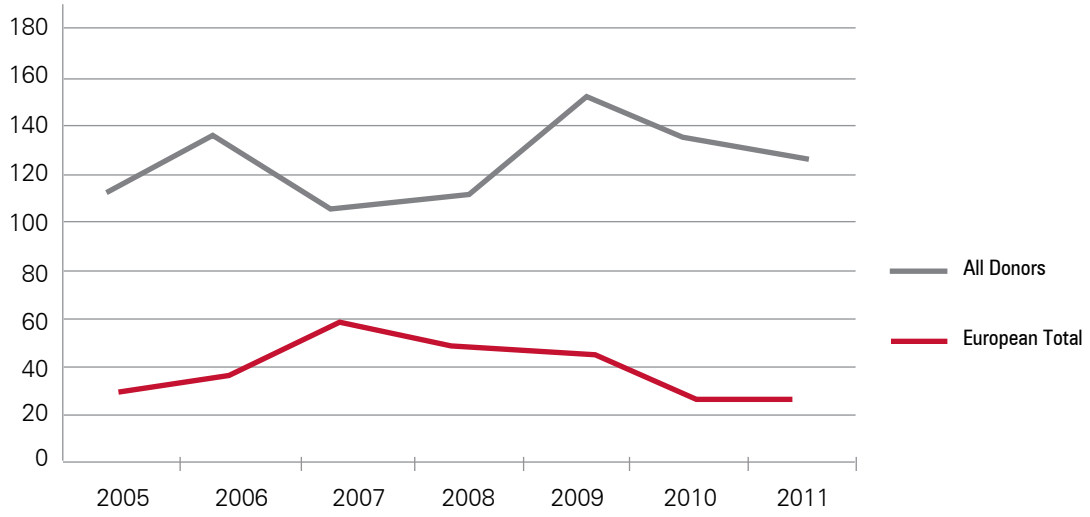
Figure 6: Donor disbursement in Uganda by sector in million USD



Source: www.oecd.org

5.2 Health assistance in Uganda

Figure 7: Total health assistance, disbursement in million USD



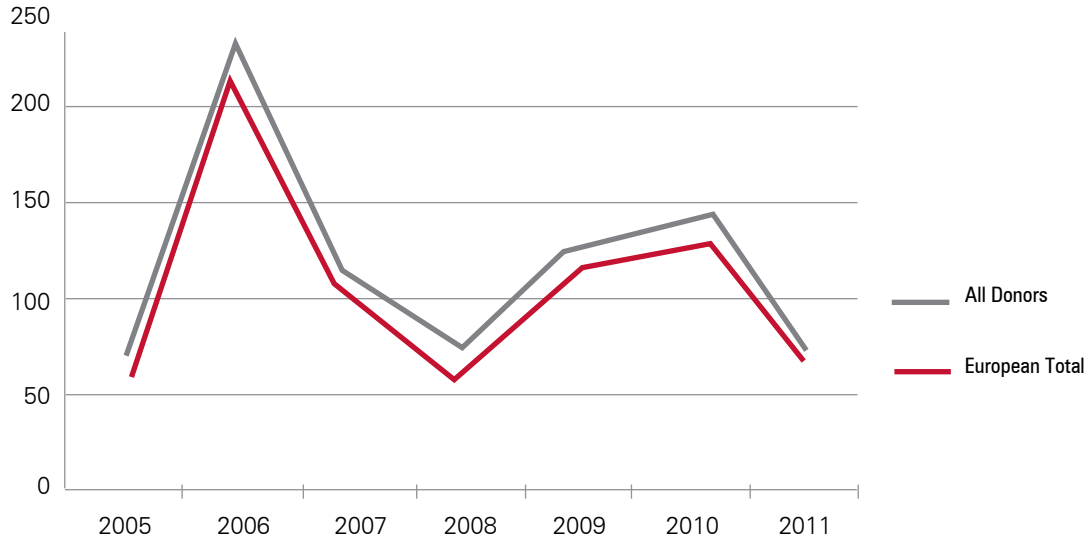
Source: www.oecd.org

Overall, external support to health has increased over time, with USD 114 million in 2005 and 132 million in 2011. However, over the same period, European donors have reduced their investments by 33%.

There is a significant gap between donor contributions to the health sector overall, and what appears in Uganda's state budget. For example, in 2011 donors spent 132 million USD on health, yet government budget estimates show only 60% of this amount. A recently published study explains that "donors contribute more than half of funds recorded on the GOU's official health budget through a combination of project support, GBS, and SBS-PAF. Project-based support from donors is consistently a large source of funds." It adds that the "… large amount of off-budget project support can largely be explained by the non-participation of PEPFAR and other USG projects in national planning frameworks like the MTEF. In the past decade, the proportion of assistance provided off-budget has increased as the proportion provided as budget support has declined.

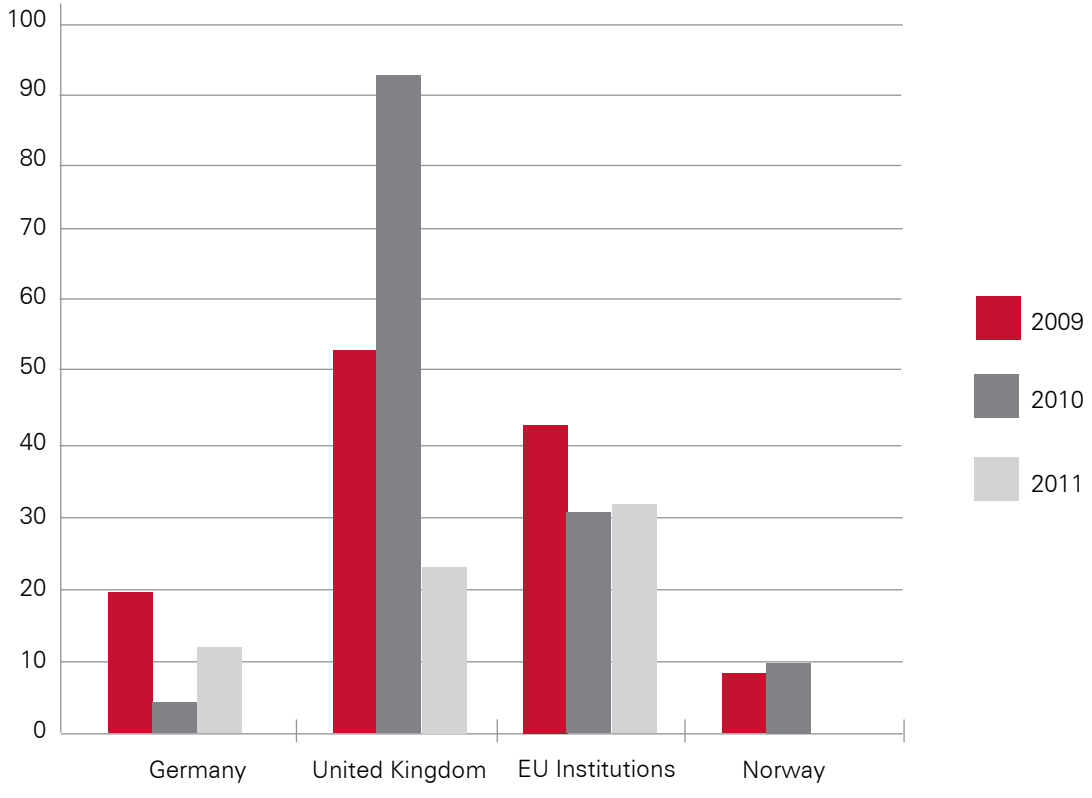
This is reflected by graph 4 showing a decline in general budget support transferred to the government of Uganda. In 2006, general budget support had reached a peak with 226 million USD and by 2011, it had declined to 69 million USD. "Even donors such as the UK Department for International Development that strongly favor budget support have delayed disbursements due to dissatisfaction with financial management in Uganda, and due to political issues".

Figure 8: General budget support, disbursements in million USD



Source: www.oecd.org

Figure 9: General budget support, disbursements, million USD



Source: www.oecd.org

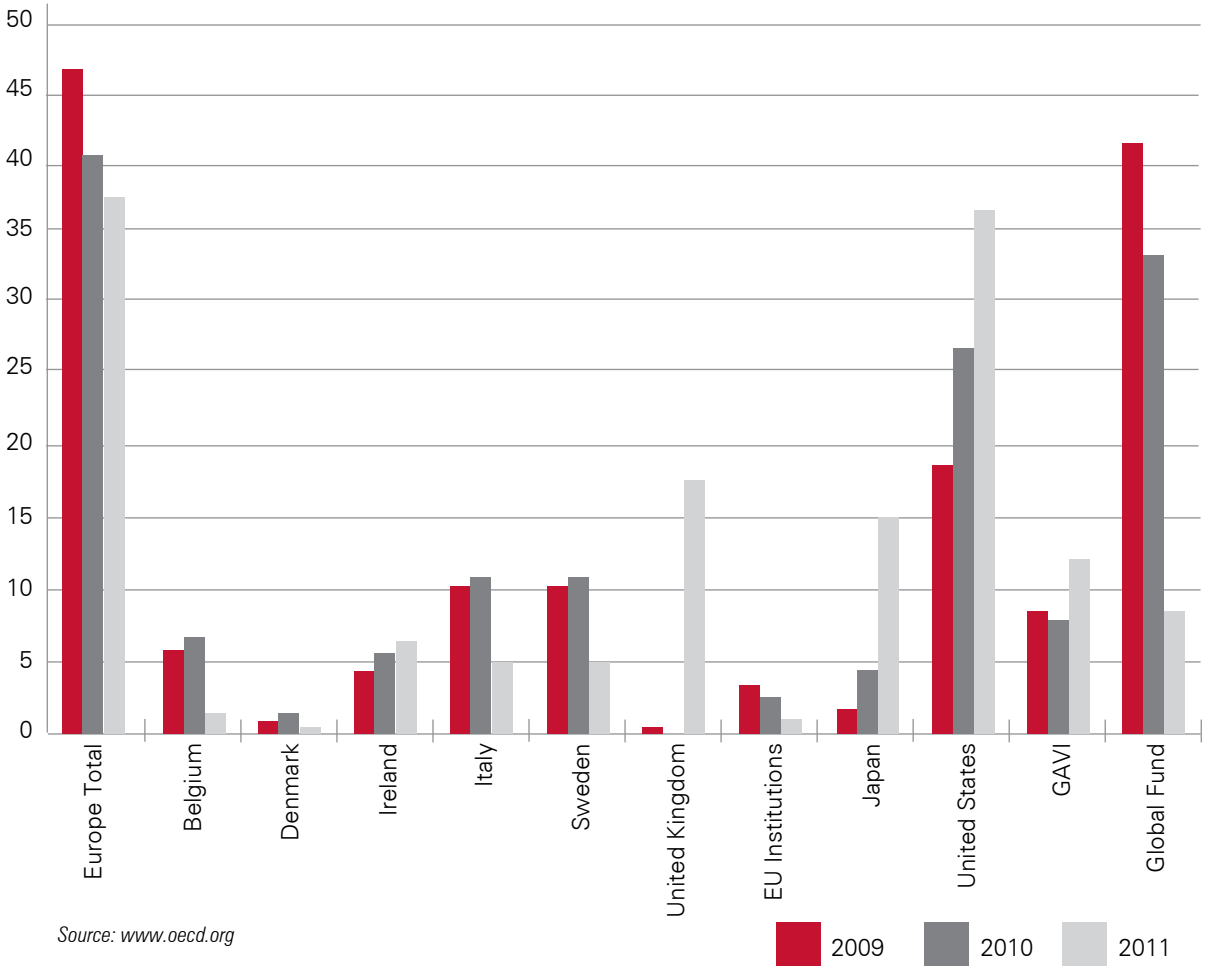
The government of Uganda has promoted an alignment of donors' health interventions with its policy goals and encouraged budget support. Stierman et al note that early on "donors were encouraged to help finance the HSSP through budget support, provided either as general contributions to the government budget or channelled through the PAF." The same authors note that that health assistance in Uganda is highly fragmented and often off-budget. Most assistance is provided as support to short-term projects rather than sector programs planned over the longer term. This pattern has become more marked over time."

"Problems of corruption, financial management, and relatively weak leadership within the health sector may have attenuated the Ugandan government's ability to encourage donors to provide flexible and aligned aid to the health sector."
This was aggravated by the several large cases of misuse of funds:

- In 2005, monies provided through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) were misused and led to the temporary suspension of GFATM support to Uganda
- In 2011, there were allegations of the embezzlement of donor funds intended for post-conflict reconstruction in northern Uganda
- Since 2006, GAVI suspended transfers to Uganda for over six years following the misappropriation of $4.3m.

"There is a need to acknowledge the limitations of donor coordination mechanisms in Uganda, and seek more fundamental reform in how donors plan, budget, and finance DAH so that reality aligns better with the rhetoric."

Figure 10: Health assistance, disbursement in million USD



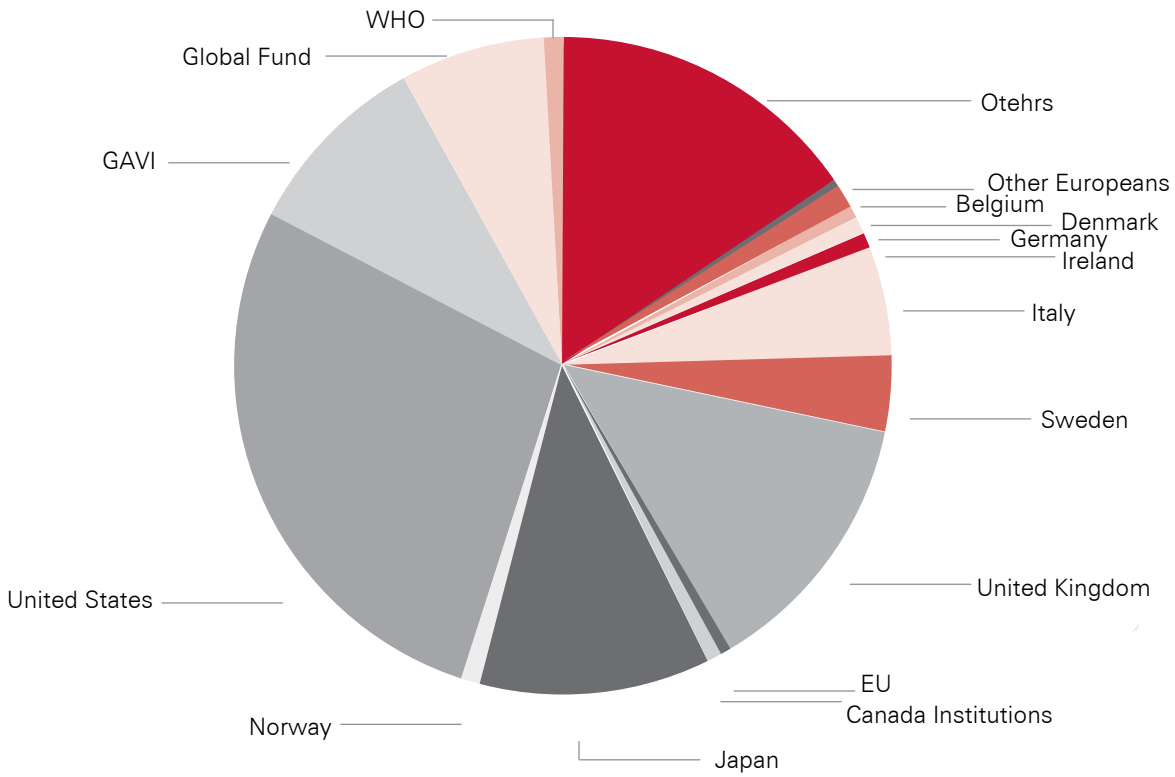
Source: www.oecd.org

In the past four years, the health sector has undergone a reshuffle of major players. It appears that Denmark and the Global Fund have reduced their funding substantially between 2009 and 2011, while UK and United States have increased their disbursements.

Stierman et al not that "funding for health support systems and essential clinical care and management of childhood illnesses is provided through numerous, small projects (generally less than 1 million USD annually) from a diverse group of donors. Meanwhile, funding for HIV/AIDS, malaria, tuberculosis, and immunizations is dominated by multimillion dollar global health initiatives, namely PEPFAR, GFATM, and GAVI."

Both PEPFAR and GFATM have created parallel systems of project and financial management, with separate monitoring and reporting requirements and, in the case of PEPFAR, a separate funding and audit timetable.

Figure 11: Health assistance, disbursements in million USD

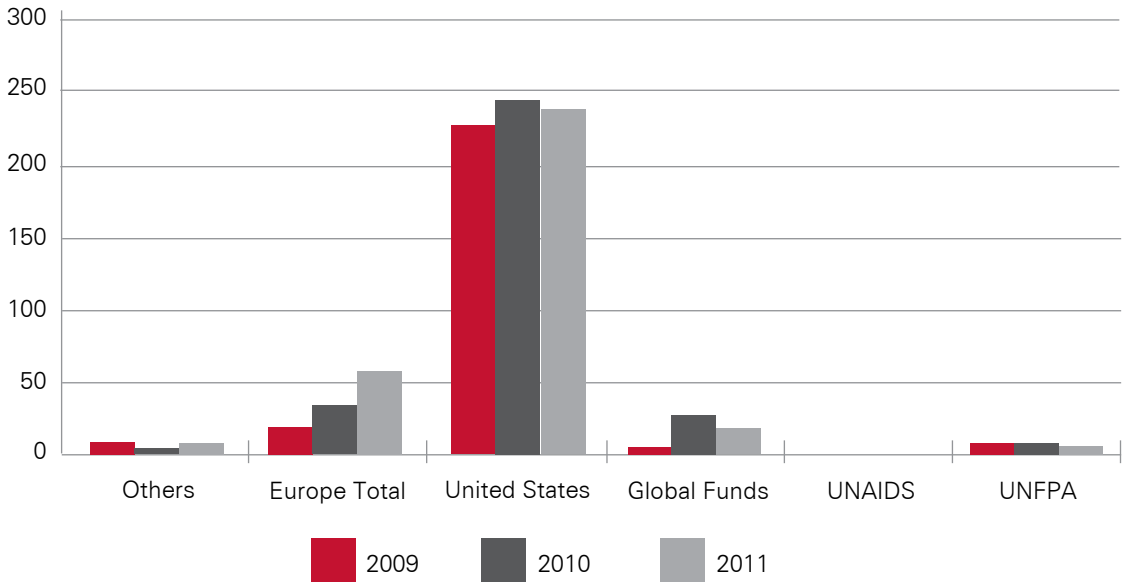


5.2 The United States dominates the reproductive health scene

From 2005 to 2011, there was an increase in funding for reproductive health from USD 157 million in 2005 to USD 328 million in 2011. Most of it flows into HIV/AIDS control programmes: in 2011, 83% were for HIV/AIDs or USD 273 million. This leaves relatively little for other reproductive health components such as family planning.

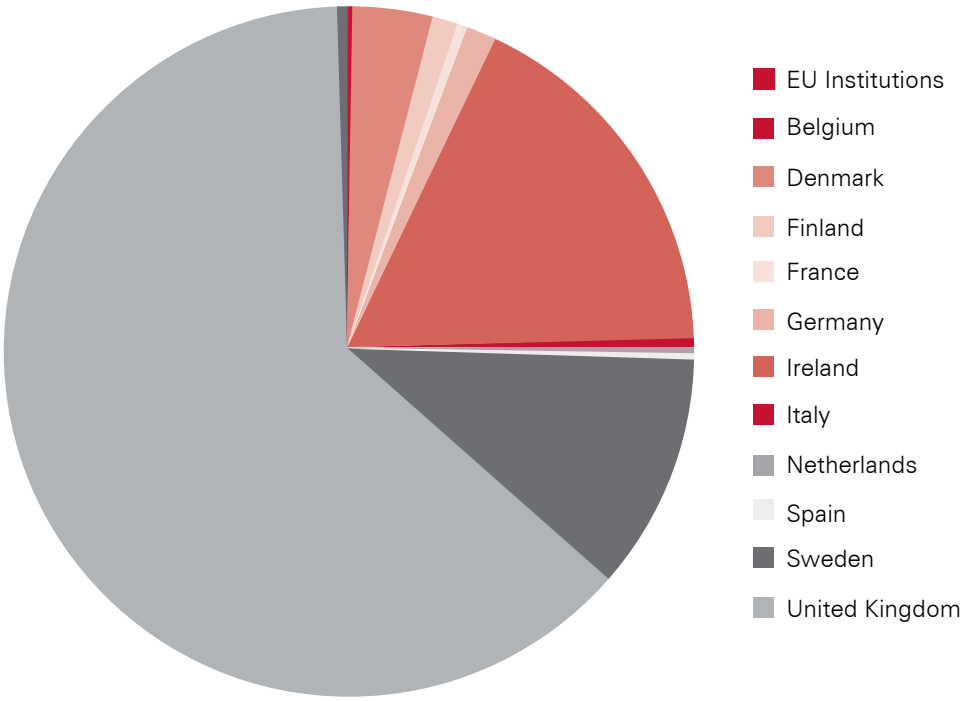
The scene is dominated by the United States. In 2011, it provided 74% of all funds slightly up from USD 238 million in 2009. As a group the European bilateral donors have only provided 57 million USD. This is due to UK, Ireland and Sweden's strong involvement as described in graph 8.

Figure 12: RH/Population assistance, disbursements in million USD



Source: www.oecd.org

Figure 13: European RH/ Population assistance in Uganda, disbursement in million USD

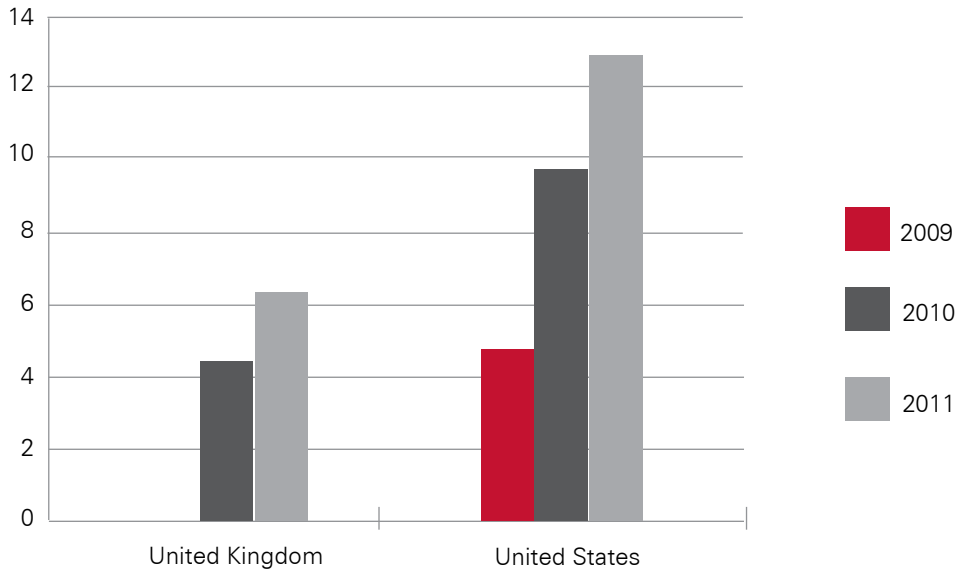


Source: www.oecd.org

5.3 Only two donors strongly support Family Planning in Uganda: USA and UK

Overall, funds for family planning have increased from 5 million USD in 2009 to 19 million USD in 2011. Two thirds of these funds were provided by United States and one third by UK (in 2011).

Figure 14: Family planning assistance, disbursement in million USD



Source: www.oecd.org

The emerging issues with donor support suggest that the USA is able to increase its share of support through controlled projects avoiding the budget support. In this way, the results are easily achieved and quantified and value for money assured. However, the budget support from the European countries has been affected by the governance and trust issues as regards accountability for funds received.

In FY 2012/13, many European donor countries withdrew from budget support for all programs due to the misuse of funds in the prime minister's office. It is not clear as to whether the donor support from the European countries will continue in form of project support.

Recommendations

National Health Budget: The total National Health Expenditure is still below the 15% Abuja declaration and the per capita expenditure is below the WHO recommendation of 44%. Advocacy efforts should be directed to the central government to ensure that the health budget is increased. The current health expenditure trend shows a continued decrease in health expenditure as a percentage of total government budget expenditure.
Reproductive Health Budget: The reproductive health budget has stagnated at 2% of the total health expenditure which does reflect the political commitment. Advocacy strategies need to be developed to ensure that more resources are invested in reproductive health in to achieve the FP2020 and UN commission on Life Saving Medicines aspirations.

Family Planning Budget: The family planning budget has increased over the years from 46% in FY 2010/11 to 76% in FY 2013/14. However this increase is not translated into activities and outputs at district and health facility level. Advocacy efforts should be targeted to the Ministry of health, chief administrative officers and the district health officers to ensure that resources are put to maximum use for achievement of family planning goals in the country
Budgetary allocations: The regional referral hospital work-plans should explicitly describe the RH services budget lines and activities to be implemented for easy support and tracking.

6.0 District Assessment

6.1 District Profiles

Mityana District is located in Central Uganda and borders with Mubende, Mpigi, Kiboga, Nakaseke, and Wakiso Districts. Mityana is located approximately 74 kilometres (46 miles), by road, between Kampala and Mubende, on an all-weather tarmac highway that links Uganda›s capital with the town of Fort Portal in western Uganda.
Mityana District was previously part of Mubende district and consists of the 2 counties of Mityana and Busujju. The distict is further divided into 3 constituencies of Mityana North, Mityana South and Busujju which are also the three Health Sub districts. The main town in the district is Mityana town which covers an area of 21 square kilometres (8.1 sq mi). The topography is made up of gentle slopes with open U-shaped valleys. This is advantageous to the developers because they do not incur a lot of expenses to put up buildings in the town.

Mityana district's estimated population is 296,000 people (UBOS 2009 mid-year projections), 40% of whom are 15-49 years (Table 3). The women in the reproductive age group (15-49 years) are 40% of the district population.

Kamuli district is located in southeastern Uganda about 150km from Kampala. Kamuli district borders Kayunga district in the west, Kaberamaido district and Soroti district in the north, across Lake Kyoga, Kaliro district in the northeast, Iganga district in the southeast and Jinja district in the south.

Administratively the district has 3 counties, 17 sub-counties, 1 town council, 104 parishes and 1293 villages (Zones). Kamuli district has a land area of about 3,444 sq km, 835 sq km of water and 27,909 hectares under forestation. Kamuli district's estimated population is 690,300 people (UBOS 2009 mid-year projections), 38% of which is 15-49 years (Table 3). The women in the reproductive age group (15-49 years) are 20% of the district population and constitute 39.4 % of the females in the district.

Table 4: Selected maternal, newborn and child health indicators

Indicator	Kamuli District	Mityana District	National
Infant Mortality Rate per 1,000 live births*	74	67	76
Child Mortality Rate per 1,000 live births (0–5 years)*	128	129	137
HIV Prevalence Rate (15-49 years) (%)**	6.5	6.5	6.4
Female Literacy Rate (15-49 years) (%)***	52.2	71.8	56.3
% 15-49 year old (women) who completed Primary School***	10.5	15.8	10.7
Total Fertility Rate*	7.5	6.3	6.7
Contraceptive Prevalence Rate (all methods) (%)*	23	36	24
Contraceptive Prevalence Rate (modern methods) (%)*	17	30	18
Unmet Need for Family Planning (%)*	44	36	41
Median age at 1st birth (Women) *	18.1	18.3	18.7
Population Growth Rate (%)*π	3.2	1.5	3.2
Male: Female Sex Ratio****π	0.9	0.9	0.9

*Source: *The State of Uganda Population report 2008 (UNFPA),*HIV/AIDS Sero-Behavioural Survey 2004-05, *** Uganda Demographic and Health Survey (UDHS), 2006, ****Uganda Bureau of Statistics (UBOS), π district specific data, the unmarked are regional data*

6.2 Focus group discussions

6.2.1 Mityana and Kamuli

Profile of focus groups

In July 2013, DSW conducted focus group discussions with women, men and youths in order to identify their perspectives on the unmet need for family planning in Mityana and Kamuli districts. In Mityana the discussions took place in Busimbi Sub-County (rural) and Mityana Town Council (peri-urban). While in Kamuli discussions took place in Kamuli Town (peri-urban) and Namasagli (rural).

The discussion centered on knowledge, awareness, attitudes, access, availability and challenges met in seeking family planning services, some recommendations were also made. The four focus groups in Mityana (2 women, 1 men and 1 youth) were composed of 38 women, 19 men inclusive of youth (male and female) with 16% aged 15 to 20, 33% aged 21 to 30 and 51% above 31 years. The proportion of women and men having experience using contraception was balanced across the genders at 79% in both cases. In both cases that having no experience using contraceptives comes to 21%. 16% of the participants were part of the Village Health Teams, 26% had some sort of leadership role, 12% were ordinary group members (Men, Women and Youth), and 40% had no leadership role. The groups also included 2 teachers and 1 businessman.

In Kamuli the four focus groups were composed of 42 women and 19 men with 21% aged 15 to 20, 44% aged 21 to 30 and 35% above 31 years. The majority of women (88%) had experience in using contraceptives, and only 12% did not. In turn, only a bit more than half of the men had experience in using contraceptives (58%) and 42% had no experience. Of all participants, 10% were active as health promoter in the community. About one fifth (21%) had a leadership role in a group (women's, men's or youth' group). An additional 31% were ordinary group members. 8% were mobilisers, there was one student and 28% had no specific role in the community.

	Women	Men
Between 15 and 20	7	2
Between 21 and 30	15	4
Between 31 and 57	16	13
	Yes No	**Yes No**
Experience using contraception	30 8	51 4
Profile	**Women**	**Men**
Village Health Team (VHT)	9	
Community Support Agent (CSA)		
Men Group Leader		7
Men Group Member		1
Women Group Leader	4	
Women Group Member	5	
Youth Group Leader	1	3
Youth Group Member		1
No leadership role	19	4
Teacher		2
Businessman		1

Source: Focus Group Discussions, Mityana Town and Busimbi Demographic Details, 26th and 27th July 2013

	Women	Men
Between 15 and 20	12	1
Between 21 and 30	19	8
Between 31 and 57	11	10
	Yes No	**Yes No**
Experience using contraception	37 5	11 8
Profile	**Women**	**Men**
Community Health Worker		
Village Health Team (VHT)	5	
Community Support Agent (CSA)	1	
Men Group Leader		6
Women Group Leader	2	
Women Group Member	9	
Youth Group Leader	1	4
Youth Group Member	8	2
Mobilizer	1	4
Student	1	
No leadership role	14	3

Source: Focus Group Discussions, Mityana Town and Busimbi Demographic Details, 23 and 24-7-2013

Awareness and attitudes about family planning Mityana

The perceptions on family planning have changed over the past years. In the past it was hard to convince people that using family planning had any advantages, many people faced stigmatization from all corners for talking about or even declaring that they used family planning. Many of the men didn't care for family planning, supported by the cultural norms and perceptions; having many children was a sign of wealth and it inevitably meant 'development'. Religion as well didn't offer any real support for using family planning which meant different people listened to their religious leaders and produced as many children as they could.

However, participants noted that in the past few years, there has been a marked change in people's perception of the number of children they can raise. *"In the villages many more people know about Family planning, out of 10 at least 6 people know about FP and they can tell you the basics including the disadvantages".* In consequence, more women and girls are using family planning to avoid unplanned pregnancies. Men have also changed their attitudes understanding that fewer children are easier to manage.

In addition, women are now working and can't stay home to look after the children as it used to happen, they too contribute to the family development and they can't do this if they are home. There's also been a shift in the discussions, more and more people are talking about family planning with their peers. People are now more conscious about issues of population and how it's impacting on the growth and development of the country, communities and families. *"The advanced family planning methods like implants have allowed many of the women to protect themselves against unplanned and unwanted pregnancies, this allows them time to look after their babies and have enough time for their families". FDG participants- Kamuli*

There are also more methods of family planning allowing people to make the choice most suited to them which was not the case; this has encouraged more people to use family planning.

Why people in Mityana and Kamuli use Family Planning

For the women in the two districts the main reason they use family planning is the will to space their children and care better for the basic needs of their children and future: *"Family planning helps to space the children and a woman can avoid having children at the same time, and having too many children, this increases the love of the mother for her children and the husband. And there's enough time to give to all the children". FDG participant- Kamuli*

Many of the women have the burden of looking after the children for several reasons; however with family planning they can plan for the education of their children, feed them well and be able to offer them with the basics in life with minimum stress.

Looking after children and taking them to good schools is a big attraction for using family planning. Many of the women noted the burden of looking after their children attributing this to several reasons. Spacing also allows for personal and community development and allows young people to become responsible and concentrate on work. Women also recognize that slowing down the rate at which a woman gives birth, has a beneficial impact on their health. They have time to recover and look after their babies with freedom.

The same sentiments are echoed by the youth. The Youth however are more concerned about the unwanted pregnancies; family planning gives them a chance to avoid unplanned and unwanted pregnancies and for those with babies it allows them *"look after their children under no pressure, and give birth to children they can ably support."*

The men are happy about family planning because it allows them to budget and plan economically and socially for the children and also they also believe having a planned number of children reduces unnecessary expenses, and helps them to create sustainable development in their homes. Many of them are discussing more and more with their wives about the best methods to use, methods that allow them to space their births and plan.

Why people in Mityana don't use family planning

Many know the advantages of family planning and they don't oppose it, yet they have no need of it as they delay their sexual encounters. Some use traditional and natural family planning methods like breastfeeding and others.

Side effects:

There are concerns about the ability to conceive after using family planning for a long time, this was raised by the youth. Many of them start early and when they are ready to conceive difficult for them to do so. And many of them have fears of giving birth to 'abnormal' children because of the effects of some of the methods.

Women were concerned about side effects like over bleeding, loss or gaining of weight, loss of appetite, strength, fears of cancer, experiencing irregular periods, sometimes periods are too heavy other times they are too light but go on for a long time, hypertension, sometimes they fail to conceive or take long, pains including headaches, backaches, drowsiness among others. For the women the biggest fear is the fact that the side effects in one way or another affect their marriages, especially loss of interest in sex and husbands don't find them attractive anymore due to lengthy bleeding or many of them experience violence because they started using family planning without the knowledge of their husbands, many families are said to have been broken this way.

For many of the women, the side effects of using family planning discourage them, and the fact that many of them don't get adequate information regarding methods, or many of them end up using what their friends are using, they are misled. The lack of adequate information leads to discontinuing family planning use and discouraging others from using that method too.

The men are concerned that when women are using especially oral contraception they usually forget the timing, and since many of them do this without the knowledge of their husbands they sneak around and forget to take the pill or when their husbands are around many of them don't take the pill. They also believe that family planning causes infertility and in a way has led to an increase in the rates of HIV/AIDS; the men also believe that using family planning has led to some women being promiscuous, *"many women fear pregnancy more than HIV/AIDS, so they protect themselves against pregnancy and then go ahead to sleep around, that is why we don't support family planning."*

Some women face their husband's resistance. In turn, men believe family planning to be a woman's job. They also perceive family planning to be the reason for broken homes. Due to a wider method mix, today, women can access family planning without involving their husband. Women in the focus groups saw this as a big advantage, while men felt cheated and excluded. Men in Kamuli estimated that 90% of women do not tell their husbands that they are using family planning; they only tell them when they get side effects which cause problems in the family. Disagreements about family planning leads to domestic violence, which makes women stop using contraceptives. *"My family was disgruntled that my wife had only three children, they were not happy with me, so I decided to marry another wife to have children with".*

Distance and access to services:

On the whole the distances to the health center also contribute to why some people don't use family planning. Due to long distances the women from villages are discouraged to seek for help from health centres and end up with having to deal with side effects in the best way they know. It appears that long distances from the villages to the next Health Centers are a deterrent to accessing family planning services.

In addition, many women they fear the lines at the health center, which means they will be late coming home and risk their husbands finding out that they are using family planning. There's also the issue of getting to the health center and encountering a rude health worker, or that there's only one health worker on duty who has to deal with other lines and lines of women, there's also lack of privacy and many times the women are affected by the issue of stock outs in the health center and at the hospital. Many times the health workers want to be bribed so that they can avail the supplies the women need.

For the youth they find family planning supplies expensive as many of them are still in school and have no stable income, they also find that they don't have any youth friendly corners in the health centers and at the hospital, they have to line up with the older people, which presents its own challenges as these are members of their communities and might inform parents. So they give up on using family planning methods on the whole. Many youth in Kamuli highlighted that their peers are ignorant of family planning, or don't know that services are available free of charge. In many cases – particularly in rural areas – people are not given information on family planning methods preferred. This creates discomfort and side effects such as over-bleeding. This fear of side effects is mixed with misconceptions - giving birth to deformed children, getting impotent / barren, loss of libido etc and is the main personal reason why some choose not to use family planning. By many, family planning is felt to promote promiscuity, immorality and prostitution. Some religions and cults don't allow their followers to go to hospitals; they don't use condoms or even take pills this coupled with societal, religious and cultural perceptions puts many off accessing family planning. Some religious beliefs do not support family planning while in some areas the men, and older generation still frown on those using family planning. Because of lack of support from family or spouses many women and men end up not using family planning. Religious, cultural and societal perceptions: Participants noted that some religious beliefs do not support family planning while in some areas the men, and older generation still frown on those using family planning. Because of lack of support from family or spouses many women and men end up not using family planning.

In addition, pressure to give birth still exists. Aunties encourage girls to give birth to secure a place in a man's home. Men and boys feel happy when they impregnate women and girls. Among polygamous families, women are engaged in competing in giving birth to a maximum of children. There is also strong pressure to give birth to boys "if a family has only girls, the woman has to give birth until she bares a boy; because a boy is more valued and is seen as wealth". FDG participant- Kamuli. The translation of family planning in the local languages is not favourable and has a negative connotation. Literally it translates to 'becoming barren/impontent'. The word planning and spacing should appear in the local language to avoid confusion. Finally, poor uneducated people believe that if they don't have money they would rather have children as a consolation, they believe that children are wealth, who can till the land for their parents' benefit. They also say that their children will in future look after them.

Common family planning methods used in Mityana

The most commonly available methods in Mityana include condoms, oral contraception, Implants and IUDs. In Implants and condoms were mentioned as most common methods in Kamuli. The women in Mityana prefer to use Implants as this method gives them more freedom and does not have so many complicated rules. While the reason Kamuli women cited for not using pills is women fear being caught by their husbands in addition to forgetting timing.

For the men the condoms are the most common method; though many of them still believe that their wives should take responsibility to use family planning methods because the methods available for men are limited. The youth/ female differ a bit, they prefer to use the pills because they believe they experience less side effects while using this method. However, youth indicated that the surge in the HIV/AIDS epidemic was due to little use of condoms and a preference for other contraception methods.

Family planning services and supplies have increased over time, taboos are broken

Today, family planning services are free of charge. Since 2009, family planning services have gradually become easier to access. Previously, only the pill and condoms were available, today many more methods area available. However, for a long time, implanon was not available. This particular implant brand is very appreciated by women, and NGOs have now filled the supply shortages. Messages on the radio and other communication channels have increased, reminding people to use family planning. Taboos seem to have been broken and more and more people discuss family planning.

Challenges at the Health Facility

According to FGD participants, health facilities face a number of challenges.

A common observation was that free services had attracted many patients, leading to long lines. Indeed the numbers of health workers had not been increased and they were not able to handle this increased demand to the satisfaction of patients. Women and youth alike, considered health workers as rude and arrogant. As there were delays in wage payment, health workers become careless, many of them are corrupt. For some women noted being asked to pay for family planning services.

Because of the numbers of the people, the health workers are faced with challenges, because of the high demand there are always stock outs of methods that are most commonly used. There are few health workers compared to the number of people.

Many of the women are battling with ignorance and yet at the health center the health workers are too stressed out because of numbers to give them counseling and advise on what's best for them. The women end up taking what's available or what they know their friends use. Many times women are given methods that are not to their preference and some of these cause problems to the women like not being able to breastfeed, bleeding etc.

There's lack of privacy at the health centers, one can't explain their problem to the health worker because then all the other patients will hear and sometimes the problem is very personal, the same problem is faced by the youth and it worse for them.

Youth emphasized that available services are not youth-friendly. This limits the number of youth making their way into the facilities. *"The lines in hospitals scare many young people, and yet many times the health workers are rude and very tired, they ask young people awkward questions that make them shy away from health centers. If Youth corners were created, these would provide safe spaces for young people to access services".* Youth also mentioned their fear of being judged by adults when they get their family planning supplies. Indeed, few centres offer services, increasing the chances of meeting acquaintances who might inform parents or embarrass one in public.

There was concern over expired drugs and substandard products as well as women's failure to attend follow up appointments especially in private clinics.

But also it was observed that the health workers faced their own personal challenges and should not be crucified, many have not paid in a long time, there's lack of drugs and sometimes the drugs even when procured don't get to the health center in time. The biggest challenge they face is the fact that they are few and they have to deal with large numbers of people, sometimes they work 24 hour shifts with no rest. This not only impacts their own health but also the way they deal with people.

Recommendations

The discussions identified the following main recommendations to improving the uptake of family planning services Education and awareness creation

- Health education and more health campaigns to reach men, youth and women. Provision of information for people to make informed decisions on when to use family planning and what methods to use. Awareness creation on going to health centres for family planning services and getting advice from health professionals instead of relying on friends.
- Involvement of community volunteers and village and village health teams to educate people on the use of family planning
- Dialogues between health workers and communities should be organized, so that they discuss issues affecting them, this will also help the community to understand their roles and responsibilities.
- Sensitization should be done on the issue of male involvement as this helps the men to understand the need for family planning and fully support their wives to access services, it does not help that the women have information and the men are left out.
- Involve religious leaders in family planning discussion using different strategies.
- The youth suggested that to improve services there should be a specific health workers assigned to working with the youth, to handle their problems, also there's need to recruit more health workers to reduce on the burden carried by those available. As well as having FP messages targeting youth.
- Involvement of religious leaders in family planning discussion using different strategies.

Services:

- Conduct outreaches and clinics in different villages targeting people who have to walk long distances, this brings services closer to the people.
- More mobile family planning clinics and HCT services as well as outreaches in different places would increase uptake.
- Community volunteers and village health teams should be trained to give basic information on family planning services to people in the villages and far to reach places.
- Health centers in the villages should be equipped well so that they can serve the communities better, also the health centers should have particular days to deal with reproductive health issues, including time to counsel and give out information to those who need it.
- The maternity and family planning clinics should be separated because the maternity clinic closes early. This would reduce the time people spend at the health centre.
- Government should enforce standards and help reduce fake and counterfeit family planning products on sale.
- Salaries of the health workers should be increased and they should come on time as this affects the way they work, one cannot work when they left their own children hungry. Numbers should also be increased, and they should be trained in offering youth friendly services.

When asked to rank these challenges according to their urgency and importance, the majority of participants identified the following two challenges:

- Inadequate information on Family Planning methods before and after uptake
- Limited access to Family Planning services due to Long distances to health centre services should be brought closer to the people.

Regarding the issues raised by the communities, the District Health Officers acknowledge that they were have existed not just come up now. They attributed poor quality services due to health worker fatigue and recommended taking services closer to people to increase uptake and improve on quality.

6.3 District Assessment Findings

6.3.1 Facility Assessments

The health facilities assessed were ten in number. There were two hospitals belonging to the public sector and located in urban setting and providing outpatient and Inpatient services. Amongst the lower level health facilities was Namwendwa health centre IV located in Kamuli district offering inpatients and outpatients services. All the health centre III's offered both outpatient and in-patient services. Health centre II's provided outpatient services according to the level of care.

6.3.2 Services available at District Hospitals

The District hospital which are sometimes referred to as general hospitals are supposed to provide preventive, promotive, curative, maternity, in-patient health services, surgery, blood transfusion services, laboratory and medical imaging services. They also provide in –service training, consultation and operational research support of the community based health care programmes. The general hospital serves a population of half a million people (500,000). The Table below shows the services that were being offered by the two hospitals.

Child immunization services, either at the facility or as outreach
Preventative and curative care services for children under 5
HIV counseling and testing services
HIV & AIDS antiretroviral prescription or antiretroviral treatment follow-up services
HIV & AIDS care and support services, including treatment of opportunistic infections 12 and provisions of palliative care
Diagnosis or treatment of STIs, excluding HIV
Diagnosis, treatment prescription, or treatment follow-up of tuberculosis
Diagnosis or treatment of malaria
Diagnosis or management of non- communicable diseases, such as diabetes, cardiovascular disease, or chronic respiratory disease
Any surgical services, including caesarean section
Blood transfusion services
Laboratory diagnostics, including any rapid diagnostic testing
Storage of medicines, vaccines, or contraceptive commodities
Breast Cancer Screening

Mityana District hospital did not offer adolescent health services and cervical screening while Kamuli district hospital never provided management of obstetric complications. The main cause of maternal death in is ante partum hemorrhage (20%) and post partum hemorrhage (10%). The absence of emergency obstetric care at Kamuli hospital presents a huge risk factor to pregnant women.

Health Centre III services

Health centre IV provides health services to a population of 100,000 and Health III serve a population of 20,000 people. HC IV acts as Health Sub district (HSD). They are mandated with planning, organization, budgeting and management of the HSD at the level. It carries oversight function of overseeing curative, preventive and rehabilitative health activities including those of PNFP and PFP service providers within the sub-county. All the Health III's did provide the services enumerated in the table below.

Family planning services
Antenatal care (ANC) services
Services for the prevention of mother-to-child transmission of HIV (PMTCT)
Delivery (including normal delivery, basic emergency obstetric care, and/or comprehensive emergency obstetric care) and/or newborn care services
Child immunization services, either at the facility or as outreach
Preventative and curative care services for children under 5
HIV counseling and testing services
HIV & AIDS care and support services, including treatment of opportunistic infections 12 and provisions of palliative care
Diagnosis or treatment of STIs, excluding HIV
Diagnosis or treatment of malaria
Laboratory diagnostics, including any rapid diagnostic testing
Storage of medicines, vaccines, or contraceptive commodities

Three out of 5 health centers namely Namwendwa HC IV, Supreme HC III and Kitajujwa HC III provided adolescent health services while Namasagali HC III and Kabuwamba HC III did not provide the adolescent health services. However, it is important to note that Namasagali HC III serves Namasagali secondary school. Uganda experiences a very high adolescent (15-19yrs) birth rate –teenage pregnancies at 24% (UDHS, 2011) way below the national target of 15% by 2015. Apart from Namasagali HC III, all the other 4 Health centres III's provided HIV & AIDS antiretroviral prescription or antiretroviral treatment follow-up services. Namwendwa HC IV, Namasagali HC III and Kitajunjwa HC III provided Diagnosis, treatment prescription, or treatment follow-up of tuberculosis. Only two health facilities at the level of HC IV and III provided Diagnosis or management of non- communicable diseases, such as diabetes, cardiovascular disease, or chronic respiratory disease and these included Namwendwa HC IV and Kitajunjwa HC III.

Health Centre II's

Health Centre II is supposed to provide outpatient services and has got minimal diagnostic capacity. They health centre II facilities do not provide ANC and maternity services; they do provide short term FP methods. They can carry out rapid test for pregnancy, malaria and HCT.

All the Health Centre II's provided the services in the table below.

Family planning services
Adolescent health services
HIV counseling and testing services
Diagnosis or treatment of STIs, excluding HIV

Kamuli V.S.C did not provide Antenatal care (ANC) services, Services for the prevention of mother-to-child transmission of HIV (PMTCT), Breast Cancer Screening and Cervical Cancer Screening. RHU Mityana did not provide the following services Child immunization services, either at the facility or as outreach, Preventative and curative care services for children under 5, Diagnosis or treatment of malaria, surgical services, including caesarean section. Red Cross Health II, did not provide Preventative and curative care services for children under 5 , Diagnosis or treatment of malaria, Storage of medicines, vaccines, or contraceptive commodities

6.3.3 Health facility observation

Mityana district hospital has a sign post showing availability of family planning services, antenatal care services and Maternal, newborn and child health services inside and outside the hospital. There was also a sign outside for HCT and HIV and AIDS services while other services had sign posts inside the building. The family planning counseling area provided for privacy, the examination room was spacious, the waiting area had seat however, and there were no Postabortion care services. Kamuli district hospital did not have a sign post outside or inside the building showing availability of FP, ANC, HCT and other services. The waiting area, counseling room, examination room were there but with limited space for privacy.

Staffing

All health facilities apart from Kamuli district hospital and Kamuli V.S.C had at least one midwifery professional and a nursing professional.

6.3.4 Family Planning services

All the health facilities did provide family planning services on a daily basis with exception of Kabuwambo HC III. In terms of availability of functioning equipment, all the health facilities had functioning blood pressure machines with exception of Namasagali HC III. There was 100% availability of contraceptives at the health facility on the day of the visit.

6.3.5 Stock availability

The availability of ale condoms was universal at al health facilities and 7 out 10 health facilities offered implants on the day of the visit. The Red Cross health centre and Kabuwambo HC III did not have combined oral contraceptive pills and progestin only contraceptive pills in stock. The combined injectable contraceptives were available in 6 out of 10 health facilities assessed. The progestin only injectables were in limited health facilities (4 out of 10).
All the health facilities at the level of Health centre II and III receive a constant quantity of contraceptives in a kit combined with the increased funding for procurement f contraceptive explains the increased availability of contraceptives in the public sector.

6.3.6 Key Findings, Implications and emerging issues

Family planning services, maternal and child health services are fully advertised at the health facilities.
There is no adequate space for seating, counseling and treatment of clients with utmost privacy at the lower level health facilities.

There are adequate supplies of contraceptives at all level of the health care system and male condoms availability is universal

All the health facilities had at least one mid-wifery professional in service

All the health facilities had capacity to conduct rapid pregnancy tests

Through focus group discussions it was realized that the common problem facing clients was inadequate provision of information by health care givers

6.3.7 Recommendation

The adolescent health services are lacking at the district and lower levels. There is need to provide more adolescent friendly services especially in locations with secondary schools where the needs of the adolescents are high.

There is need to increase resources allocation to increase access to information on family planning

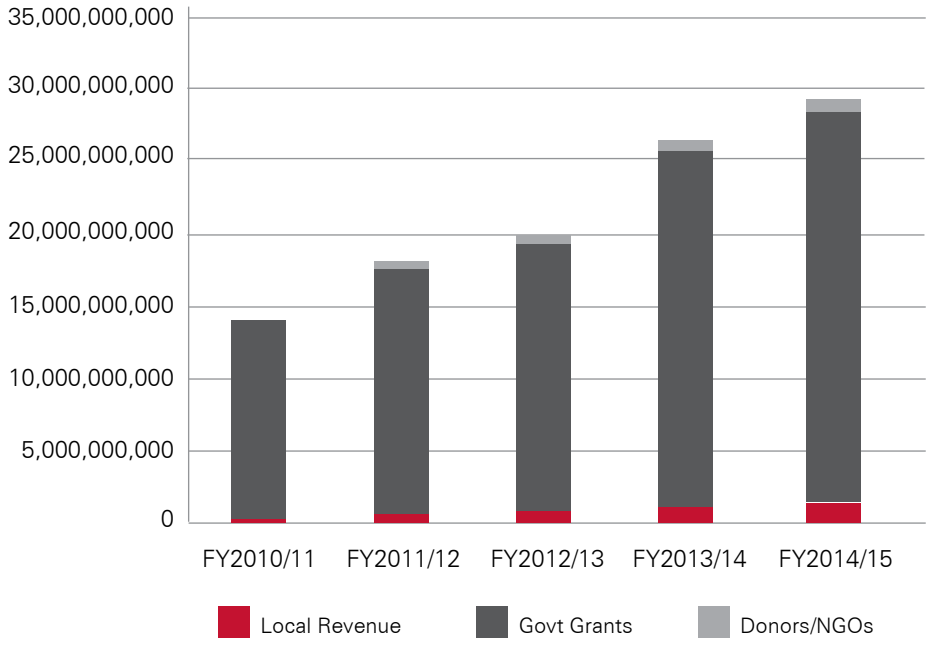
The districts should be supported on understanding the importance of reproductive health and how the districts would gain with implementation of vibrant RH services. This would be reflected in the district budget and work-plan. The RH activities within the district budget and work-plan should be separate and clear for easy tracking.

The adolescent health services should be supported and strengthened at health facility level including considerations for ensuring there is seating place, privacy during counseling and treatment.

6.4 Budget analysis

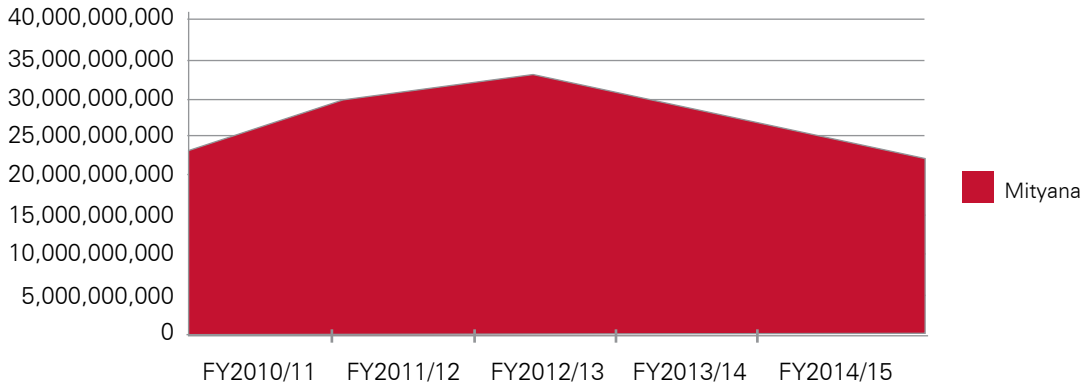
6.4.1 Budget in Mityana

Figure 15: Mityana, Total district Budget by source in UGX



There has been a steady increase of Mityana's overall district budget from 14.6 billion UGX in 2010/11 to 28.9 billion UGX in 2014/15. The biggest source of funds for Mityana are central government grants. Very few donors or NGOs align their activities into district priorities. Their projects are mostly implemented off budget making it hard to track or understand their contribution. Local revenue is insignificant.

Figure 16: Mityana total health budget in UGX



Although the overall budget increased, the health budget stagnated, with 2.3 billion UGX in 2010/11 and 2.4 billion in 2014/15. Hence, the health sector has lost priority in Mityana. The portion of health in the total district budget was 16.09 in 2010/11 and it has dropped to 8.16 in 2014/15.

Figure 17: Mityana health budget by source in UGX

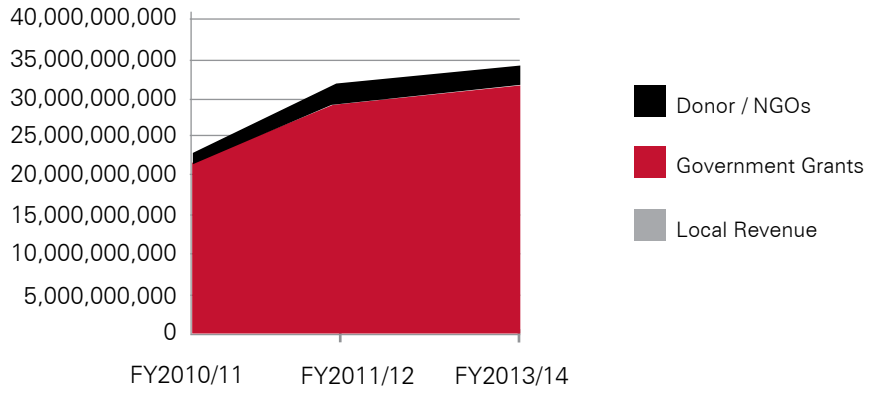
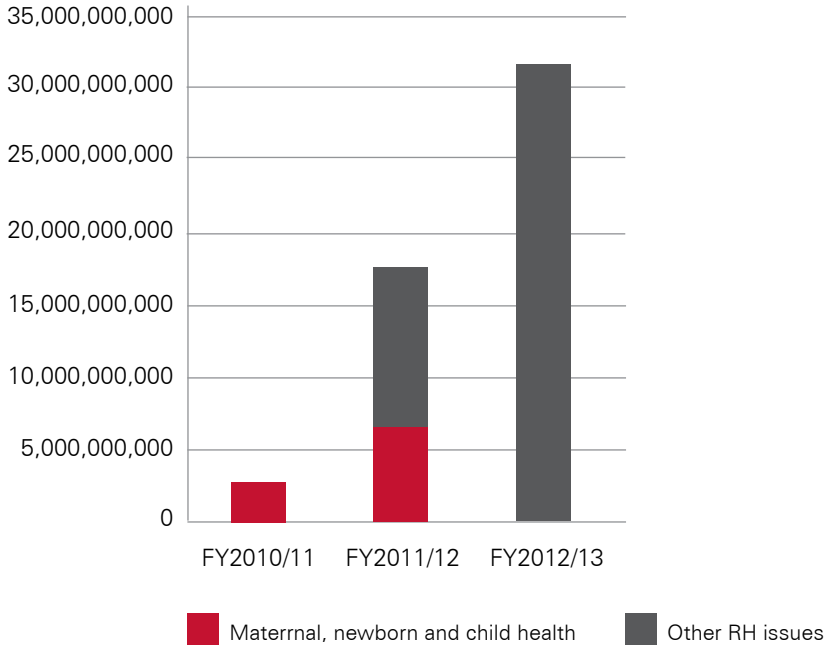


Figure 18: Mityana health budget



Mityana's health budget does not cater for any family planning activities. However, it caters for some reproductive health activities: 1.22% of the health budget in 2010/11 and 9.40% in 2012/13.

Between 2010 and 2013, Mityana has constructed a maternity ward in Bulera and provided HIV/AIDS services including on prevention of mother to child transmission of HIV/AIDS as well as prevention of sexually transmittable diseases. Some minor activities have included the sensitization of sub county leaders in Kikandwa and Ssekanyonyion violence against women and girls and children rights, as well as the dissemination of national population policy to lower local governments.

Table 5: Health, reproductive health and family planning budget ratios in mityana

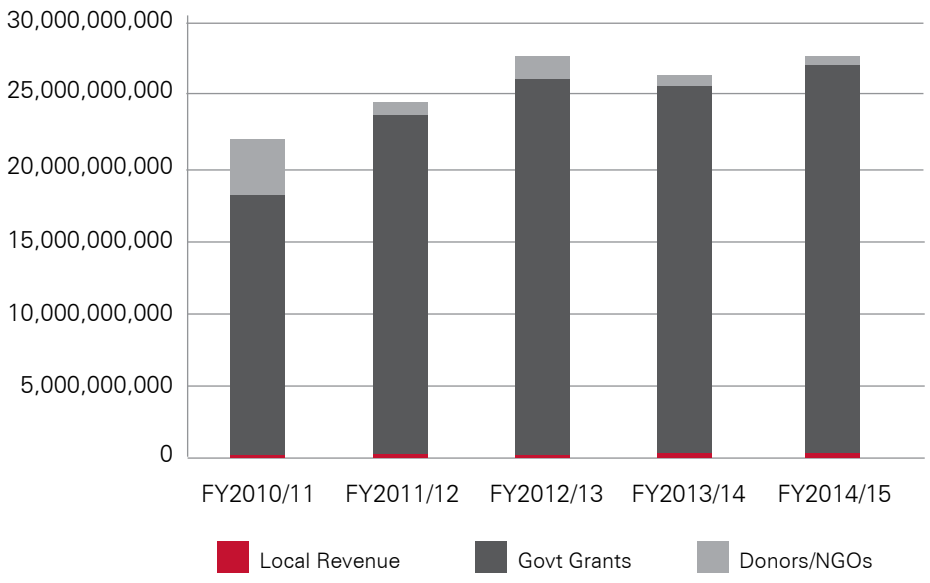
	FY2010/11	FY2011/12	FY2012/13	FY2013/14	FY2014/15
Health percentage share of District budget	16,09%	16,94%	16,82%	10,98%	8,16%
RH percentage share of district health budget	1,22%	6,84%	9,40%	0,16%	0,00%
FP percentage share of district RH budget	0,00%	0,00%	0,00%	n/a%	n/a

Observations

- Although the District Development plan highlights maternal and child health as a key area, the annual work plans does not reflect this over the years. This maybe a result of non alignment of the annual work plan with the development plan meaning that at the planning level the development plan is not reviewed to inform the process.
- It was also noted that activities of NGO/Donor are hardly captured also through interaction with the District officials and through the FGDs was clear that there were NGOs providing RH/FP services for example Reproductive Health Uganda. This calls for pro-activeness by District Health Department as well in NGO/Donor.
- The implication of lack of any activity directly reflected in the Department work plan shows lack of prioritization as well as poor documentation of activities by officers.

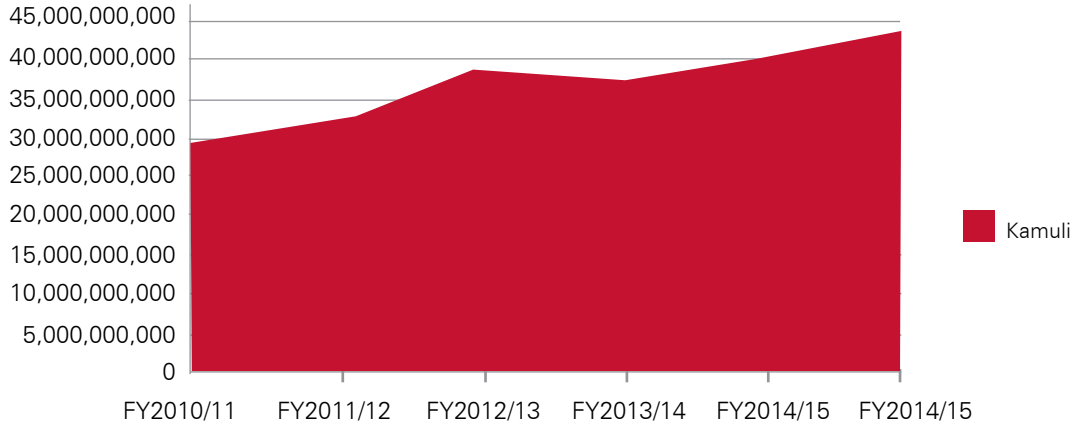
6.4.2 Budget in Kamuli

Figure 19: Kamuli total district budget by source in UGX



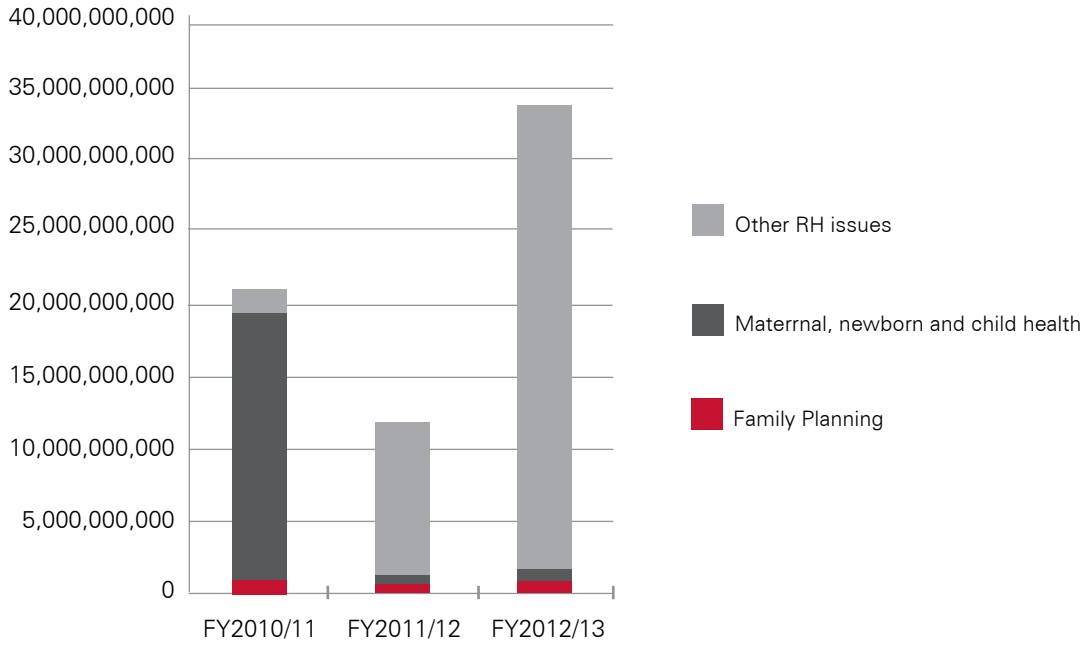
Kamuli's overall district budget has slightly increased over time, from 22 billion UGX in 2010/11 to 27 billion UGX in 2014/15. Most of its funding is transferred by the central government. However, in 2010/11 3.3 billion UGX came from donors and INGOs.

Figure 20: Kamuli total health budget in UGX



Kamuli's health budget has strongly increased between 2010/11 and 2012/13, from 3 billion UGX to 4.2 billion UGX. Projections up to 2015/16 show a very slow increase to 4.7 billion UGX. The district budget share dedicated to health has increased over time. In 2010/11 health received 13.7 % of the total budget and in 2012/13 this share had increased to 16.2%.

Figure 21: Kamuli reproductive health budget in UGX



Kamuli's health workplan shows many activities related to family planning. In 2010/11, these activities had an overall budget of 209 million UGX in 2010/11, 127 million in 2011/12 and 339 million UX in 2012/13. As a share of all the funds allocated to health, this made about 7%, 3.8% and 8% in those three years.

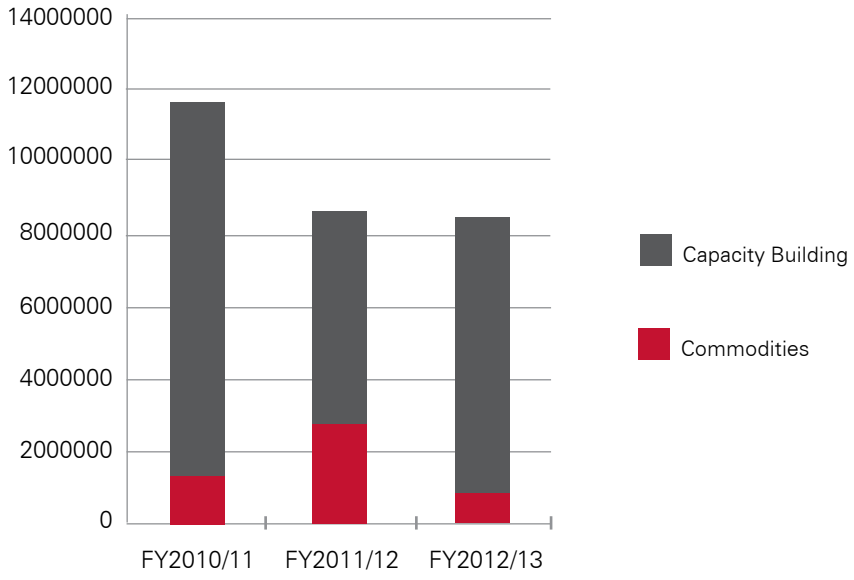
In 2010/11 the District Health Office's priorities lay mainly on maternal, newborn and child health with 185 million UGX. Starting from 2011/12, the District Health Office shifted its priorities to HIV/AIDS prevention with 114 million UGX (2011/12) and 322 million UGX (2012/13) respectively.

The workplans have consistently included family planning activities, yet at a low level: 11.6 million in 2010/11 and 8.8 million in 2011/12 and 8.7 million in 2012/13.

Table 6: Reproductive health and family planning budget ratios in Kamuli

	FY2010/11	FY2011/12	FY2012/13	FY2013/14	FY2014/15
Health percentage share of District budget	13,69%	14,21%	16,20%	16,56%	16,57%
RH percentage share of district health budget	6,98%	3,81%	7,97%	0,00%	0,00%
FP percentage share of dstrict RH budget	5,55%	2,96%	2,27%	n/a	n/a

Figure 22: Family planning budget in Kamuli by category in UGX



A closer look at the family planning budget shows that a major part is financing capacity building activities. Every year, the District Health Office has updated health workers on family planning eligibility criteria. It has included trainings for peer educators to promote condom use and its distribution. This was complemented with a smaller budget for commodities financing information, education and communication activities including distribution of condoms.

The District Health Officer acknowledges that the money allocated to RH/FP is very low and unlike the general impression people have that Health receives a lot of money. She recommended advocacy with the district leaders.

It should be noted that FP activities are mainly supported by NGOs/Donors and less contribution by the Districts. Activities of all contributors to RH/FP are not captured in the District plan creating a gap on the total amount contributed by the NGOs.

These issues have existed not just come up now. I have even gone for outreaches and facility activation activities and so many women turn up meaning that access is limited by long distances. As regards the information, health worker fatigue is high and quality of care is low in the facilities. We have some radio programs but not everyone listens and some information on posters is available but most women can not read.

More needs to be done in terms of policy dissemination as health workers as well as district officials hardly knew about RH/FP policies. The implication here is that work is being down but the possibility of not following policy guidelines is likely. This can partly explain why policy review is not taken into account when formulating annual work plans.

Annexe: Research Methodology

Document Review: A document review of the Health Sector Ministerial policy statement, MOH annual Activity work-plan was carried out. From these documents financial data was collected including budget allocations and expenditure for Health, Reproductive Health and Family Planning. The following policies were assessed; the population policy, the NDP, Vision 2040, national health policy, health Sector strategic and investment plan. The analysis focused on evidence of alignment of the policies to the international and regional principles regarding family planning and evidence of prioritization of RH and family planning within the policy framework. At district level district work-plans for Kamuli and Mityana districts were reviewed and the district budget documents for the past 3 years were reviewed.

Key Informant Interviews: A structured questionnaire was used to collect key informant interviews with the Ministry of Health, Ministry of Finance and the National Medical Stores. At district level structured questionnaire for key informant interviews were carried out. The key informants were the district health officers, the chief administrative officer and district finance officer. Qualitative and quantitative data was collected from ten health facilities in the two districts. From Mityana, the following health facilities were assessed: Mityana district hospital, supreme health centre III, Kabuwambo Health centre III, Red Cross Health II. In Kamuli the following health centers were assessed: Kamuli district hospital, Namuwemdwa Health Centre IV, Namasagali Health Centre III, Kitajunjwa Health centre III and Kamuli V.S.C health II. Overall two district hospitals, one health centre IV, four health centre III and 3 health centre II were assessed. The health facilities were assessed for the family planning, maternal, and child health services, adolescent health services, STI, HIV/AIDS and treatment of opportunistic infections. The areas of focus were services availability, commodities and basic equipment availability, human resources availability.

Focus Group Discussion: Focus group discussions were held in the two target districts of Mityana and Kamuli. A total of 8 FDGs were conducted composing of (4 women, 2 men and 2 youth). The FDGs focused on the issues and/ or bottlenecks to access to RH/FP services. The discussion had a total of 118 participants (80 females and 38 men). In Mityana district, the discussions were held at Mityana Town Council and Busimbi while in Kamuli the were held in Kamuli Toun Council, Kitayungwa and Namasagali subcounties. Selection of participants was prew-determined using the already agreed methodology/criteria and mobilization was in contacts at the district level and health office. The FDGs had a direct bearing on where the facility assessment was conducted

Data Analysis: Data collected was entered into an excel spread sheet and analysed for both the district and national level. Data collected was triangulated through key informant interviews with relevant government officers

Limitations of research: The Ministry of health activity work-plans were only available for Vote 014. Under Vote 014 there are differences between information provided in the Ministerial statement and in the work-plans. For the other votes, the research relies on "Annual Health Sector Ministerial Policy statements". These statements are less detailed than activity work plans. As regards Vote 162 for Mulago Hospital Complex, the statements do not provide information on FP activities. Some referral hospitals (Kabala and Soroti) consistently do not refer to FP, in places where all the other hospitals do. The budgets of these hospitals have not been included in the analysis, as the methodology only captures where FP is mentioned explicitly. The Ministerial statements mention constructions of maternity wards. However, it is not clear whether these mentions are consistent. Therefore, the authors have chosen not to capture such data

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