MINISTRY OF HEALTH
UGANDA

UGANDA FAMILY PLANNING COSTED IMPLEMENTATION PLAN, 2015–2020

November 2014

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Uganda Family Planning Costed Implementation Plan, 2015–2020

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

November 2014

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FOREWORD

As shown by our statistics, Uganda's total fertility, maternal mortality, and teenage pregnancy rates remain amongst the highest globally. Clearly, we still have a tall and uphill task, as many women and families would like to delay, space, or limit their childbearing but are not using family planning (FP). Many women cite health concerns, including fear of side effects or opposition from their partner as reasons for not using contraception.[1] We need to address these women's health concerns and fears, improve our counselling about side effects, and involve men as partners.

Our efforts to scale up use of modern family planning methods are motivated by the knowledge that family planning helps women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing.[2] More broadly, family planning improves maternal and child health, facilitates educational advances, empowers women, reduces poverty, and is a foundational element to the economic development of a nation.

H.E President Museveni has provided excellent leadership and has made strong commitments to family planning at the London Summit on Family Planning in July 2012 and again at the Uganda National Family Planning Conference in July 2014. We need to take advantage and maximise the benefits of this political commitment to implement robust family planning programmes to reach women, men, youth, and communities with voluntary high-quality services and information to meet their needs.

The Ministry of Health (MOH), in collaboration with partners, developed the Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP) as an overarching document to provide national guidance for increased knowledge of and access to family planning interventions. In summary, the FP-CIP is aligned to several national frameworks, including the Committing to Child Survival: A Promise Renewed, 2013, and Vision 2040. The plan emphasises the following key strategic priorities that will enhance the achievement of our objectives:

- Increasing efforts to reach all young people
- Developing a national social and behaviour change communication strategy with harmonised programme efforts
- Implementing task sharing amongst health care workers to increase access to rural and underserved populations. so as to scale up service delivery
- Mainstreaming family planning in a multisectoral manner to improve policy, interventions, equity, and implementation
- Ensuring FP commodity security across the public and private service delivery points

We believe that our joint efforts will lead to a decline in the unmet need for family planning and an increase in the modern contraceptive prevalence rate (mCPR) to a level of impact by 2020.

This, therefore, is the plan of action that government, partners, and civil society must follow to achieve our desired goals of carrying forward the Government of Uganda's commitments to family planning.

The MOH pledges to bolster all coordination efforts and calls on development and implementing partners to work with us to support and implement the FP-CIP to ensure the success of the national FP programme intended to improve the quality of life and well-being of our people.

Hon. Sarah Aceng Opendi
Minister of State for Health, Primary Health Care and Member of Parliament, Tororo District

PREFACE

The Government of Uganda is committed to improving access to family planning, as it is a low cost, high dividend investment for addressing Uganda's high maternal mortality ratio and improving the health and welfare of women, men, and ultimately, the nation. Family planning is an essential component in our national development agenda to become a middle-income country in the next 30 years.

Increased access to, and use of, family planning has far-reaching benefits for families and the nation. As Uganda's fertility rates have begun to decline, Uganda has the potential to benefit from the opportunity of the demographic dividend. The demographic dividend refers to faster economic growth due in part by changes in the population age structure that result in more working-age adults and fewer dependents. This population shift can contribute to both national development and improved well-being for families and communities.[3] However, if we are to realise the demographic dividend, we must make substantial investments to improve health outcomes and meet the needs for family planning, while also educating and training workers, promoting new job opportunities for young people, and strengthening economic stability and governance.

Therefore, let us work together to ensure the health and wealth of our nation. By committing ourselves to the full financing and implementation of the Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP), we can realise our goals of reducing unmet need for family planning to 10 percent and increasing the modern contraceptive prevalence rate amongst married and women in union to 50 percent by 2020.

H.E. President Yoweri Kaguta Museveni has said, *"The wealth of a nation is not in the soils and stones. It is in its people, its population....we need to educate our children, give them skills and create an enabling environment for employment and job creation. That way, we shall create wealth, make savings and Ugandans will invest and spur economic productivity and growth."*

Full and successful implementation of the FP-CIP requires the concerted and coordinated efforts of government (executive, legislature, ministries, and local government structures), the private sector, civil society, and development partners. We must all work together to ensure an enabling environment for policy, financing, service delivery, advocacy programmes, and the effective mobilisation of communities and individuals to overcome sociocultural barriers to accessing family planning services.

The Government of Uganda is committed to providing the required leadership to coordinate and implement the FP-CIP, so as to ensure that every Ugandan has the right to health, education, autonomy, and personal decision making about the number and timing of their childbearing.

For God and our country,

Rt. Hon. Dr. Ruhakana Rugunda
The Prime Minister of Uganda

ACKNOWLEDGEMENTS

The Ministry of Health (MOH) would like to express its appreciation to the many partners and groups who supported the development of the Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP). This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, development partners, implementing partners, professional associations, and for-profit organisations working in aligned areas.

This publication was produced with funding and technical support from the United Nations Population Fund (UNFPA)/Uganda and the United States Agency for International Development (USAID), through the Health Policy Project (HPP) and Advancing Partners & Communications (APC).

In addition to the organisations and projects named above that provided technical and financial support, a variety of government agencies, development partners, implementing partners, professional associations, and for-profit organisations also provided valuable input and feedback throughout the process via in-person meetings and online communications. These organisations include

- Ministry of Education and Sports; Ministry of Finance, Planning and Economic Development (MOFPED); Ministry of Gender, Labour and Social Development; Ministry of Urban Planning; National Medical Stores (NMS); Parliament of Uganda; Population Secretariat (Popsec); Uganda AIDS Commission
- District and assistant district health officers from Agago, Amolator, Bududa, Buliisa, Bushenyi, Gulu, Isingiro, Kabale, Kamuli, Kasese, Kiruhura, Kiryandongo, Kyenjojo, Lamwo, Lira, Lwengo, Masaka, Masindi, Mitooma, Mubende, Nakaseke, Nwoya, Sheema, Tororo, and Wakiso
- AAR Health Services; Act Together–Uganda; Advance Family Planning, Gates Institute on Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health;African Medical and Research Foundation (AMREF); Buganda Kingdom; Bugolobi Community Development Centre; Busoga Kingdom; Catholic Relief Services; Centre for Health, Human Rights and Development (CEHURD); Coalition for Health Promotion and Social Development (HEPS) Uganda; Comfort Home Care Clinic; Communication for Development Foundation Uganda (CDFU); Communication for Health Communities Project (CHC); Community Health Alliance Uganda; Deutsche Stiftung Weltbevoelkerung (DSW); Family Impact; Federation Uganda; FHI360; Futures Group; Institute of Health Science Uganda; International Community of Women Living with HIV in East Africa; IntraHealth International; JHPIEGO; John Snow, Inc. (JSI); KCCA Clinic, Kamwokya Station; Kitante Medical Centre; Makerere School of Public Health; Management Sciences for Health (MSH)/ STRIDES for Family Health; Marie Stopes Uganda; Media representatives from WBS and New Vision; Medical Access Uganda Limited (MAUL); Metha Hospital; Merck Sharp and Dohme (MSD); Mildmay Uganda; Mulago Hospital; National Association for Women's Action in Development (NAWAD);National Youth Council; Nile Breweries Limited; Nsambya Police Clinic; NSD–UHT; PACE; Pacific Diagnostics; PATH; Pathfinder International; Partners in Population and Development Africa Regional Office (PPD ARO); Praise Blue Star; PULLIRA; Reach a Hand Uganda (RAHU); Representatives from Bussi Island Village Health Team; Reproductive Health Uganda (RHU); Samasha Medical Foundation; Save the Children; Sexual Reproductive Health Alliance; The AIDS Support Organisation (TASO);TYDI–Uganda; Uganda Catholic Medical Bureau; Uganda Christian University Mukono; Uganda Family Planning Consortium; Uganda Health Marketing Group (UHMG);Uganda Health Systems Strengthening Project (UHSSP); Uganda Muslim Medical Bureau; Uganda National Medical Council; Uganda Private Midwives Association; Uganda Protestant Medical Bureau; United Nations Population Fund (UNFPA); United States Agency for International Development (USAID); and WellShare International

- Youth representatives drawn from organisations, including Baylor, International Youth Alliance on Family Planning Uganda, Naguru Teen Centre, Red Cross, Reproductive Health Uganda (RHU), and Uganda Young Positives (UYP)

Special appreciation is also made to the Task Force for steering this process, namely: Dr. Jotham Musinguzi, PPD ARO; Dr. Diana Nambatya Nsubuga, PPD ARO; Mr. Kenneth Nyehoora Mugumya, Uganda Family Planning Consortium; Dr. Ismail Ndifuna, UNFPA, Ms. Christine Kajungu, UNFPA; Ms. Roselline Achola, UNFPA; Dr. Jennifer Wanyana, PACE; Dr. Angela Akol, FHI360, Mr. Frederick Mubiru, FHI360; Dr. Espilidon Tumukarate, UHMG; Dr. Betty Kyaddondo, Population Secretariat; Dr. Frederick Makumbi, Makerere School of Public Health; and Dr. Collins Tusingwire, Ministry of Health

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Finally, I acknowledge the efforts and dedication of Mr. Lawrence Were, Ms. Juliet Tumuhairwe, and Dr. Zainab Akol, of the Ministry of Health, who manned the Secretariat that coordinated the whole development process of the FP-CIP

Dr. Jane Ruth Aceng
Director General of Health Services, Ministry of Health

PROCESS AND FORMULATION OF THE FP-CIP

Uganda began developing its Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP) in early 2014, with support initiated by the United Nations Population Fund (UNFPA)/Uganda and direction from a small CIP Task Force that served as a steering committee. In July 2014, the Health Policy Project (HPP) and Advancing Partners & Communications (APC), funded by the United States Agency for International Development (USAID), assembled a Technical Support Team to provide additional expertise.

Through November 2014, the Technical Support Team worked under the direction of the Ministry of Health's (MOH) Reproductive Health Division to conduct a comprehensive situational analysis, including a desk review and consultations; identify strategic priorities; solicit for strong stakeholder input (through group consultations, in-person meetings, and an online survey receiving 81 responses); develop activities; and estimate costs. The team was guided throughout the process by the CIP Task Force, a group of high-level experts from the MOH, development partners, implementing partners, civil society, advocates, and beneficiaries, including those belonging to traditionally marginalized and excluded communities.

The Technical Support Team, in consultation with expert groups, and under the guidance of the Task Force, developed the technical strategy through an inclusive, country-driven process that included goal setting, situation analysis, results formulation, and activity planning. The FP-CIP technical strategy was built on a comprehensive understanding of the family planning (FP) issues, gaps, and opportunities at the service delivery, program, and policy levels in Uganda and follows the fundamental elements of sound FP program design. The technical strategy was first informed by the country goals of reducing unmet need and increasing the contraceptive prevalence rate (CPR) (the targets were vetted and approved through an expert meeting, and a separate sub-goal to increase the CPR for unmarried women was projected in line with the target increase for married women). The Technical Support Team conducted a situation analysis to gather information and data—comprising a desk review, secondary analysis of statistical data, and stakeholder consultations to gather information.

The plan and activity matrix was presented in various forms to expert groups throughout the process, including the CIP Task Force; groups of various partner experts across technical areas; and the Family Planning/Reproductive Health Commodity Security Working Group. The plan was refined based on this feedback and input. Following the November 2014 launch of the CIP, the Technical Support Team will conduct a gap analysis and detail an implementation and monitoring roadmap for 2015–2020.

More than 30 group consultations were held at the national and district levels to solicit input from experts and stakeholders on topics including

- Contraceptive security
- Human resources
- Health systems management
- Advocacy (including policy, resources, and enabling environment)
- Social and behaviour change communication
- General FP service delivery
- Youth-friendly FP/reproductive health services
- Integration of FP services into other health services and sectors
- Decentralization and family planning

Specific focus groups were also held with

- Government of Uganda (GOU) sector ministries
- Development partners

- Private sector
- District health officers
- Youth
- Local communities (around Kampala and in Kodito, Moroto, and Gulu, through focus group discussions with community members and interviews with health care providers, implementing partners, and district health officers)

A list of key issues and associated causal factors was developed from the detailed situation analysis and stakeholder consultation work. The Technical Support Team then conducted a root-cause analysis of the issue list to identify the context and interrelationship of problems and to develop a comprehensive list of inter-connected causal factors for each key issue and discrete issues that could be addressed by various interventions. This information was then organised, classified, and entered into an issue-solution matrix. The strategic priorities were developed from this data gathered during the consultation process and desk review and proposed again to stakeholders for vetting, refinement, and approval.

The Technical Support Team next converted issues into results (strategic outcomes), drafting a partial implementation framework listing inter-connected strategic outcomes, expected results, and outputs. This framework was developed and strategic outcomes and results were aligned according to the six categories, emerging from the situation analysis and stakeholder consultation process. This framework was then circulated to stakeholders (including the Task Force) for additional feedback and edits. The matrix was further detailed and refined with interventions through stakeholder meetings and one-on-one consultations with key partners, and targets were set for activity outputs.

In addition, the Technical Support Team identified and considered global best and high-impact practices,[4] analysed them for applicability in Uganda, and included relevant interventions activities in the FP-CIP (including activities for piloting and evaluation before larger scale-up), as appropriate to the country context and according to the expert opinions of various stakeholders. Intervention activities for each output were then prioritised by stakeholders, based on potential impact and the feasibility of success in the local context. The Technical Support Team consulted with stakeholders to detail intervention activities further into sub-activities to the level where inputs can be defined, followed by scheduling the sub-activities over the time period of the plan. An implementation framework listing inter-connected strategic outcomes/strategic priorities, expected results, and outputs was developed with each output listing intervention activities and sub-activities, quantified estimates for outputs (i.e., output targets), and a timeline for implementation. Stakeholders then provided feedback and suggested edits to the framework through various large and small group consultation meetings, as well as revisions to the matrix, which was widely circulated. The team conducted additional consultations and key informant interviews with more than 15 partners, donors, and other GOU sector ministries and MOH departments to ensure that the activities were feasible and the costing details were correct and aligned with local costs for implementation. The costing was developed based on international best practices and customised to the Uganda context (refer to the Costing Assumptions section for further details). Finally, the MOH circulated multiple draft versions of the complete FP-CIP to its partners and stakeholders before the plan was finalised.

During CIP execution, further refinement of the technical strategy will become necessary as information is generated from performance monitoring of the FP-CIP.

“Family planning is good for the health of the mother, good for the health of the children. It [family planning] is good for the welfare of the family; [it] is good for the welfare of the country.”

— H.E. Yoweri Kaguta Museveni,
President of Uganda
National FP Conference, 28 July 2014

EXECUTIVE SUMMARY

The Government of Uganda (GOU) has committed to reducing unmet need for family planning (FP) to 10 percent and increasing the modern contraceptive prevalence rate to 50 percent by 2020. The full implementation of the Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP) by the GOU and partners will enable Uganda to reach these ambitious goals.

Strategic priorities were identified to ensure that the current gaps in family planning in Uganda are adequately addressed:

- Priority # 1: Increase age-appropriate information, access, and use of family planning amongst young people, ages 10–24 years
- Priority # 2: Promote and nurture change in social and individual behaviour to address myths, misconceptions, and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies
- Priority # 3: Implement task sharing to increase access, especially for rural and underserved populations
- Priority # 4: Mainstream implementation of family planning policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation
- Priority # 5: Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors

Uganda's goal of reaching 50 percent of women who are married or in union with modern contraceptive methods is ambitious and must be matched with commensurate support in the areas of human resources, financing, and political commitment from national to community levels throughout the country.

The cost of the total plan is 622 billion Uganda shillings (UGX) or $235 million USD between 2015 and 2020, which will increase the number of women in Uganda currently using modern contraception from approximately 1.7 million users currently in 2014 to 3.7 million in 2020. Between 2015 and 2020, the annual cost of the plan is about $39 million USD. The interventions, activities, and accompanying costs in this plan will help the GOU and partners to mobilise resources and monitor the implementation of Uganda's family planning programme.

ABBREVIATIONS

ADHO	assistant district health officer
CPR	contraceptive prevalence rate
CS	contraceptive security
CYP	couple years protection
DC	demand creation
DHO	district health officer
DHS	Demographic and Health Survey
DHT	district health team
DMPA	depot medroxyprogesterone acetate
DRHO	district reproductive health officer
EAC	East Africa Community
F	financing
FP	family planning
FP-CIP	Uganda Family Planning Costed Implementation Plan
GDP	gross domestic product
GOU	Government of Uganda
HCW	health care worker
HMIS	health management information system
HPAC	Health Policy Advisory Committee
HRH	human resources for health
ICT	information, communication, technology
IPC	interpersonal communication
IUD	intrauterine device
JMS	Joint Medical Stores
LARC	long-acting reversible contraceptive
LMIS	logistics management information system
mCPR	modern contraceptive prevalence rate
MDG	Millennium Development Goal
MH	maternal health
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MP	member of Parliament
NDA	National Drug Authority
NMS	National Medical Stores
NPA	National Planning Authority
OPM	Office of the Prime Minister
PEE	policy and enabling environment
PFP	private for-profit
PMA2020	Performance, Monitoring and Accountability (2020)
PNFP	private not-for-profit
POPSEC	Population Secretariat
QI/QA	quality improvement/quality assurance
RH	reproductive health
RHCS	reproductive health commodity security
RMNCH	reproductive, maternal, newborn, and child health
SBCC	social and behaviour change communication
SDA	service delivery and access
SDG	Sustainable Development Goal
SMA	stewardship, management, and accountability
SMC	Senior Management Committee

SRH	sexual and reproductive health
STMC	Senior Top Management Committee
TMC	Top Management Committee
TOR	terms of reference
TOT	training-of-trainer
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHT	village health team

SECTION 1: INTRODUCTION

This document serves as the blueprint for Uganda to achieve its country vision:

> **Universal access to family planning to help Uganda attain the middle-income country status by 2040.**

This vision is further specified through the operational goals of this plan:

> **Reduce unmet need for family planning to 10 percent, and increase the modern contraceptive prevalence rate (mCPR) amongst married and women in union to 50 percent by 2020.[5]**

The Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP) details the country's plans to achieve its vision and goals to improve the health and well-being of its population and the nation through providing high-quality, right-based family planning (FP) information and services.

The July 2012 London Summit on Family Planning renewed the global community's enthusiasm and commitment to family planning and led to countries making a pledge to develop costed implementation plans (CIPs). The FP-CIP is based on FP2020 pledges and the additional national commitment and revitalisation for family planning as a key input for development realised at the National Family Planning Conference held in Kampala from 28–30 July 2014.Uganda's plan was also guided by the need to further detail the strategies for family planning as identified in Committing to Child Survival: A Promise Renewed, 2013.[6]

Access to family planning and contraception is a fundamental dimension of sexual and reproductive health and reproductive rights. However, many Ugandans are still unable to enjoy their reproductive rights. This situation has an unintended impact on the lives and productivity of women and girls who, in turn, cannot fulfill their rights to education, health, and work due to the lack of information and means that would enable them to delay motherhood and plan their family size (should they decide to form a family). On the one hand, these human rights issues are intrinsic to a life of dignity and wellbeing, thus meriting the government's protection. On the other hand, the non-fulfillment of these rights bears an important cost on the country's economic and social development for current and future generations.

1.1 Rationale for and Use of the FP-CIP

The FP-CIP is the guide for all FP programming for the government across all sectors, development partners, and implementing partners. Uganda's FP-CIP details the necessary programme activities and costs associated with achieving national goals, providing clear programme-level information on the resources the country must raise domestically and from partners. The plan gives critical direction to Uganda's FP programme, ensuring that all components of a successful programme are addressed and budgeted for in government and partner programming.

More specifically, the FP-CIP will be used to

- **Ensure one, unified country strategy for family planning is followed:** The FP-CIP articulates Uganda's consensus-driven priorities for family planning—derived through a consultative process—and thus becomes a social contract for donors and implementing partners. The plan will help ensure that all FP activities are aligned with the country's needs, prevent fragmentation of efforts, and guide current and new partners in their family planning investments and programmes. All stakeholders must align their FP programming to the strategy detailed in this document. In addition, the Ministry of Health (MOH) must hold development and implementing partners to account for their planned activities and to realign funding to the country's needs identified as priorities. At the same time, the FP-CIP details

commitments, targets, actions, and indicators to make the MOH ultimately accountable for their achievement. All other sectoral ministries should work in tandem with the MOH to implement the FP-CIP and coordinate efforts.

- **Define key activities and an implementation roadmap:** The FP-CIP includes all necessary activities, with defined targets appropriately sequenced to deliver the outcomes needed to reach the country's publically committed FP goals by 2020.
- **Determine impact:** The FP-CIP includes estimates of the demographic, health, and economic impacts of the FP programme, providing clear evidence for advocates to use to mobilise resources.
- **Define a national budget:** The FP-CIP determines detailed commodity costs and programme activity costs associated with the entire FP programme. It provides concrete activity and budget information to inform the MOH budget requests for FP programmes aligned with national goals between 2015 and 2020. It also provides guidance to the MOH and partners to prioritise the funding and implementation of strategic priorities.
- **Mobilise resources:** The FP-CIP should also be used by the Government of Uganda (GOU) and partners to mobilise needed resources. The plan details the activities and budget required to implement a comprehensive FP programme, and as such, the MOH and partners can systematically track the currently available resources against those required as stipulated in the FP-CIP and conduct advocacy to mobilise funds from development partners to support any remaining funding gaps.
- **Monitor progress:** The FP-CIP's performance management mechanisms measure the extent of activity implementation and help ensure that the country's FP programme is meeting its objectives, ensuring coordination, and guiding any necessary course corrections.
- **Provide a framework for inclusive participation:** The FP-CIP and its monitoring system provide a clear framework for broad-based participation of stakeholders within and outside of the GOU and are inclusive of relevant groups and representatives from key populations in the implementation and monitoring of the plan.

1.2 The Global Context

Scaling up FP services is one of the most cost-effective interventions to prevent maternal, infant, and child deaths globally. Family planning interventions aid in lowering maternal, infant, and child mortality, contributing to the Millennium Development Goals (MDGs) and the newly established Sustainable Development Goals (SDGs). Through a reduction in the number of unintended pregnancies in a country, it is estimated that one quarter to one third of all maternal deaths could be prevented. Family planning is linked indirectly as a contributor to positive health outcomes. For example, FP interventions contribute to reducing poverty, increasing gender equity, preventing the spread of HIV, reducing unwanted teenage pregnancies, and lowering infant deaths.[7] Additionally, each dollar spent on FP initiatives on average results in a six dollar savings on health, housing, water, and other public services.[8]

Lack of access by adolescent girls to family planning, including contraceptive information, education, and services, is a major factor contributing to unwanted teenage pregnancy and maternal death. In low and middle-income countries, complications of pregnancy and childbirth are the leading causes of death amongst adolescent girls ages 15–19.[9]

Currently, more than 200 million women in developing countries desire to space or limit pregnancies; however, they lack access to FP options. Amongst women of reproductive age in developing countries, 57 percent (867 million women) need access to contraceptive methods because they are sexually active but do not want a child in the next two years. Of these women, 645 million (74%) are using modern methods of contraception; the remaining 222 million are not, resulting in significant unmet need for modern FP methods.[10]

FP2020

The UK government, through the Department for International Development (DFID), and the Bill & Melinda Gates Foundation partnered with the United Nations Population Fund (UNFPA) to host a gathering of leaders from national governments, donors, civil society, the private sector, the research and development community, and other interest groups to renew and revitalise global commitment to ensuring the world's women and girls, particularly those living in low-resource settings, have access to contraceptive information, services, and supplies.[11] The resulting event was the London Summit on Family Planning, held on 11 July 2012. At the summit, implementers, governments, and FP stakeholders united to determine priorities and set forth commitments. The GOU made several significant commitments (See Figure 1: Uganda country commitments to FP2020).

Figure 1: Uganda country commitments to FP2020

1. **Commitment 1:** Develop and implement an integrated FP campaign
2. **Commitment 2:** Accelerate the passing of the National Population Council Bill into law, immediately making the inter-ministerial structure functional and appropriating the necessary budget support through a supplementary request
3. **Commitment 3:** Improve reproductive health (RH) commodity distribution and effective services delivery, review post-shipment testing policy to reduce delays in the release of vital RH supplies, including FP supplies from the National Drug Authority
4. **Commitment 4:** Finance commitments
5. **Commitment 5:** Strengthen the technical and institutional functionality of the Uganda Health Marketing Group and National Medical Stores in a dual private and public sector RH supplies distribution system
6. **Commitment 6:** Scale up partnerships with civil society organisations and the private sector for FP outreach and community-based services, including social marketing, social franchising, and task sharing linked to a comprehensive training programme
7. **Commitment 7:** Partner with appropriate private sector bodies and institutions for the integration of maternal health and FP/RH and HIV/AIDS information and services for their employees and families
8. **Commitment 8:** Roll out youth-friendly services in all government Health Centre IVs and district hospitals
9. **Commitment 9:** Ensure timely completion of the annual household panel surveys by the Uganda Bureau of Statistics (UBOS) to ascertain progress on health, including FP service delivery; also carry out a robust evaluation of all FP investments in Uganda
10. **Commitment 10:** Conduct bi-annual joint supervision and bi-annual FP/RH national review meetings
11. **Commitment 11:** Strengthen the institutional capacity of the public health facilities and community-based distributors to provide family planning and increase choice and quality of care at all levels

The summit aimed to "mobilize global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020."[12] Achieving this ambitious target would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 child birth-related and maternal deaths, and 3 million infant deaths.[13]

The London Summit on Family Planning called on all stakeholders to work together on various areas,[14] including

- Increasing the demand and support for family planning
- Improving supply chains, systems, and service delivery models
- Procuring the additional commodities countries need to reach their goals
- Fostering innovative approaches to family planning challenges
- Promoting accountability through improved monitoring and evaluation

Sustainable Development Goals

Building on the commitments of the Millennium Development Goals, the global SDGs[15] are newly proposed by the United Nations to address domestic and global inequalities by 2030. Proposed Goals 3 and 5 give include direct and indirect outcomes related to family planning. Proposed Goal 3 specifies to "ensure healthy lives and promote well-being for all at all ages." Further, the sub-activity states

- 3.1—By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.7—By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes

Further, proposed Goal 5, "achieve gender equality and empower all women and girls," includes sub-activity 5.6: To ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action and the outcome documents of their review conferences. Given the focus areas in family planning and equitable access, if the necessary resources, political will, advocacy, and in-country priorities are provided, the SDGs are set to achieve substantial impact outcomes.[16]

1.3 The Regional Context

The total fertility rate remains high for many of the countries in the region (4.6 in Kenya and Rwanda, 5.4 for Tanzania, 6.2 for Uganda, and 6.4 for Burundi). Modern contraceptive prevalence in the East African Region is generally low and with a wide range of disparity (17.7% in Burundi to 45.1% in Rwanda). The contraceptive prevalence rate is a product of many variables, including access to information, education, and counseling; FP commodity security; staff availability; and skills and social and cultural factors. Efforts to improve access to contraceptive information, particularly for adolescents and youth, and expand the range of contraceptive choices need to be made.

Levels of unmet need for family planning are generally higher than contraceptive use in most countries in Eastern Africa. In most Demographic and Health Survey (DHS) reports, injectables and pills are the most popular methods, with low utilisation of condoms, implants, and intrauterine devices (IUDs). Use of condoms and IUDs are plagued by numerous myths and misconceptions—both amongst health workers and the general population. Major challenges with the provision of FP services in the region include inadequate number of skilled providers and frequent stock-out of contraceptive commodities within many facilities.[17]

Figure 2: Reproductive health indicators for selected countries in Eastern Africa, latest available data[18]

Country	2014 Population (millions)[19]	Total Fertility Rate[20]	Modern Contraceptive Prevalence Rate, married women[21]	Unmet Need for FP, married women[22]	Maternal Mortality Rate per 100,000 Live Births[23]	Infant Mortality Rate per 1,000 Live Births[24]
Burundi	10.4	6.4	17.7%	32.4%	740	54.8
Ethiopia	96.6	4.8	27.3%	26.3%	420	44.4
Kenya	45.0	4.6	39.4%	25.6%	400	47.5
Rwanda	12.3	4.6	45.1%	20.8%	320	37.1
Tanzania	49.6	5.4	27.4%	22.3%	410	36.4
Uganda	34.9[25]	6.2	26.0%	34.3%	438[26]	31[27]

1.4 The Ugandan Context

Overview

Due to the country's high fertility rate, Uganda has one of the most youthful populations in the world, with slightly more than half of its population under age 15. As noted in the 2008 National Population Policy and Vision 2040, the high child dependency ratio is a major barrier to social transformation and development in Uganda. A large average family size makes it difficult for families and the government to make the requisite investments in education and health that are needed to develop high-quality human capital and achieve a higher level of socioeconomic development.[28] Family planning not only improves maternal and child health and survival, but also increases the economic well-being of individuals, families, communities, and nations and empowers women while promoting human rights for all citizens.[29] Strong national FP programmes also foster environmental sustainability.[30]

Uganda's population dynamics can be turned into a valuable demographic dividend if it emulates the policy roadmap followed by the East Asian Tigers—against which the country benchmarks itself in its long-term strategy, Vision 2040.[31] The demographic dividend refers to the economic benefit a society enjoys when fertility and mortality rates decline rapidly and the ratio of working-age adults significantly increases relative to young dependents. The dividend is not automatic—it depends on investments and reforms in three sectors: family planning, education, and economic policy. First, a country must undergo a steady decline in fertility to achieve a structure concentrated in the working ages. Voluntary FP programmes play an important role in reducing fertility desires and enabling couples to realise their reproductive preferences, thereby shaping a country's demographic path while simultaneously improving health and increasing savings across development sectors.[32] If only modest investments in family planning and education are made along with aggressive economic and governance policies, gross domestic product (GDP) per capita in Uganda is projected to reach $6,084 USD by 2040 (up from $506 USD in 2011). However, when more ambitious FP and education programmes are prioritised together with economic and governance policies, a demographic dividend of about $3,500 USD in GDP per capita could be realised, bringing it to more than $9,500 USD by 2040, achieving the country's Vision 2040[33] national development plan.[34]

Uganda's population has seen extreme growth from 9.5 million in 1969 to 34.9 million in 2014.[35] With an annual growth rate of about 3.03 percent, the population is projected to reach 47 million by 2025 and continue to increase.[36] Rapid population growth is fuelled by the high fertility rate in Uganda. High fertility is a result of sex preference, early marriage, high school drop-out rates for girls, and unintended pregnancies as a result of low contraceptive use.[37]

Although the overall population is growing, Uganda has seen a reduction in the total fertility rate from 6.9 live births per woman in 2000 to 6.2 per woman in 2011. However, with more than half of the total population being ages 15 and under, even with increased FP use and continued decreases in fertility, a shift in population distribution will take time.[38,39,40]

To meet the Vision 2040 goals, Uganda is taking progressive steps towards socioeconomic transformation goals.[41] Over the past three decades, the country has made strong progress in socioeconomic development, moving from a state of recovery to economic growth. The GDP growth averaged a 7 percent increase per year between 2000 and 2012.[42] In addition, Uganda has already met two of its 17 MDG targets—halving the number of people living in absolute poverty and achieving debt sustainability—and is on track to achieve another eight.[43]

Despite advances in socioeconomic indicators, Uganda faces key health and developmental challenges to achieving its strategic goals. Vision 2040 clearly outlines the demographic challenge as a priority for the country to achieve middle-income status by 2040.[44] The high rate of population growth creates strains on the country's natural resources, which in turn drives up the poverty rate and threatens future development gains. This priority is further reflected in the 2008 Population Policy, which calls for a rapid demographic transition from high to low fertility and child mortality rates to

reduce the high child dependency ratio and stimulate economic development.[45] If successful in lowering fertility and child mortality rates, Uganda will be better placed to harness a dividend for economic growth as desired in the Vision 2040.[46]

Figure 3 provides a list of current key development indicators and targets pertaining to FP outcomes.

Figure 3: Development indicators: Baseline and Vision 2040, MDG 2015, GOU of Uganda, and FP2020 targets

	Baseline	Target
Annual population growth rate	3.03% (UBOS)	2.4% (Vision 2040)
Percentage of population below the poverty line, 2009/10	24.5% (MDG)	5% (Vision 2040)
Per capita income	$506 USD (Vision 2040)	$9,500 USD (Vision 2040)
Income distribution (GINI Coefficient)	0.43 (Vision 2040)	0.32 (Vision 2040)
Total fertility rate (children per woman)	6.2 (UBOS)	
Maternal mortality rate per 100,000 live births	438 (MDG)	131 (UBOS)
Unmet need for FP (married women)	34.3% (UBOS)	10% (FP2020)
Modern contraceptive prevalence rate (married women)	26% (UBOS)	50% (RHCS 2009)
Infant mortality rate per 1,000 live births	54 (MDG)	31(MDG)
Under 5 mortality rate per 1,000 live births	90 (MDG)	56 (MDG)

FP2020[47]
MDG[48]
RHCS 2009[49]
UBOS[50]
Vision 2040[51]

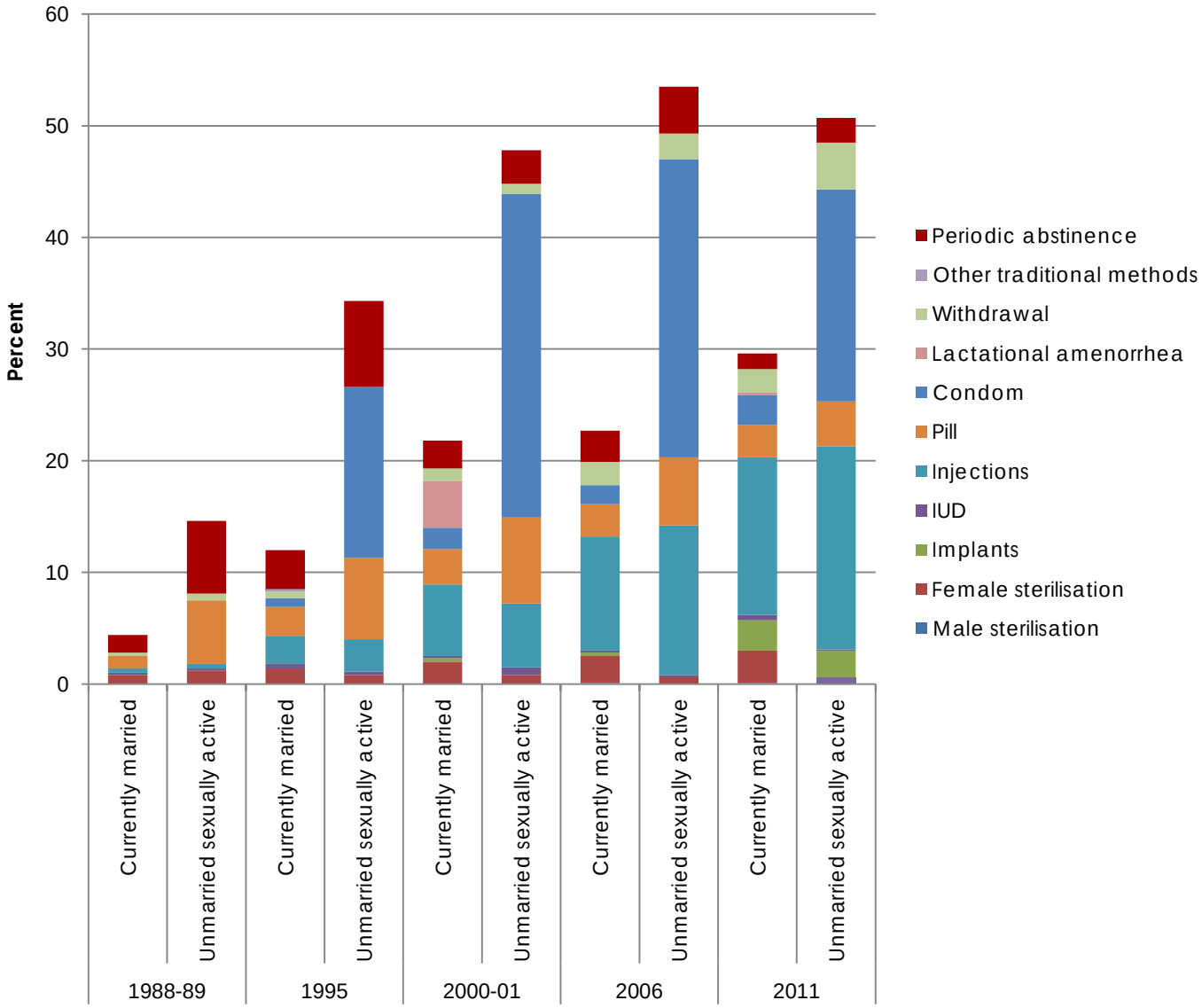
Unmet need

Unmet need is the percentage of women who want to space their births or do not want to become pregnant but are not using contraception.[52] Unmet need in Uganda is at 34.3%percent, with 21 percent in need of spacing and 14 percent in need of limiting. This is a decrease from 41 percent in 2006.[53] Poor access to quality family planning services characterized by few skilled providers and inadequate commodities that give the client little or no choice of methods of family planning and undermines the ability of men and women to freely decide on the number and spacing of their children contributes to high levels of unmet need in the country. High unmet need also contributes to unplanned pregnancies—43 percent of all pregnancies in Uganda are unplanned.[54]Women in rural areas report higher levels of unmet need at 37 percent compared to their counterparts in urban areas at 23 percent.[55] Also, women in the lowest wealth quintile have the highest levels of unmet need at 42.3 percent, compared to women in the highest wealth quintile at 22.9 percent.[56]

Contraceptive use

In 2011, 30 percent of married women of reproductive age (15–49 years) were using family planning methods—an increase from 15 percent in 1995 and 24 percent in 2006.[57] Use of modern FP methods increased considerably, with the mCPR increasing from 8 percent to 26 percent between 1995 and 2011.[58] Despite this positive trend, the mCPR is still far below the goal of 50 percent set by the Ministry of Health.[59]

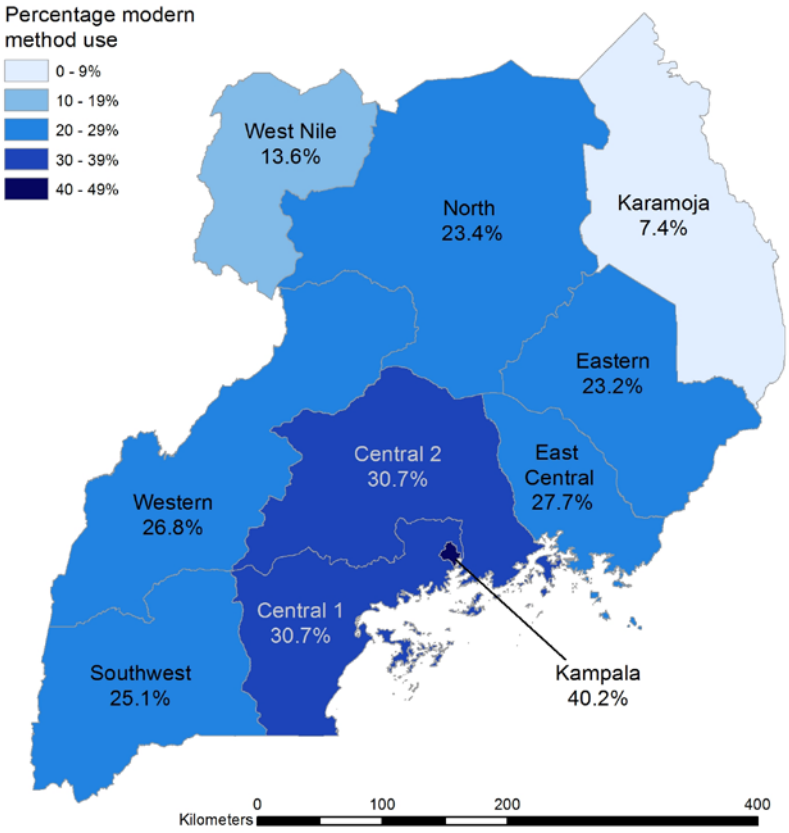
Figure 4: Contraceptive use trends amongst married and unmarried sexually active women, 1988/89–2011[60]



Disparities in contraceptive use exist by age, marital status, education, socioeconomic status, and rural-urban geographic location. Unmarried women of reproductive age have a substantially higher use of modern contraceptive methods compared to married women.[61] CPR is higher amongst those with higher schooling, at 38 percent for those with secondary education and only 16 percent amongst those with no education. The poorest women have the lowest levels of use, 39 percent of women in the highest wealth quintile use family planning, compared to those from the lowest wealth quintile who have a CPR rate of only 13 percent (UDHS, 2011).

Women in urban areas have a higher contraceptive prevalence rate (CPR) compared to women in rural areas. There are also clear regional differences. For example, Kampala has the highest CPR at 40%, and Karamoja in the Northeast region has the lowest at 7%.[62]

Figure 5: Modern method use by sub-region, percent currently married women using any modern contraceptive method, 2011[63]



Unintended pregnancies

Unintended pregnancies lead to high levels of unplanned births, unsafe abortions, and maternal injury and death. According to the 2011 Uganda Demographic and Health Survey, more than four in 10 births (43%) are unplanned.[64] Unplanned births are substantially higher amongst rural, poor, and less educated women than amongst their urban, wealthier, and better educated counterparts.[65]

Seventy-seven percent of Uganda's population is under age 30.[66] Thirty percent of Ugandans are between ages 10 and 19.[67] Adolescents and young adults are particularly at risk for unintended pregnancy, as CPR is lowest amongst married young people ages 15–24 years at only 11 percent—a serious concern given the youthful population of the country.[68] Twenty-five percent of teenage girls in Uganda are either pregnant or have given birth. More than half of young women have had their first sexual encounter before age 18.[69] In addition, 43 percent of girls in one study of rural Ugandan secondary school had been "very unwilling" during their first sexual experience; another study found that 20 percent of women in a rural area reported that they had been threatened or forced into having their first sexual experience.[70] Faced with threat and/or force, women, particularly young women, are often unable to negotiate contraceptive and condom use and are at increased risk for unwanted pregnancy, STIs, and HIV, necessitating access to emergency contraceptives to prevent unwanted pregnancy and post-exposure prophylaxis to reduce HIV transmission rates.

To reach the MDG on reducing maternal mortality, Uganda must reduce its maternal mortality ratio by three quarters to 131 per 100,000 live births by 2015.[71] In Uganda, the most substantial contributor to maternal mortality is haemorrhage, accounting for 42 percent of maternal deaths, followed by obstructed or prolonged labour and complications from abortion at 26 percent.[72] Reducing unwanted pregnancies through accessing and utilising family planning will curb a high proportion of maternal mortality. It is important to note the indirect causes of maternal mortality, including malaria, anaemia, and HIV/AIDS.[73] These causes have attributed to the lack of significant progress in the goal to reduce maternal mortality and exacerbate the negative impacts from unmet need.[74]

1.5 Key Issues and Challenges

Uganda has, over the years, enhanced the capacity of institutional and social structures at national and subnational levels to mobilise communities and deliver family planning services. The FP programme, however, continues to face a number of challenges and constraints that must be addressed to meet the country's FP goals of a 50 percent CPR and 10 percent unmet need by 2020.

Satisfying existing and creating additional demand

Knowledge of family planning is an important determinant of increased FP uptake.[75] The majority of Ugandans know at least one method of contraception.[76] However, youth often remain ignorant about family planning and contraception, and the engagement of parents in the sexual education of their children is low.[77] Modern contraception uptake is challenged by misconceptions or misinformation and misinterpreted side effects.[78, 79] Culture and religious ties also serve as substantial barriers to increasing the mCPR.[80] Other barriers to FP use include personal or partner opposition to contraceptive use, reliance on breastfeeding or postpartum amenorrhea as an FP method, and fear of adverse health effects.[81] Furthermore, amongst women who start using contraceptives, 43 percent discontinue within 12 months; and of the 43 percent, at least 16 percent can be attributed to the fear of side effects or other health concerns.[82]

Figure 6: Ongoing interventions and remaining gaps for satisfying existing and creating additional demand

- The National Family Planning Advocacy Strategy, 2005–2010, is in place; however, it is due for review.
- The policy for community-based distribution of injectables was developed; however, since the pilot, there has been no optimal scale-up of the intervention.
- The male involvement strategy for supporting sexual and reproductive health and rights is in place, but the male action groups created in some districts need to be introduced throughout the country.
- The momentum and advocacy for increasing FP budgets at the national and lower local governments should be sustained.
- National champions exist; however, the programme needs to be extended to the district and community level.

In Uganda, gender inequalities commonly affect women's ability to make decisions in the household.[83] The power dynamic in many cases limit a woman's ability to use contraceptives, resulting in low FP uptake. In addition, even when men are not opposed to women's FP use, they often consider family planning a women's issue.[84] There is a well-accepted belief in Uganda that religion prohibits the use of modern FP methods. This creates an impediment for demand.[85]

Service delivery and access

Family planning counseling and commodities should be accessible for both men and women, including youth. There are numerous supply-side barriers to accessing contraception in Uganda; for example, clients are often unable to access care due to geographical distances and the lack of supplies or equipment at facilities. Rural populations and the poorest populations in urban areas also face continuing access issues.[86] With the majority of Ugandans residing in rural areas, distance to health

facilities is a barrier to FP access for nearly 41 percent of women.[87] Those who decide to use family planning often find distance to a facility providing FP services a barrier to access.[88] Additionally, stock-outs of FP commodities at facilities further impede access.[89] Reducing inequities related to poverty, HIV status, gender, age, and marital status in access to and use of family planning are continuing challenges. Married and unmarried sexually active youth also face challenges related to access and cost of FP services.[90]

In Uganda, almost half of current FP users obtain their modern contraceptive methods from the public sector.[91] The remaining 45 percent access family planning through private hospitals or clinics.[92] Private pharmacies, mobile clinics, and village health teams (VHTs) constitute less than 5 percent of the market share.[93]

The Ugandan National Health System comprises the public and private sectors, with the government operating 54 percent of all health facilities.[94] The public health delivery system comprises all MOH health facilities, health services of the Ministry of Defense, Education, Internal Affairs (Police and Prisons), and the Ministry of Local Government.[95] The private sector includes private not-for-profit providers, private health practitioners, and traditional and complementary medicine practitioners.

Health service delivery is decentralised, with districts and sub-districts responsible for delivery and management of health services at lower levels. The health system is organised through a hierarchical system, with each higher level carrying out more specialised functions and supervising the lower level.[96] This hierarchical system in Uganda is designed around three referral levels consisting of

Figure 7: Ongoing interventions and remaining gaps for service delivery and access

- Service providers in both public and private health facilities have been trained in the provision of long-acting FP methods through a public -private partnership; however, this training needs to be scaled up.
- Several models of service delivery are employed, including routine service provision, outreach, social franchising (through the private sector), and community-based distribution of commodities.
- Efforts to scale up service delivery using task sharing have been implemented, such as community-based distribution (CBD) of injectable contraception by VHTs, tubal ligation by trained clinical officers, and provision of long-acting FP methods by midwives; however, this has been mainly on a pilot basis.
- Promotion of long-acting methods through public-private partnerships is beginning to result in an increase in the CPR specific to these methods.
- Innovations such as the voucher scheme, postpartum IUD, and postpartum FP are increasing access.
- Integration of FP into other services is a key intervention being used to scale up FP service provision and coverage.

- The primary level, which includes the VHTs, Health Centre IIs, Health Centre IIIs, Health Centre IVs, and general hospitals
- The secondary level, which includes the regional referral hospitals (12) and other private not-for-profit hospitals with large bed capacities
- The tertiary level, which includes national referral hospitals (3) and other highly specialised hospitals[97]

Hospitals make up 3 percent of all health care facilities, and Health Centre IVs make up 4 percent of all health care facilities.[98] Seventy percent of all health care facilities are Health Centre IIs.[99]

Health service delivery is decentralised, with districts and sub-districts responsible for the financing, delivery, and management of health services. Districts face several challenges, including the recruitment and retention of human resources for health, especially at lower levels of health facilities.[100]

Shortages of human resources for health (HRH) have severely hampered the scale-up of FP service delivery.[101] The numbers of skilled medical staff are too few in comparison with the need.[102] The current staffing, skill level, and service structure within the Ugandan health care system do not provide adequate and equitable FP services to the population. Without adequate training, time, supplies, and equipment to provide services, health care workers struggle to perform their duties and adequately council clients on contraceptive methods.[103] Health care providers often operate with minimal supervision due to a lack of resources, and support management is a continuing challenge. The lack of performance incentives also contributes to low motivation and poor performance amongst providers, inevitably affecting quality of service delivery.[104]

Figure 8: Staffing by level of health facility, 2013[105]

Facility Level	Number	# of Staff Required	# of Filled Positions	Staffing Level (%)
National referral hospital	2	2,883	2,239	78
Regional referral hospital	14	4,744	3,820	81
Specialised institutions	3	645	471	73
District health office	105	1,155	938	81
Municipal health office	21	189	184	97
General hospital	42	7,790	5,313	68
Health Centre IV	179	8,640	6,734	78
Health Centre III	936	17,746	13,399	76
Health Centre II	1,618	14,364	7,096	49

As of December 2013, the combined staffing level at central-level institutions (national referral hospitals, regional referral hospitals, and specialised institutions) was 79 percent; the combined staffing at decentralised health facilities and management offices at the district local government and municipal council levels was much lower at 67 percent. FP service delivery is impeded due to turnover as a result of low wages, rural placement, and being overstretched.

Capacity is a central part of HRH. Regulations that limit what level of provider can offer services further restrict FP services available at various health centre levels. Depending on the level, health care workers may only be able to offer short- or medium-term FP methods and not long-term methods. Further, pharmacies cannot dispense many modern contraceptive methods.

Figure 9: Staffing in public health sector for selected cadres of health workers[106]

Cadre	# of Staff Required	# of Filled Positions	Staffing Level (%)
Doctors	1,296	936	72
Nurses	19,946	16,584	83
Midwives	6,061	4,607	76
Clinical officers	2,758	2,780	101
Laboratory staff	2,758	2,780	101
Anesthetic staff	725	215	30
Pharmacists	370	31	8
Dispensers	430	232	54

Other allied health staff	1,177	820	70
Cold chain technicians	284	115	40
General administrative cadres	1,337	1,356	101
Health administration staff	374	124	33
Support staff	8,622	4,573	53

The overall staffing level in public facilities increased by 14 percent between 2009 and 2013.[107] However, the staffing level for the majority of cadres of health care workers remains low. The staffing level for doctors is 72 percent, nurses 83 percent, and midwives 76 percent. Several crucial cadres of health workers are in even more limited supply, including pharmacists (8%), anesthetic staff (30%), and cold chain technicians (40%).[108]

The low number of skilled FP providers in Uganda further impacts the access, coverage, and distribution of FP services.[109] There are challenges around resources for in-service training, insufficient coverage of FP topics in pre-service curricula, and transitioning of trained providers to other health services.[110] Health care providers leave training without the sufficient skills to provide high-quality FP services. Turnover due to low wages, rural placement, and being overstretched is another challenge. Understaffing and resource constraints have contributed to a weak supervision system. Medical officers with clinical and administrative responsibilities have little time for adequate supervision and lack resources for making regular site visits.[111]

The ratio of health workers to the population remains poor, as the ratio of doctors to the national population is estimated at 1: 24,000; the midwife to population ratio is 9,000 and the nurse to population ratio is 1,700.[112] Moreover, the staffing level is skewed in favour of specialised health institutions and larger health facilities, such as regional referral hopistals, while health centre IIs have a greater shortage of staffing. [113] This suggests a poorer quality of service delivery in the lower and peripheral health facilities, owing to a shortage of skilled human resources as well as poor geographical, temporal, and financial accessibility of health services.[114]

The VHT programme was established to bring primary and preventative health services closer to communities. However, challenges in the current VHT system include the diverse background and capacity of providers (e.g., traditional birth attendants, community-based distributors, etc.) and the varying levels of training in health service delivery. In addition, VHTs work as volunteers. There is no clear and sustainable mechanism for their payment within communities. This affects their motivation and the attrition/high turnover rate.[115]

Turnover amongst health workers is also high. The percentage of health workers who were trained and remained in the role for two years was under 50 percent.[116] Guidelines and service protocols for service providers also need updating. These policy updates are necessary to strengthen counselling skills and address provider bias and attitudes and to ensure that services are provided in accordance with human rights and quality of care standards.[117] The responsibility for in-service training of service providers currently resides at the central level with the Ministry of Education. Therefore, coordination amongst the ministries is crucial to strengthening the FP HRH force.

There is a National Strategy for Integration of Sexual and Reproductive Health and Rights and HIV/AIDS in Uganda, but there are several missed opportunities to integrate, promote, and provide family planning as part of other health services, including postpartum, HIV-related, post-abortion care, and child immunization services. Even when providers for these services lack the time or skills to provide direct services, they can assess the need for family planning and refer clients to another source. Referral systems, however, also need strengthening.[118] At a minimum, this requires that the referring provider has (1) knowledge of what FP services are available at referral centres and (2) a

mechanism to link clients to those centres. Examples might include vouchers for FP services or a linked records system.

Contraceptive security

The availability of a reliable supply of high-quality contraceptives is essential to ensuring that FP demand is met at all levels. Health facilities are often not adequately stocked with FP commodities due to challenges with contraceptive security. This is particularly relevant for long-acting and permanent methods.[119] Availability of FP commodities has increased in recent years. The availability of injectable contraceptives increased from 69 percent in 2012 to 94 percent in 2013.[120] For oral pill contraceptives, there was also an increase from 63 percent to 84 percent.[121] Strengthening the FP commodity supply chain resulted in a substantial reduction in stock-out reports, including no stock-outs of Depo-Provera in 2012/13.[122]

Uganda has an Essential Medicine and Health Supplies List (EMHSLU) that contains all contraceptives classified by level of care. This document is revised to keep up with new developments in technology and therapeutics and guides the national procurement agencies to select the FP commodities for use in Uganda.

The Quantification and Procurement Planning Unit within the Pharmacy Division of the MOH serves as a single, centralised system for quantifying national requirements of essential medicines and health supplies to ensure that appropriate products at adequate quantities are supplied on a timely basis.[123] Implementation of the Contraceptive Procurement Strategy, developed with support from partners, has led to a dramatic reduction in the percentage of contraceptive stock-outs.[124] However, the current system for quantification, ordering, and distribution from national to district levels, and from districts to facilities and end users, faces challenges. Forecasting is not done in tandem with the budgeting cycles. Quantification is also constrained by lack of programme data on distribution, demand, and use.[125] There is limited involvement of the private sector in RH supply chain management, especially during the forecasting process, and this limits its ability to acquire the required intelligence to guide market development efforts.[126]

A combined Family Planning/Reproductive Health Commodity Security Working Group, led by the MOH, meets quarterly to coordinate partners and review stock levels and shipments.[127] The working group has developed a comprehensive supply plan and coordinates the distribution of commodities. In addition, the Maternal and Child Health Working Group and Medicines Procurement and Management Technical Working Group are Ministry of Health structures that bring together Ministry of Health, development partners, private sector and civil society to, amongst others, discuss matters related to FP including contraceptive security and reviewing commitments made.

National Medical Stores (NMS) is mandated to procure, store, and distribute commodities for public health facilities. Joint Medical Stores (JMS), a channel of health commodity access for the private sector, does not handle FP commodities because of religious principles, leaving a gap in access for the private sector. To increase availability, access to, and use of FP commodities, the Ministry of Health developed the Alternative Distribution Channel Strategy to make available free public sector commodities in the private not-for-profit (PNFP) sector and private for-profit (PFP) sector.[128] This has greatly increased the total commodities distributed from the central warehouses. Institutionalisation of the Alternative Distribution Strategy is still ongoing. In addition, a large segment of the population accesses FP commodities through social marketing efforts, which are significantly subsidised by development partners. The Ministry of Health, with partners, is piloting the Total Market Approach (TMA) in the bid to increase access to FP services and commodities across all the FP market segments (public, PNFP, PFP, and social marketing).

A push system involving sending pre-packaged kits for medicines and health supplies is used for lower-level government health facilities (HC 2 and HC 3) with limited capacity to make requisitions. MOH and partners support regular review of the kit system to improve responsiveness. A pull system

is used for higher-level facilities; this means that health facilities place orders for contraceptives and other essential drugs, depending on their stock on hand and past consumption data. Minimum and maximum inventory levels are established at two months and five months of stock to forecast upcoming need. First-expiry, first-out stock management is followed, and expired or damaged products are separated from other supplies based on the guidelines. Stock taking is required on a monthly basis.[129]

The National Drug Authority established by the National Drug Policy and Authority Act mandates the availability and supply of contraceptive supplies. The Act regulates quality to ensure safe, efficacious, and cost-effective care for the population.[130]

In 2010, the MOH published Policy Guidelines and Service Delivery Standards for Community-Based Provision of Injectable Contraception in Uganda, which is an addendum to the Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health. The policy guideline makes it possible for VHTs to provide injectable contraception.[131]

Figure 10: Ongoing interventions and remaining gaps for contraceptive security

- One harmonised national quantification for all sectors (public, PNFP, Private and social marketing) exists
- There is strong central level stock monitoring, however, there is need for continued support of the coordination roles
- Institutionalization of the alternative strategy is still ongoing
- The second major supplier of EMHS, Joint Medical Stores, does not carry contraceptives
- GOU and partners are gradually working towards a transition from push to pull system for lower level facilities
- Involvement of the private sector in supply planning and commodity tracking is still inadequate.

  Real-time reporting of consumption and stock status at facility level remains inadequate.
- Task sharing/ shifting strategies being used to address the HR issues in the short to medium term.

The MOH developed the Reverse Logistics Strategy to facilitate the redistribution of contraceptives between health centres at the district level and the National Medical Stores.[132] In situations where a health unit experiences a stock-out, additional supplies may be picked from a health unit with surplus, thus enabling those out of stock to restock from others in the district. Although the logistics strategy is in place, challenges include weak capacity and poor linkages between reproductive health commodities planning, procurement, and distribution with the budget cycles at national and district levels.[133] There is no centralised or coordinated system for the logistics management information system (LMIS) reporting.[134] Stock-outs are reported to National Medical Stores, while other LMIS information is sent to the Resource Centre at the MOH. The LMIS form (HMIS 018) lacks essential logistics data (consumption data, losses, and adjustments); yet, this is the form used to collect RH commodity data.[135] This is further complicated by lack of a dedicated budget for LMIS; there is no system for sustaining the availability of logistics tools.

There are also capacity challenges for the inventory management system, including but not limited to a lack of guidelines for storage, destruction, withdrawal, and re-distribution of commodities between and across levels and providers.[136]

Policy and enabling environment

The current policy environment is conducive for strengthened implementation of the FP programme in Uganda. Family planning is recognised as a key strategy to promote social, economic, and environmentally sustainable development, to realize sexual and reproductive health and reproductive rights, and to improve the health of women and their children by preventing unintended pregnancies and improving child spacing, thus reducing maternal and neonatal morbidity and mortality.[137] Family

planning has the highest level of support from the President of the country, who pledged to commit $5 million USD (12.5 billion UGX) annually to funding FP services in Uganda at the London FP 2020 Summit in 2012.[138] The President further committed to reduce unmet need for family planning to 10 percent by 2020.[139]

The Government of Uganda has shown commitment to improve the quality of life through focusing on creating an enabling environment for sexual and reproductive health services—of which family planning is an integral component.[140] While Uganda has developed various policies, guidelines, and strategies, implementation remains a challenge to reaching the goals of the country and FP2020.[141] However, family planning is not adequately mainstreamed and budgeted under other relevant strategies of other sector ministries. In particular, understanding of the centrality of family planning to harnessing the demographic dividend is lacking amongst policymakers and implementing partners.

Figure11: Ongoing interventions and remaining gaps for policy and enabling environment

- The GOU's FP2020 commitments make a strong policy stance in favour of improving the policy environment for family planning.
- FP commodities are included in the Uganda Implementation Plan for Life-Saving Commodities for Women and Children.
- Key RMNCH-related policies integrate family planning holistically.
- However, task sharing of family planning has yet to be operationalised
- Family planning has yet to be concretely embedded in broader development issues and addressing family planning on a multisectoral level across line ministries remains a challenge.

Financing

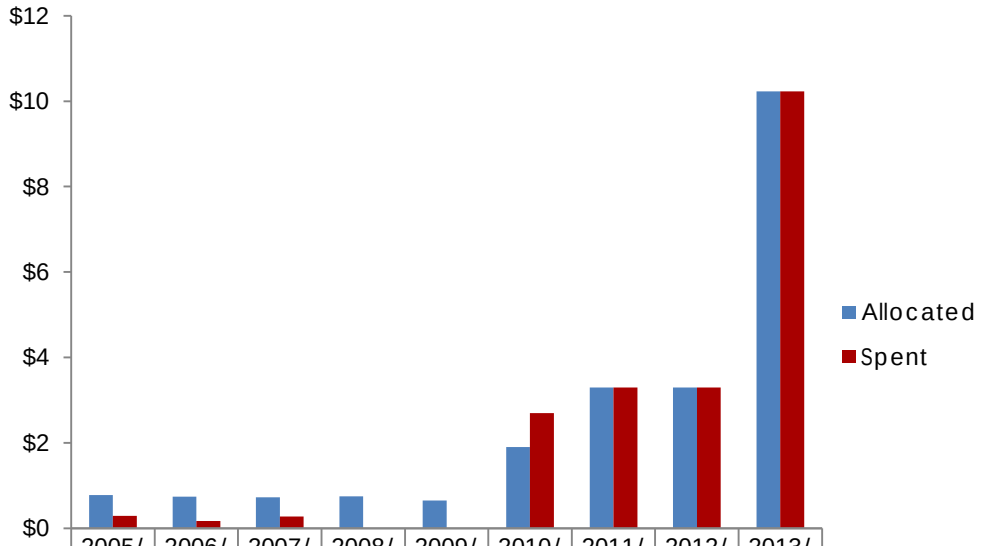
The government allocated 8.6 percent of the 2013/2014 approved budget to the health sector.[142] The majority of health funding comes from donor organisations, with between 50 percent and 70 percent of the MOH budget for drugs and services provided by donor organisations.[143] There are several other challenges in financing FP services, including donor fatigue; despite the growing demand, funding is inadequate to match the needs. In addition, there is a lack of funding for FP services for youth.[144]

Recent FP advocacy efforts have had positive effects on increasing financing for reproductive health commodities. The GOU commitment to improve FP indicators is reflected in an increase in funding for reproductive health commodities from less than $1 million USD in 2009/10 to more than $10 million USD in FY2013/14.[145] This dramatic increase in funding is due to consistent political involvement, strong leadership of the advocacy community, high network strength, external expertise, and opportunity timing which, in combination, led to strong advocacy efforts, the passage of Vote 116 allowing for direct funding of NMS, and increased government commitment to budgeting for and fully expending the reproductive health commodity line item.[146]

Figure 12: Ongoing interventions and remaining gaps for financing

- Budget allocation from GOU to the health sector has increased by 20 percent over the Health Sector Strategic and Investment Plan period.
- Recent FP advocacy efforts have seen positive effects in increasing FP financial resources, especially towards commodities. More advocacy is required for the districts and lower local governments.
- Clear systems to track financial resources to "the last mile" need to be established.

Figure 13: Utilisation of GOU budget line for reproductive health commodities: Allocation versus expenditure, 2005/06–2013/14, in millions USD[147]



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Allocated	$0.78	$0.74	$0.73	$0.75	$0.65	$1.90	$3.30	$3.30	$10.2
Spent	$0.29	$0.17	$0.28	$-	$-	$2.70	$3.30	$3.30	$10.2

While the overall policy environment for family planning is positive, including the incorporation of FP/RH into the GOU's development and health frameworks, the government's strong policy and strategy commitments have not been accompanied by an equally commensurate dedication of national financial resources to meet the full need for FP services.[148] In particular, while funding for RH commodities has been growing over recent years, accompanying equipment and supplies remain unfinanced.[149] In addition, the alternative distribution system does not currently receive government financing. And FP (or even health) financing at the district level is not monitored systematically.[150, 151]

Stewardship, management, and accountability

Clear leadership responsibility and authority are essential for repositioning family planning in the multisectoral environment. Current bottlenecks in supervision, monitoring, and coordination include limited dedicated staffing resources at the national and district levels.[152] The RH department requires the visibility within other sector ministries to carry out the responsibility to mainstream FP activities in a multisectorial environment. The RH division of the Community Health Department faces human resource limitations. The staff managing FP activities are also responsible for a variety of other activities and are thus overburdened and unable to effectively manage their responsibilities. In addition, a lack of clear systems and processes to supervise, monitor, track, and coordinate government and partner activities at the national and decentralized levels has hampered the overall management of FP activities in Uganda.[153]

Figure 14: Progress and remaining gaps for stewardship, management, and accountability

- There is strong MOH collaboration with private sector partners, especially private not-for-profits.
- Some coordination of inter-ministerial efforts is ongoing.
- Civil society involvement in accountability monitoring is weak or non-existent.
- FP indicators are usually not present in key documents, especially in other related sectors.
- Supervisory and management skills of health staff needs to be strengthened.

SECTION 2: LINKAGE OF KEY ISSUES TO A STRATEGY

The linkages between the key issues identified in the situation analysis and the technical strategy are as follows (refer to the earlier section, Process and Formulation of the FP-CIP for details on the process):

Demand creation. Uganda has a high level of unmet need for family planning, meaning that many women who want to delay or limit childbearing are currently not using any FP method. Demand for and uptake of family planning can be increased by expanding knowledge and addressing myths and misconceptions through public visibility and campaigns. Dissemination of accurate information about FP methods and their availability and encouragement of FP use to promote the health of women and their families will increase knowledge of, and demand for, family planning. Champions and advocates can increase demand for family planning within communities, producing a supportive environment; reducing social, cultural, and religious barriers; and mobilising community support.

Service delivery and access. As discussed in the situation analysis, the current staffing, skill level, and service structure within the Ugandan health care system do not provide adequate and equitable FP services to the population. Without adequate training, time, supplies, and equipment to provide services, health care workers struggle to perform their duties and adequately council clients on contraceptive methods. It is necessary both to bolster the current delivery system and to deploy new FP service approaches to optimise availability and accessibility. Reducing inequities related to poverty, HIV status, gender, age, and marital status in access to and use of family planning are continuing challenges. These inequalities need to be addressed through clear policy, programming, and financing commensurate to need. Rural populations and the poorest in urban and rural areas also face continuing issues of access and equity that need to be addressed through high-impact strategies.

Contraceptive security. Maintaining a robust and reliable supply of contraceptive commodities to meet clients' needs, prevent stock-outs, and ensure contraceptive security is a priority for the program to achieve its goal. It is crucial to ensure that contraceptive commodities and related supplies are adequate and available to meet the needs and choices of FP clients. The activities of this strategic priority will be implemented in line with other commodity security plans of the MOH. Providing a full method mix of FP methods to meet the changing needs of clients throughout their reproductive lives not only increases overall levels of contraceptive use, it also ensures they are fully able to exercise their rights and be able meet their reproductive goals. Modern method use will increase and traditional method use will decrease as an overall percentage of the total method mix, as shifting users from less effective to more effective methods while maintaining the widest possible range of method choices allows women and families the ability to best fulfil their reproductive intentions. The method mix available influences not only successful client use and satisfaction, but also has implications for provider skills confidence and competence. In addition, specific activities will ensure that the contraceptives available in the country are of high quality. Currently, significant distribution challenges are a limiting factor in ensuring the availability of high-quality FP services at all levels of care. Specific activities will be undertaken to ensure that contraceptives are delivered through the "last mile" to the health facility to ensure RHCS throughout the country.

Policy and enabling environment. Although family planning has been recognised in policy as a key element in improving national health and development, the enabling environment for family planning remains weak; and a lack of political will, commitment, and clear message from leaders has hampered policy implementation. In addition, key stakeholders and implementers are often unaware of policy implications for their work, as policy dissemination is often inadequate. The policy strategy focuses on advocacy for family planning within various levels and sectors of the government to ensure the right policies are not only present but also fully implemented.

Financing. To address the distance between the overall positive policy environment for family planning and the low allocation of national financial resources to fully meet the need for FP services,

advocacy and monitoring will be a key driver for increasing government allocations. As the tracking of family planning (or even health) financing at the district level is not monitored systematically, processes will be institutionalised to better monitor financing at all levels. Sustaining financing from development partners and improving value for money within family planning are also important drivers for system-wide change.

Stewardship, management, and accountability. To meet the targeted increase in mCPR and decrease in unmet need by 2020, strong monitoring, management, leadership, and accountability are necessary. Effective management and governance of FP activities at all levels is needed to ensure that family planning goals are reached. There are established forums for FP coordination led by the MOH; however, with numerous implementing partners and stakeholders involved, improved coordination with accountability mechanisms is needed. Better systems are essential to improve collaboration amongst partners and the MOH and to ensure that activities are implemented as a harmonised national effort. Upgrades in systems and processes to supervise, monitor, track, and coordinate government and partner activities at the national and decentralized levels will improve the management of FP activities in Uganda. With the increased range of activities, energy, and focus to meet the FP goals, it is essential that roles are redefined to support the priority areas and numerous activities under the FP-CIP. Strengthening the coordination of inter-ministerial efforts is vital to improving stewardship, and greater civil society involvement in monitoring will improve accountability at policy and programme levels.

SECTION 3. COSTED IMPLEMENTATION PLAN

The Ministry of Health developed the FP-CIP to clearly define the country vision, goal, strategic priorities, interventions, and inputs and to present the estimated cost to achieve them. The FP-CIP details the strategic priorities that will drive the government and nongovernment sector in increasing FP access to meet the ambitious national targets for increasing mCPR and reducing unmet need by 2020, as well as generally in increasing knowledge of and access to family planning without discrimination, coercion, or violence.

As detailed in the "3.4 Plan Alignment with National Policies and Strategic Plans" section, the FP-CIP aligns with the Health Sector Strategic Plan III for 2010/11–2014/15 and related strategic plans for HIV/AIDS, reproductive health commodity security, reduction of maternal and neonatal mortality, and adolescent health policies; however, the specific aim of the FP-CIP is to specify the interventions and activities to be implemented and to itemise the financial and human resources needed to meet the comprehensive national FP goals in order to help women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing, and support the achievement of gender equality. More broadly, voluntary family planning reduces preventable maternal mortality and morbidity, decreases unwanted teenage pregnancies, improves child health, facilitates educational advances, reduces poverty, and is a foundational element to the economic development of a nation.

3.1 Country Vision

- Universal access to family planning to help Uganda attain the middle-income country status by 2020

3.2 Operational Goals

- Reduce unmet need for family planning to 10 percent
- Increase the modern contraceptive prevalence rate amongst married and women in union to 50 percent by 2020[154,155]

3.3 Strategic Priorities

The strategic priorities in the FP-CIP represent key areas for financial resource allocation and implementation performance. Strategic priorities reflect issues and/or interventions that must be acted on to reach the country goals. Uganda's strategic priorities include specific outreach to population groups and detail key issues or interventions that cut across core components of an FP programme (i.e., supply, demand, and enabling environment).

The strategic priorities of the FP-CIP ensure that limited available resources are directed to areas that have the highest potential to reduce the unmet need for family planning in Uganda. In the case of a funding gap between resources required and those available, the priority activities should be given precedence to ensure the greatest impact and progress towards the objectives laid out. Priority activities allow for the MOH to focus resource and time investments for coordination and leadership for FP-CIP execution. However, all of the components necessary for a comprehensive FP programme (all of the activities that support, complement, and complete the FP programme) have been detailed with activities and costed; the strategic priorities of the plan will be used to guide national priorities for additional and new funding and programme development.

Five strategic priorities

- Priority # 1: Increase age-appropriate information, access, and use of family planning amongst young people, ages 10–24 years

- Priority # 2: Promote and nurture change in social and individual behaviour to address myths, misconceptions, and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies
- Priority # 3: Implement task sharing to increase access, especially for rural and underserved populations
- Priority # 4: Mainstream implementation of FP policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation
- Priority # 5: Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors

Intervention and activity mapping to strategic priorities and FP2020 commitments

The activities in the FP-CIP are structured around six essential components or Thematic Areas of an FP programme:

1. Demand creation
2. Service delivery and access
3. Contraceptive security
4. Policy and enabling environment
5. Financing
6. Stewardship, management, and accountability

The five strategic priorities and eleven FP2020 commitments are addressed through various activities under these six areas.

Figure 15: Costs for strategic priorities, by area, in millions USD

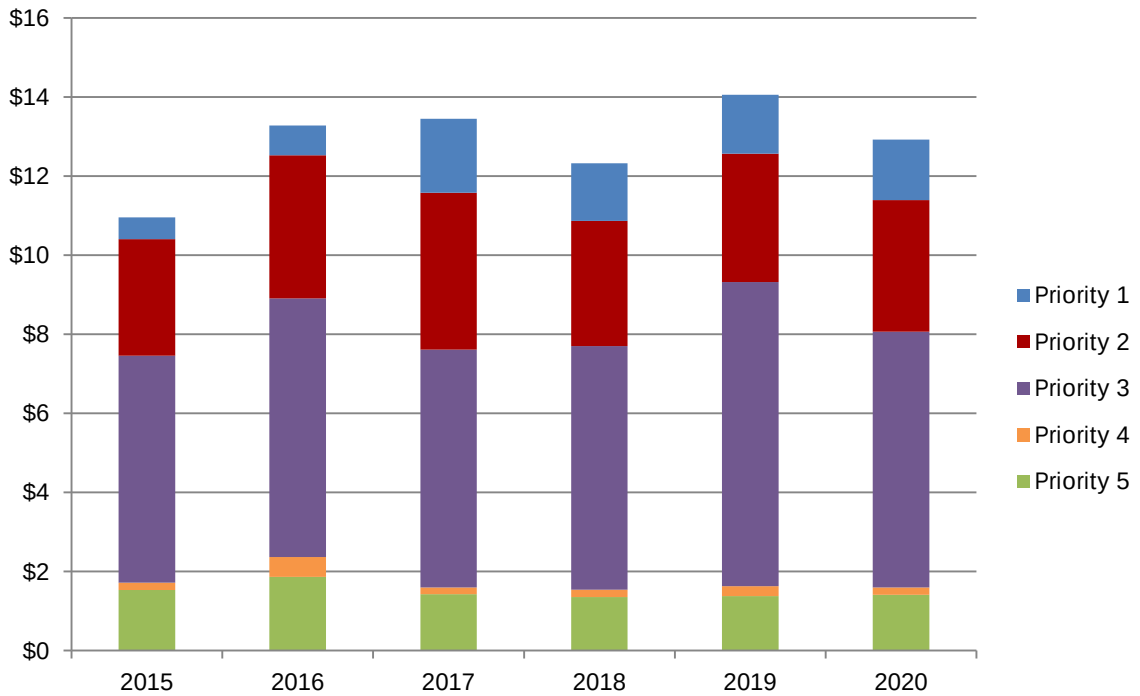


Figure 16: Costs for strategic priorities, by area, in millions USD

	2015	2016	2017	2018	2019	2020
Priority # 1: Increase age-appropriate information, access, and use of FP amongst young people, ages 10–24 years	0.554	0.754	1.865	1.453	1.489	1.526
Priority # 2: Promote and nurture change in social and individual behaviour to address myths, misconceptions, and side effects and improve acceptance and continued use of FP to prevent unintended pregnancies	2.944	3.614	3.972	3.164	3.243	3.325
Priority # 3: Implement task sharing to increase access, especially for rural and underserved populations	5.741	6.546	6.007	6.158	7.689	6.469
Priority # 4: Mainstream implementation of FP policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation	0.187	0.499	0.176	0.187	0.253	0.190
Priority # 5: Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors	1.532	1.864	1.426	1.358	1.381	1.410

Figure 17: Costs for FP2020 commitments, by area, in millions USD

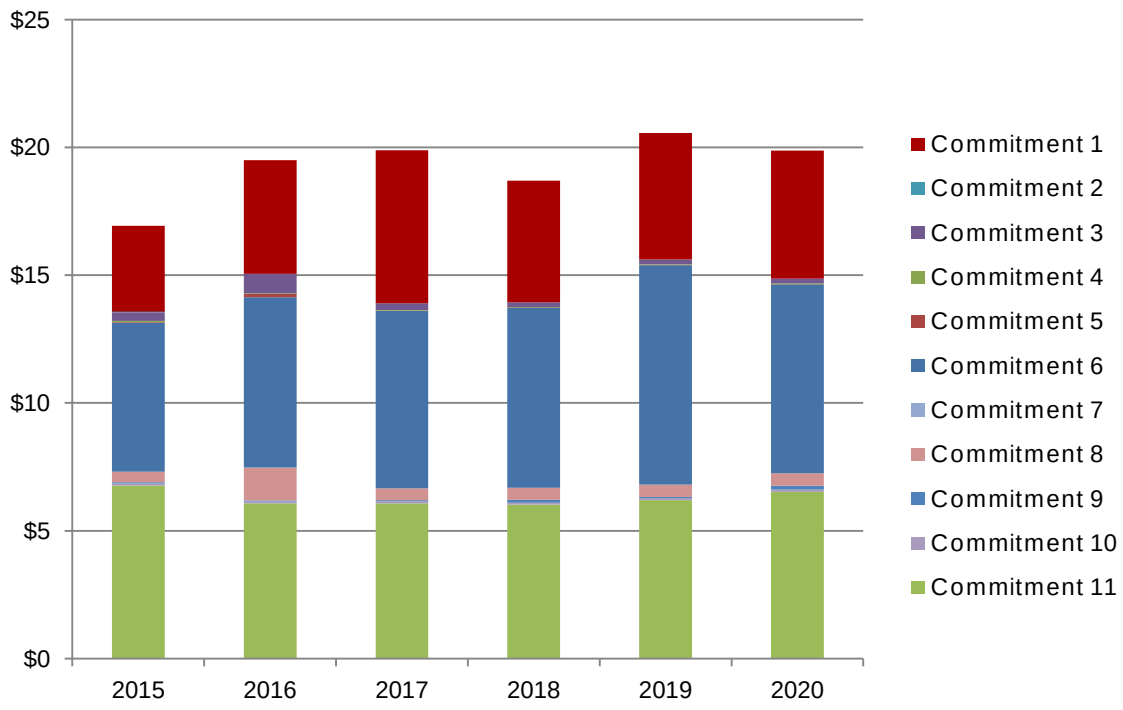


Figure 18: Costs for FP2020 commitments, by area, in millions USD

Costs by FP2020	2015	2016	2017	2018	2019	2020
Commitment 1: Develop and implement an integrated FP campaign	3.356	4.446	5.983	4.767	4.954	5.008
Commitment 2: Accelerate the passing of the National Population Council Bill into law, immediately making the inter-ministerial structure functional and appropriating the necessary budget support, through a supplementary request	0.020	-	-	-	-	-
Commitment 3: Improve RH commodity distribution and effective services delivery, review post-shipment testing policy to reduce delays in release of vital RH supplies, including FP supplies from the National Drug Authority	0.339	0.764	0.272	0.183	0.186	0.192
Commitment 4: Finance commitments	0.050	0.024	0.024	0.025	0.026	0.026
Commitment 5: Strengthen the technical and institutional functionality of the Uganda Health Marketing Group and National Medical Stores in a dual private and public sector RH supplies distribution system	0.027	0.129	0.006	0.006	0.007	0.007
Commitment 6: Scale up partnerships with civil society organisations and the private sector for FP outreach and community-based services, including social marketing, social franchising, and task sharing linked to a comprehensive training programme	5.830	6.654	6.943	7.029	8.582	7.385
Commitment 7: Partner with appropriate private sector bodies and institutions for the integration of maternal health and FP/RH and HIV/AIDS information and services for their employees and families	-	0.012	-	0.007	0.007	-
Commitment 8: Roll out youth-friendly services in all government Health Centre IVs and district hospitals	0.410	1.276	0.459	0.470	0.482	0.494
Commitment 9: Ensure timely completion of the annual household panel surveys by UBOS to ascertain progress on health, including FP service delivery; also carry out a robust evaluation of all FP investments in Uganda	0.043	0.044	0.045	0.111	0.048	0.153
Commitment 10: Conduct bi-annual joint supervision and bi-annual FP/RH national review meetings	0.076	0.076	0.078	0.080	0.082	0.084
Commitment 11: Strengthen institutional capacity of the public health facilities and community-based distributors to provide FP services and increase choice and quality of care at all levels	6.779	6.071	6.077	6.023	6.196	6.522

3.4 Plan Alignment with National Policies and Strategic Plans

Activities described in the FP-CIP serve to operationalise and interpret the principles, priorities, and policy guidance outlined in several pertinent directives and programmes of the GOU, as shown in Figure 19: Alignment of the FP-CIP with other government policies and strategies. Therefore, the FP-CIP represents a common plan with inputs from multiple source documents.

Figure 19: Alignment of the FP-CIP with other government policies and strategies

Policy/Strategy Document	Description	Alignment with FP-CIP
Health Sector Strategic Plan III, 2010/11–2014/15[156]	This plan prioritises sexual and reproductive health, focusing on • Strengthening information, education, and communication activities about sexual and reproductive health • Expanding provision of sexual and reproductive health (SRH) services • Strengthening the legal and policy environment to promote delivery of SRH services • Building institutional and technical capacity at national, district, and community levels for reproductive health (RH) • Strengthening adolescent SRH services	The FP-CIP identifies the resources needed to implement these priority interventions through several approaches included in • Thematic Area # 1: Demand creation, where communication strategies and materials will be developed and used through multiple media channels • Thematic Area # 2: Service delivery, where FP provision will be expanded through integrating FP service delivery in other health areas, conducting mobile clinics, enhancing private sector provision, and strengthening the VHT system and drug shops • Thematic Area # 4: Policy and enabling environment, which describes several advocacy activities, including ensuring the FP legal and policy environment is strengthened, and includes the participation of women, adolescents, and youth and marginalised and excluded population groups • Thematic Area # 5: Stewardship, management, and accountability, which will strengthen the capacity at the MOH to effectively lead, manage, and coordinate the FP programme • In addition, increasing access and use of family planning by young people is given much precedence as it is one of the five strategic priorities for the plan
National HIV/AIDS Strategic Plan 2015/16 –2019/20 NATIONAL HIV/AIDS STRATEGIC PLAN 2015/16- 2019/20 [157]	Objective 1: To Increase Adoption of Safer Sexual Behaviours and Reduction in Risky Behaviours includes activities to: scale-up comprehensive sexual and reproductive health (SRH)/HIV programs targeting, adolescents (both in and out of school) and young people; and provide a comprehensive package of SRH, HIV prevention, care and treatment through harmonized programming and ensure access by vulnerable populations such as women and	The FP-CIP further operationalises these objectives under Thematic Area # 1: Demand Creation, which will strengthen the knowledge of young people about family planning and reproductive health. Under Thematic Area # 2: Service Delivery, protocols for integrating family planning into HIV/AIDS services will be developed and rolled out into facilities; in addition, specific efforts will be made to improve service delivery and access to better serve youth and clients with disabilities. Under Thematic Area # 4: Policy and enabling environment, specific advocacy will be conducted to ensure that policies and guidelines for family planning promote access to FP services rather than

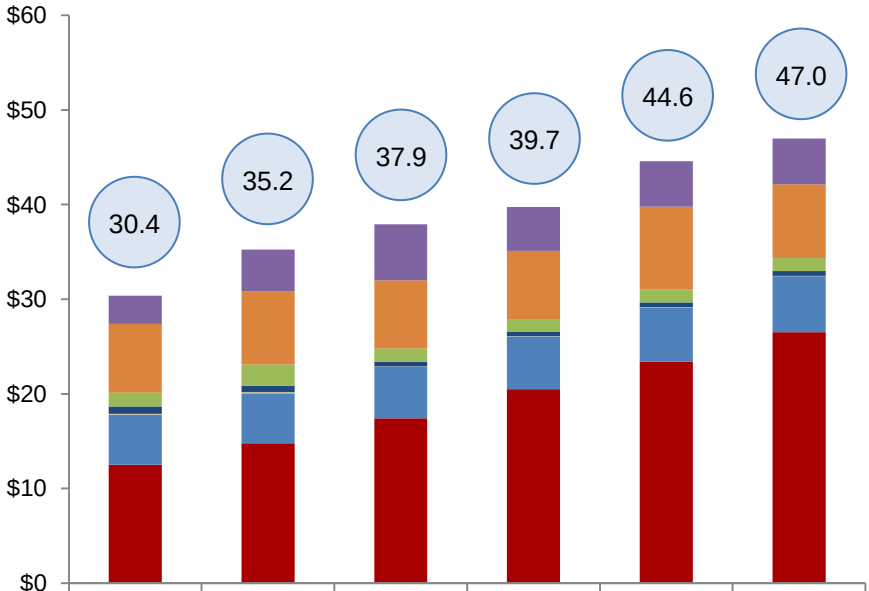
Policy/Strategy Document	Description	Alignment with FP-CIP
	girls and people with disabilities. In addition, to integrate SRH; maternal, newborn and child health (MNCH) and TB services with HIV prevention is included under Objective 2: To Scale-Up Coverage and Utilization of Biomedical HIV Prevention Interventions Delivered as Part of Integrated Health Care Services. Under Objective 4: To strengthen integration of HIV care and treatment within health care programs, an activity is to: integrate HIV care and treatment with maternal, newborn and child health, sexual and reproductive health and rights, mental health and non-communicable /chronic diseases.	hamper access for often-marginalised groups such as the rural population and youth.
Reproductive Health Commodity Security Strategic Plan, 2009/10–2013/14[158]	This plan intends to increase the proportion of health facilities with no stock-outs of selected RH commodities to 80 percent by 2015 and to increase public sector/government budget allocation and expenditure on RH commodities, including contraceptives, to 80 percent by 2015.	Contraceptive security is a strategic priority under the FP-CIP and a dedicated Thematic Area (# 3); the FP-CIP includes numerous approaches to increase resources for commodities; strengthen forecasting, quantification, and procurement of FP commodities; use innovative mechanisms to improve the supply chain of commodities from the central warehouse to facilities; and foster an enabling environment.
Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, 2007–2015[159]	Family planning is one of the three objectives of the roadmap, which has a focus on increasing access to and quality of services and building capacity of training institutions and service providers.	The service delivery area of the FP-CIP features interventions to expand access at all levels, including through integrating FP service delivery in other health areas, conducting mobile clinics, enhancing private sector provision, and strengthening the VHT system and drug shops; furthermore, the plan directs advocacy efforts to increasing the budget for training and support for midwives and nurses and reviewing pre-service curriculum to advance task-sharing practices.
Committing to Child Survival: A Promise Renewed, 2013[160]	The promise renewed calls for a prominent role by the members of the 9th Parliament to conduct constituency outreach activities to educate the population on reproductive, maternal, newborn, and child health, including extra effort placed on the Karamoja, Eastern, East Central, North, West Nile, and South Western regions.	Parliamentarians are recognised in the FP-CIP as one of the key sources of champions for family planning, and the goal is to establish and support a national coalition of FP advocates/champions.

Policy/Strategy Document	Description	Alignment with FP-CIP
National Adolescent Health Policy for Uganda, 2004[161]	This policy aims to double the contraceptive use rate amongst sexually active adolescents; it also targets a reduction in the proportion of women that have their first child before age 20 from 59 percent to 30 percent.	Increasing access for young people is a strategic priority for the FP-CIP, with a focus on increasing knowledge and access amongst young people ages 10–24, establishing youth-friendly corners in clinics, and extending service delivery hours to include outside school hours to better accommodate youth.
National Family Planning Advocacy Strategy, 2005-2010[162]	This strategy seeks to create an enabling environment that supports improved access to accurate information about family planning.	Strategic Priority # 4 is dedicated to an enabling policy environment—mainstreaming implementation of FP policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation. Thematic Area # 4, Policy and Enabling Environment, describes several advocacy activities, including ensuring that family planning is seen and used as a tool to achieve the demographic dividend and is considered a strong component of the health sector strategy. In addition, the legal framework and knowledge of policies for family planning will be improved, and a national coalition of advocates/champions to support family planning will be established and supported.

3.5 Thematic Areas

Across the six thematic areas, there are 43 total strategic outcomes for implementing a full FP strategy in Uganda. Each area is further detailed with expected results, activities, sub-activities, inputs, outputs, and timeline information (refer to Annex A: Implementation Framework with Full Activity Detail). Many of the strategic outcomes listed in this section map to an FP2020 commitment (2020) and/or a strategic priority (SP) (see Annex D for details).

Figure 20: Summary costs by thematic areas and total, in millions USD



	2015	2016	2017	2018	2019	2020
Demand	3.0	4.4	5.9	4.6	4.8	4.9
Service delivery	7.2	7.7	7.2	7.2	8.8	7.8
Contraceptive security	1.5	2.2	1.4	1.3	1.4	1.4
Policy and enabling environment	0.8	0.7	0.5	0.5	0.5	0.5
Financing	0.1	0.1	0.0	0.0	0.1	0.0
Stewardship, management, and accountability	5.3	5.3	5.4	5.6	5.7	5.9
Commodities	12.5	14.8	17.4	20.5	23.4	26.5

Demand creation

Strategy

The wide gap between knowledge about contraceptives and utilisation indicates a clear need for refocusing the FP programme and for change in the communication strategy to promote more widespread usage. Therefore, key interventions proposed aim to sustain support for family planning from the highest policy levels and promote public dialogue at all levels—from the national through to the community level—about the important role of family planning in promoting health and supporting development. By implementing national-level advocacy, along with on-the-ground community mobilisation, demand will increase as awareness and adoption do. The design of social and behaviour change communication (SBCC) campaigns will be harmonised across interventions, so communications to the public about family planning are accurately targeted with slogans and messages that are evidence-based and include target market segmentation to increase demand.[163] SBCC efforts will also be designed to ensure clear messaging to target current non-users of contraception who have high motivation to adopt,[164] as this population will then be best positioned to become FP champions to address myths and misconceptions to their non-user peers.[165] This will help lower the percentage of unmet need. High-impact, demand generation activities are included to close the knowledge-use gap by addressing cultural and religious beliefs that impact FP uptake and utilisation, myths and misinformation, and fear of side effects and health concerns that impede its adoption and continuous use. Innovative technology and multiple media outlets, such as mobile health platforms, will be integrated to maximise the success of the initiatives.

In addition, specific demand creation efforts will be targeted at men and youth. While men share responsibility for reproductive health, lack of focus on them can infer that family planning is not their

concern. Male involvement is crucial to a successful demand creation campaign.[166] Barriers for uptake include power and gender dynamics that inhibit women from making open decisions on family planning in their households. Dispelling myths and misconceptions amongst men is important to ensuring their support of family planning.[167]

Overall, successful SBCC campaigns will use formative and assessment research to inform the appropriate community-based strategy and methodology. It is important to create campaigns that are malleable for different cultural audiences.[168] For example, for campaigns to speak to the needs of the population, they should likely be region- or even district-specific. Multiple media outlets— including mass media; information, education, and communication materials; interpersonal communications; advocacy campaigns; and champions—will increase demand and uptake of services.[169] The formative research will outline the knowledge, attitudes, and perceptions of the audience so that the campaign addresses the actual needs of the target population.[170] Successful campaigns can result in increased demand, open acceptance of family planning in the home, increased knowledge and access to FP services, and advocacy amongst users for FP methods.[171] Further, the integration of services, included in Thematic Area # 2 Service Delivery and Access, is a strategy that is successful and sustainable to increase demand for family planning, particularly amongst hard-to-reach populations. Appropriate services for the integration of family planning include primary, postnatal, HIV/AIDS, and gender-based violence services.

Strategic outcomes

DC1. Demand for FP services is increased. To increase the percent of women ages 15–49 years with demand for family planning (met demand and unmet need), a communications strategy (including information packages for select media channels) will be developed to (1) ensure tailored honest, objective, non-judgmental, accurate, clear, and consistent messaging around family planning in a multisectoral dimension (i.e., family planning as a development intervention) and (2) target various audiences (rural/urban youth, adolescents in and out of school settings, married youth, men, people living with HIV and key populations at risk, people with disabilities, faith-based organisations, commercial sex workers, etc.). A mass media campaign will be developed and implemented, including radio spots, TV soaps/drama, print media, and mobile technology. In addition, non-health sector cadres will be encouraged to lessen the burden on health care workers by incorporating positive FP messages in their programmes.

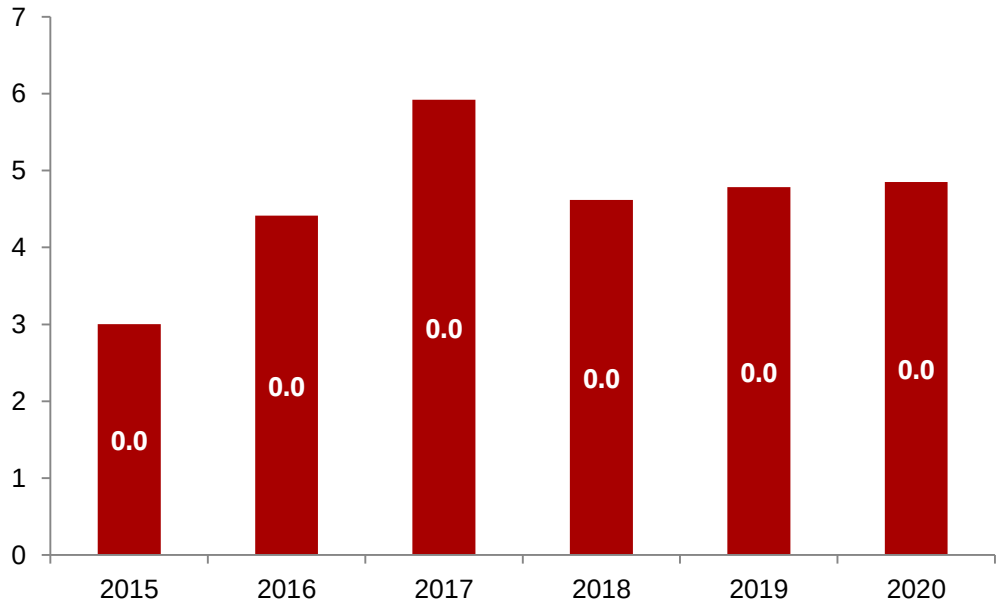
DC2. Men support the use of modern contraception for themselves and their partners. The number of men who support the use of modern contraception for themselves or their partners will be increased by conducting community outreach events to engage men in FP dialogue and services, based on formative research.

DC3. Young people, 10–24 years old, are knowledgeable about family planning and are empowered to use FP services. To increase the knowledge and empowerment of young people, peer educators will be engaged and supported; media (print and online) targeting youth will be disseminated; and "edutainment" community events will provide the opportunity for knowledge exchange amongst young people and empower adults to help youth avoid teenage pregnancy.

DC4. Social marketing of free products and commercial sector increases FP demand. A pilot project to brand free condoms provided by the public sector will be initiated and evaluated.

Costing summary

Figure 21: Demand creation costs, in millions USD



Service delivery and access

Strategy

Uganda's approach to FP service availability is a rights-based approach that includes voluntarism, informed choice, free and informed consent, respect to privacy and confidentiality without having to seek third party authorization, equality and non-discrimination, equity, quality, client-centered care, participation and accountability; it also responds to community factors that impede access. Therefore, it is essential to develop and update protocols and training tools for health care workers at all levels in order to guarantee the provision of FP information and services in accordance to human rights and quality of care standards. A systematic application of these standards by health care workers will contribute to ensuring that family planning uptake is based on the widest choice of contraceptive methods while preventing potential cases of coercion, discrimination, and negative attitudes against certain users.

Several innovative FP service delivery models have been successfully implemented by nongovernmental organisations in Uganda. Community-based distribution of certain FP commodities has also been successful at expanding access, and task-shifting of injectable contraception to VHTs has proved to be a safe, viable method for increasing availability.[172] Other innovative approaches that optimise use of limited staff resources or encourage health-seeking behaviours (e.g., vouchers and scale-up of public-private partnerships) and that have similar potential for increasing FP availability and access and should be piloted and, if proven safe and effective, implemented. Managers of health care workers will be trained to implement a performance plan system, and performance-based incentives for health care workers will be established to increase their motivation to counsel clients on full, free, and informed choice, without introducing method-specific bias.

To improve the FP service delivery capacity in Uganda's resource-constrained setting, several strategies will be employed. Task shifting will be instituted so that FP methods are available from the lower levels of the health system, relieving the burden at higher levels of care. Task shifting has been shown to help mitigate the human resource crisis in many countries, including Uganda. Included in

this initiative will be expansion of the community-based distribution (CBD) of contraceptives, including depot medroxyprogesterone acetate (DMPA) (or Depo Provera®) and/or Sayana® Press. Waivers for task sharing from the Ugandan National Council of Science and Technology to cover specific cadres of health workers from litigation will be also developed for tubal ligations and implants, in addition to covering VHT members' ability to provide injectable contraceptives.

The integration of family planning into other health services is also a key strategy in enhancing the availability of FP services. At higher-level facilities with sufficient staff, FP services should be co-located with other services, providing a "one-stop shop" for women and men seeking other health care services. Referral for FP services will be stressed in the training and supervision of all health care workers who do not provide FP services.

Through these activities, the limited resources dedicated to family planning will be maximised to reach youth, rural, and underserved populations such as people living with HIV. Although reaching these populations through a mix of service delivery clinics and CBD may in some cases prove difficult and is usually more expensive than stand-alone, clinic-based services, these initiatives could help ensure more equitable access to FP services.[173]

Strategic outcomes

SD1. Access to FP services is increased. To increase access to FP services, service delivery points, including community-based distribution, will be increased for rural communities. Mobile clinics will be piloted, reviewed, and scaled up. FP services will be expanded through public-private partnerships.

SD2. Referral services are strengthened. To strengthen referral services, a uniform FP referral system will be created with appropriate referral forms, and district health officers (DHOs) and assistant district health officers (ADOHs) will be trained on implementation.

SD3. Motivation for FP health care workers is increased. To increase motivation for health care workers, performance-based incentives will be developed, and managers will be trained. The performance-based incentives will increase health care worker motivation to counsel clients on full, free, and informed choice, without introducing method-specific bias.

SD4. Family planning services are integrated into other health services. FP services will be integrated into cervical cancer screening, postnatal care, postpartum care, prevention and treatment of sexually transmitted infections, including HIV prevention, care, and treatment and malnutrition programmes. Protocols will be developed, and service providers will be trained. Specific efforts will be made to ensure that outreach is tailored to address the needs of key groups, such as people living with HIV, who need counselling on topics such as safe conception, drug interactions, dual protection, etc.

SD5. Family planning services are accessible by people with disabilities. To increase access of people with disabilities to FP services, FP clinical service delivery guidelines—to ensure the provision of FP services in accordance with human rights and quality of care standards—will be developed and disseminated, and health care workers will be trained on providing services to FP clients with various disabilities.

SD6. Family planning side effects are managed. To improve the management of FP side effects, counselling guidelines for family planning will be re-assessed, trainers will be trained on side effects, and reporting tools will be printed and disseminated.

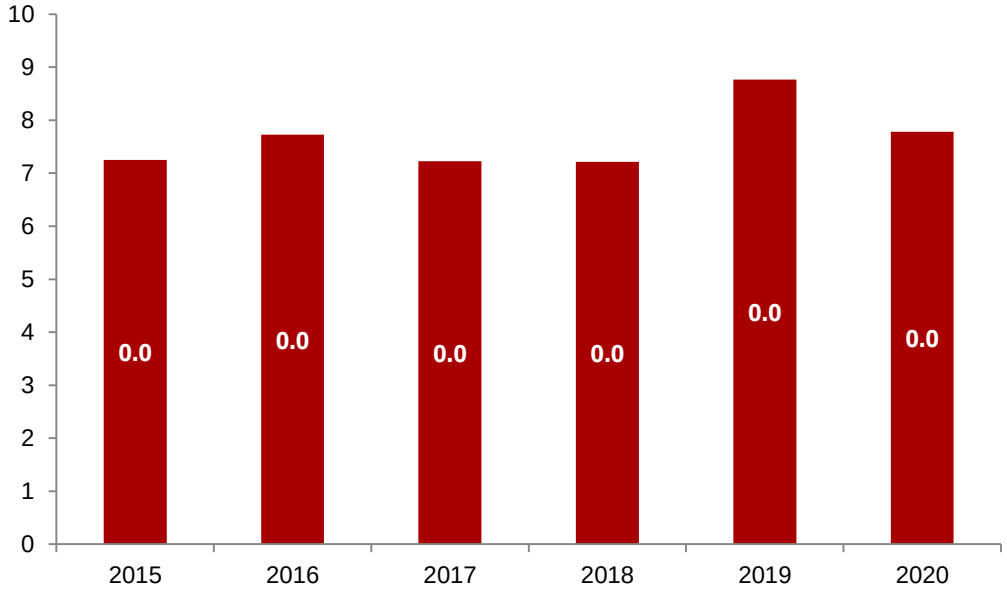
SD7. In-service training is improved to include family planning. In-service training will include family planning; the revised training manual will be printed and disseminated; and trainers will learn the new components of the documents.

SD8. Family planning in the VHT system is strengthened. FP in the VHT system will be strengthened through revision of the VHT training manual. VHT training will be scaled up. Use of depot medroxyprogesterone acetate (DMPA) (or Depo Provera®) and/or Sayana® Press by VHTs will be operationalized, and a harmonised benefits package for VHTs will be instituted.

SD9. Youth-friendly services are provided in clinics. To increase the availability of youth-friendly services, youth-friendly corners will be established, and health workers will be trained on youth-friendly services. In addition, FP service delivery hours will be increased to include outside school hours to accommodate youth.

Costing summary

Figure 22: Service delivery costs, in millions USD



Contraceptive security

Strategy

Maintaining a robust and reliable supply of contraceptive commodities to meet clients' needs, prevent stock-outs, and ensure contraceptive security is a priority for the programme to achieve its goal. This area also addresses the sustainable supply of contraceptive commodities and related consumables. It is aimed at ensuring that contraceptive commodities and supplies are adequate and available to meet the needs and choices of FP clients.[174] The activities of this strategic priority will be implemented in line with other commodity security plans of the MOH.

Because central-level supply is currently not a significant challenge for FP commodities, forecasting, quantification, and procurement will continue as in recent years, with continued capacity strengthening particularly focused at lower levels of the system. Lower-level facilities are receiving commodities on a push system, but the system will be modified and improved to better meet local needs. In addition, the push system will be improved, and a plan will be put in place to move all facilities to a pull system, as capacity grows. The FP LMIS/health management information systems (HMIS) will also be improved to increase commodity security.

Providing a full mix of FP methods to meet the changing needs of clients throughout their reproductive lives not only increases overall levels of contraceptive use, it also ensures they are fully

able to exercise their rights and meet their reproductive goals. Modern method use will increase, and traditional method use will decrease as an overall percentage of the total method mix—as shifting users from less effective to more effective methods while maintaining the widest possible range of method choices allows women and families to best fulfill their reproductive intentions. The method mix available influences not only successful client use and satisfaction but also has implications for provider skills confidence and competence. In addition, specific activities will ensure that the contraceptives available in the country are of high quality. Currently, significant distribution challenges are a limiting factor in ensuring the availability of high-quality FP services at all levels of care. Specific activities will be undertaken to ensure that contraceptives are delivered through the "last mile" to the health facility to ensure reproductive health commodity security throughout the country.

Strategic outcomes

CS1. Comprehensive forecasting, quantification, and procurement of FP commodities is implemented. FP commodities will be forecasted, quantified, and procured. Annual quantification, forecasting, and procurement workshops for FP commodities and consumables (for IUDs, implants, tubal ligations, etc.) will be held; the supply plan will be monitored, and the quarterly Family Planning/Reproductive Health Commodity Security Working Group meeting will review stock status.

CS2. District staff are able to quantify and forecast FP commodities. Through sensitisation and training, staff will forecast FP commodities more accurately. Trainings and field assessments will facilitate appropriate forecasting and ensure facilities are stocked more efficiently by integrating forecasting and quantification within routine facility, district, and procurement activities.

CS3. VHTs and community-based distributors have commodities. By strengthening the supply chain system, accurate and timely re-stocking of commodities and distribution to VHTs and community-based distributors will improve. Training and the development of job aids for logistics managers to quantify and distribute commodities to community-based distributors will strengthen the lower levels of the commodity distribution system and ensure that supplies are available.

CS4. The push system to lower-level facilities is strengthened to increase effectiveness and responsiveness to local needs. The MOH and partners will support the regular review of the push kit contents to increase its effectiveness and responsiveness to local needs. Evaluations of the push system will continue, and a capacity-building plan will be developed to guide efforts until the transition to the pull system takes place.

CS5. Lower-level facilities build capacity to move to a pull system. As in the strategic outcome above, the capacity of lower-level facilities will be assessed and built on to allow them to transition to a pull system. In addition, the pull system for higher-level facilities will be strengthened through training of providers/pharmacists in FP logistics and procurement and the supervision of and support for trainers.

CS6. LMIS and HMIS improved. The LMIS and HMIS will be improved to increase commodity security; for example, new technologies (e.g., short message system via mobile phones) will be explored to improve real-time stock monitoring and re-supply planning, especially to re-supply VHTs.

CS7. Challenges with distribution and requisition of FP commodities proactively identified and addressed. Distribution challenges will be addressed—including for remote and hard-to-reach and currently underserved areas—through commodity mapping to track the availability of commodities at the facility level.

CS8. Policies and strategies that impact FP commodity security are aligned with the FP-CIP. To ensure that policies and strategies align with the FP-CIP, the Alternative Distribution System 2016–2020 will be reviewed and the Reproductive Health Commodity Security Strategy 2015–2020

will be developed. The clinical guidelines and essential medicines and health supply list will also be reviewed and updated to reflect current FP practices.

CS9. Commodity distribution to private not-for-profits increased. The MOH will advocate with and support Joint Medical Stores (JMS) to include FP commodities in procurement to improve FP access for non-Catholic clients in facilities supplied by JMS.

Costing summary

Figure 23: Contraceptive security costs, in millions USD

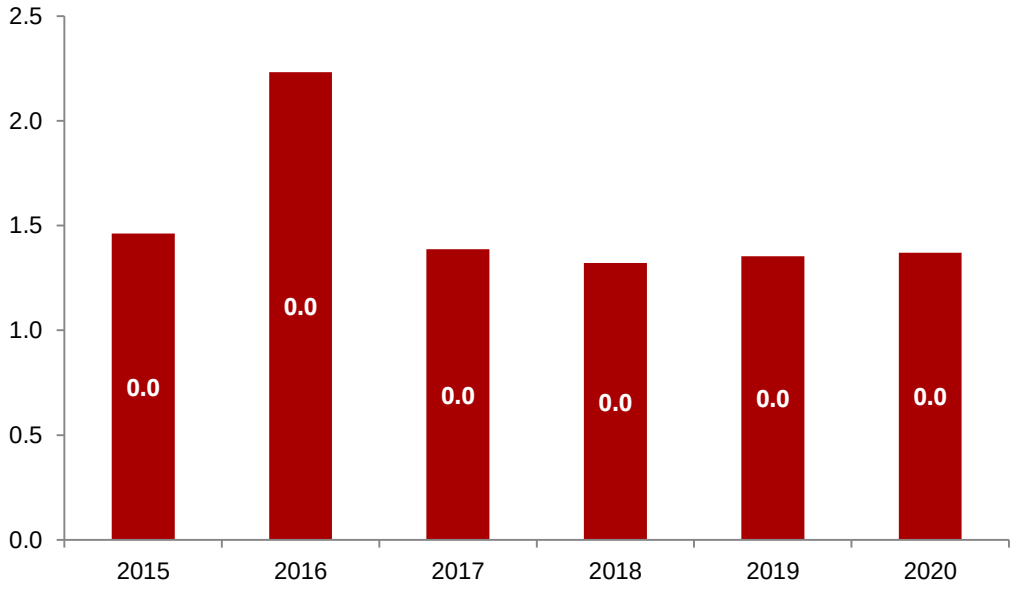


Figure 24: Contraceptive and direct FP-consumable commodity costs, in millions USD

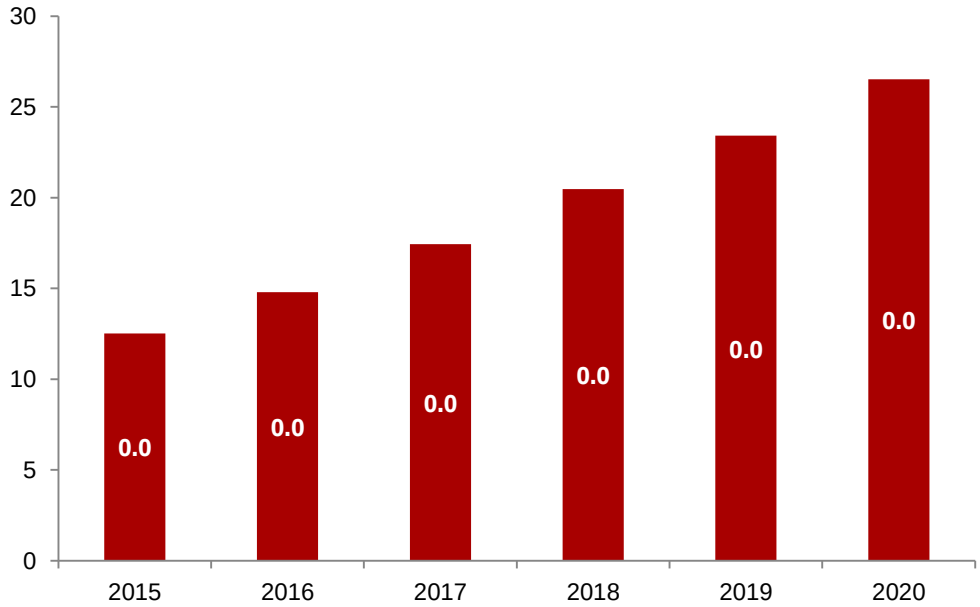


Figure 25: Projected method mix, mCPR, married women and women in-union to reach 50 percent target CPR

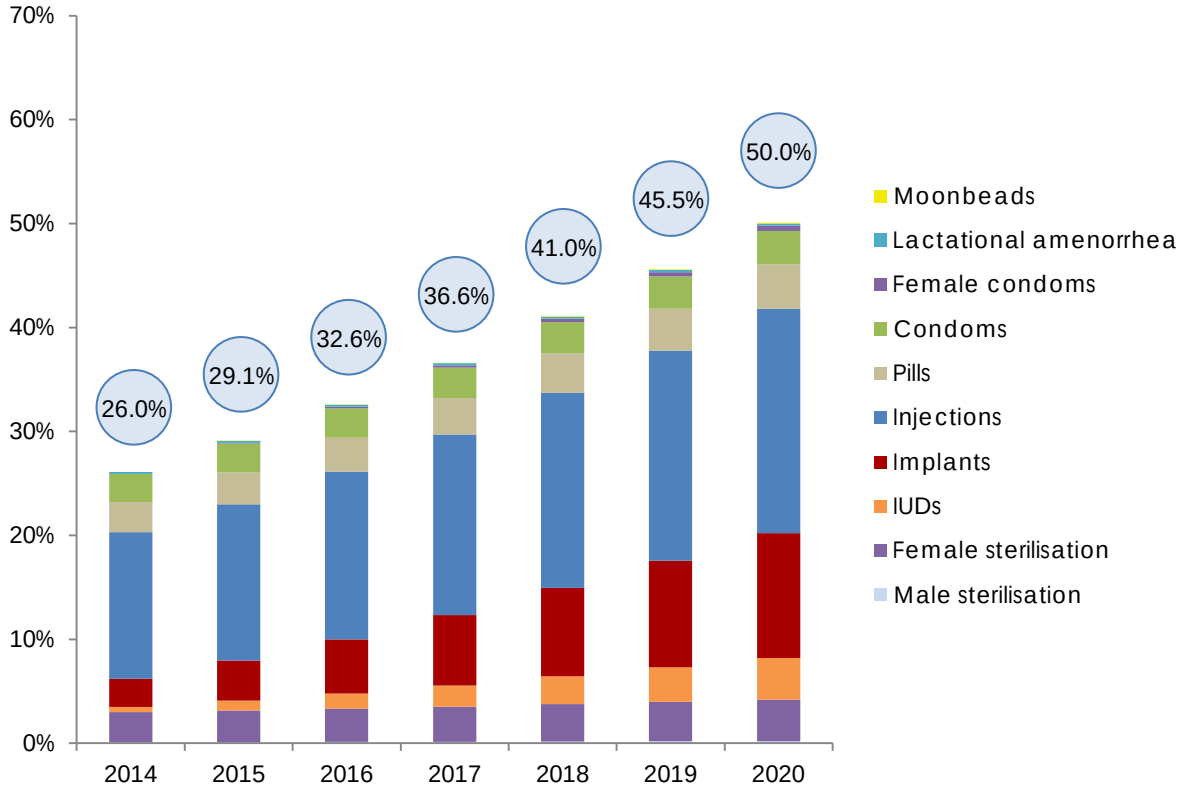


Figure 2: Projected method mix, unmarried sexually active women to reach 68.3 percent target CPR

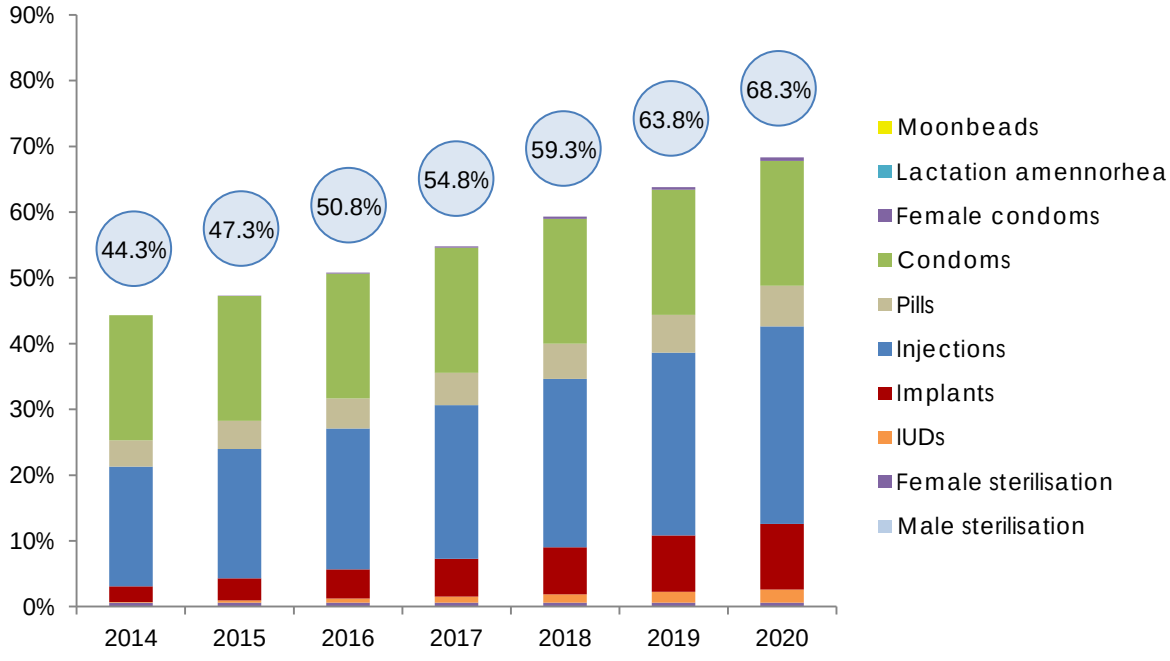
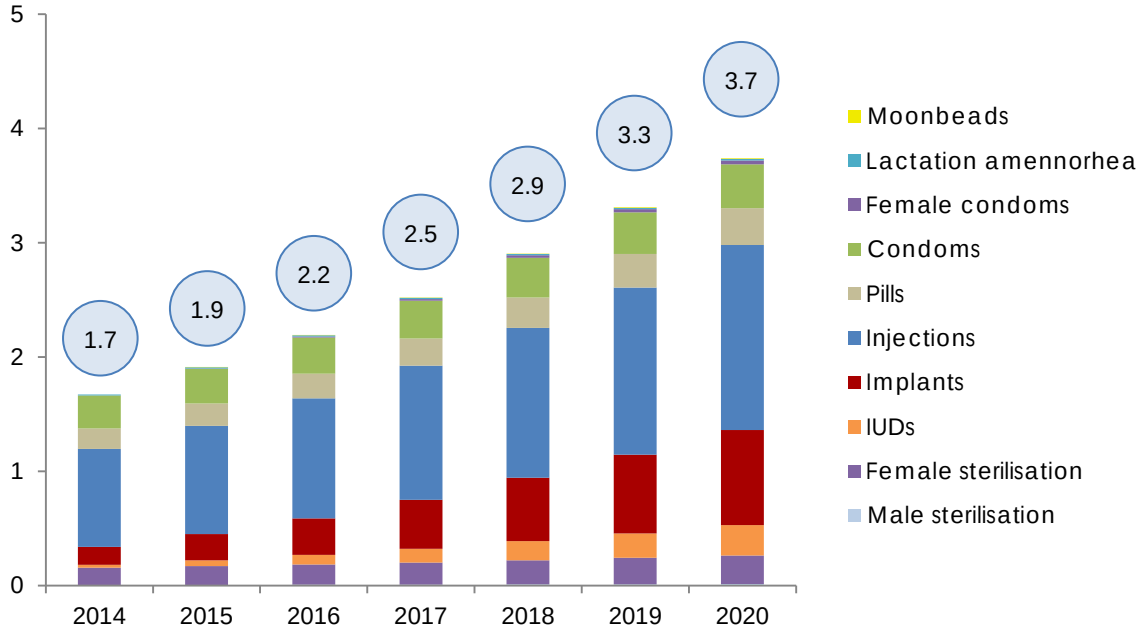


Figure 27: Total contraceptive users, married and unmarried, in millions



Policy and enabling environment

Strategy

To improve the policy environment for family planning, government policies and strategies will be reviewed to ensure that FP is integrated appropriately. The MOH and partners will ensure that family planning is integrated into the preparation and review procedures of national health and development processes, as a cross-cutting intervention for national development. Specific advocacy will also be conducted to ensure that policies and guidelines for family planning promote access to FP services rather than hamper access for often-marginalised groups such as the rural population and youth and to ensure the provision of FP services in accordance with human rights and quality of care standards.

For example, the FP guidelines will be revised to give health care providers clarity on how to counsel and provide services to adolescents younger than 16 years old. The community-based distribution of injectables pilot has provided local evidence that task shifting for injectable distribution is not only safe, but also effective in expanding access to FP services for rural communities.[175] Policy revisions will allow the scale-up of CBD of injectables throughout Uganda. The MOH is also planning to conduct research in 2015–2016 on the feasibility and cost-effectiveness of the self-injection of injectable contraception; results of those studies may have further implications for expanding access to family planning, and relevant policy and programmatic updates may be considered when those results are available. In addition, the MOH and its partners will create and support national-level advocates who can play a key role both publically and behind-the-scenes in ensuring that family planning remains a priority for the GOU in both policy and domestic resource allocation.

Strategic outcomes

PEE1. Family planning is repositioned as a key cross-cutting intervention for national development. Family planning will be repositioned as a fundamental element of the national development agenda, including as a tool to achieve the demographic dividend; a key contributor to environmental sustainability; and a strong component of the health sector strategy through inter-ministerial collaboration, public dialogues, and advocacy for acceleration of the National Population Council Bill.

PEE2. Legal framework and knowledge of policies for family planning are improved. The legal framework that promotes family planning will become popularised through dissemination of the revised public acts and sensitisation of members of Parliament, district health teams (DHTs), and health providers.

PEE3. The full spectrum of FP commodities is available. The full range of contraceptive methods will be available, as the Essential Medicines List will include all World Health Organisation pre-qualified commodities; the contraceptive testing policy will be reviewed; and task-sharing policies will be implemented. In addition, the alternative distribution system currently providing commodities to nongovernmental organisations will be operationalised and facilitated so it is functioning. Advocacy with the National Drug Authority (NDA) and MOH to declassify the contraceptive injection DMPA or Depo Provera® and/or Sayana® Press and emergency contraceptives will be conducted with the goal of including drug shops as providers of an expanded FP method mix.

PPE4. Parliament, local, cultural, and religious leaders are supportive of family planning. A national coalition of advocates and champions will be established and supported to scale up best practices in advocacy. These champions will include members of Parliament; local, cultural, and religious leaders; as well as prominent celebrities and business leaders who can use their public platforms to improve the enabling environment for family planning and inform their communities on the benefits of family planning.

PEE5. Knowledge of FP policies amongst stakeholders and health care workers improved. FP policies will be widely disseminated and made available on the MOH website, and specific briefs addressing the role of health care workers in policy implementation will be developed and disseminated, with particular efforts made to ensure health care worker knowledge about the provision of FP services in accordance with human rights and quality of care standards.

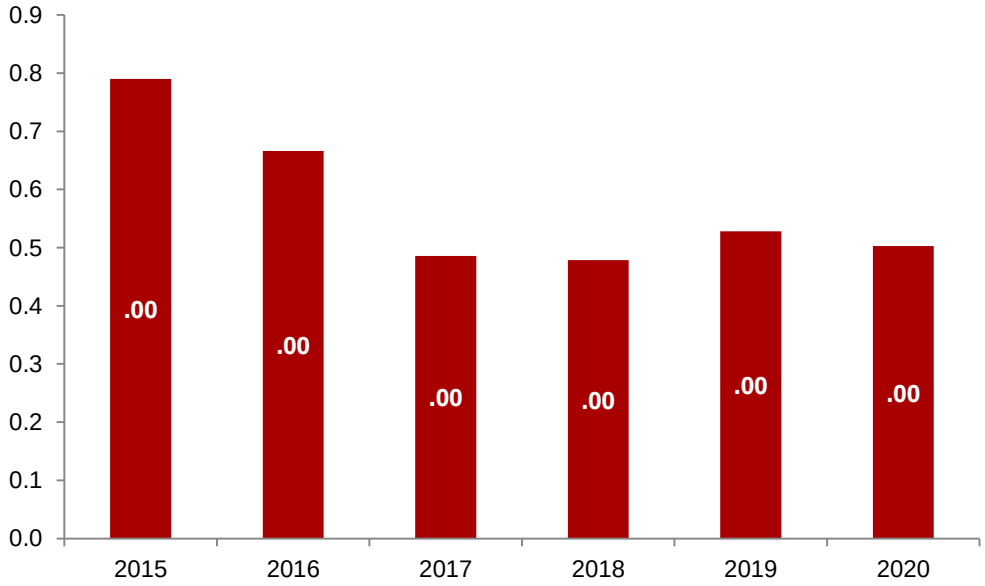
PEE6. FP health care workers are retained. To increase retention, advocates will lobby members of Parliament and the MOH to standardise the salary scales for similar cadres of health care workers.

PEE7. The non-health sector integrates FP behaviour change communication into their programmes. Advocacy will be conducted to convince non-health sector programmes—such as environment, livelihoods, and agriculture programmes—to integrate FP behaviour change communication into their activities to address the holistic and full needs of communities, such as exhibited in population-health-environment programmes.

PEE8. Policymakers are able to advocate for contentious bills on sexual and reproductive health and family planning. Training and orientation for policymakers on how to advocate for contentious bills on SRH-related policies (e.g., approval of clinical officers to perform surgical contraceptive methods) will contribute to improvements in the policy environment for family planning.

Costing summary

Figure 38: Policy and enabling environment costs, in millions USD



Financing

Strategy

To address the limited financial commitment to family planning commensurate to need, the MOH and its partners will advocate for increased funding within national budgets, in addition to funding secured from development partners and corporations. The MOH will also cultivate FP advocates within the Ministry of Finance, Planning and Economic Development (MOFPED), as well as within Parliament, to ensure that the national budget includes a line item for family planning programming, which is increased over time to meet the growing demand for FP services as SBCC and FP access activities are rolled out over the next eight years. Advocacy for the creation of budget lines for family planning at the district level will support the prioritisation and integration of family planning into district planning and budgeting processes.

As out-of-pocket expenditures on FP and reproductive health services remain high in Uganda, the MOH and partners will conduct advocacy to ensure that the health insurance scheme includes coverage for all FP methods in all insurance packages. Advocacy for increased funding for training and support for midwives and nurses at lower-level health facilities will help increase the national financial investment for human resources development for health. In addition, pooled procurement for RH commodities will be explored to reduce regional prices for commodities.

Strategic outcomes

F1. Government funding for family planning is increased. The MOH and its partners will advocate with parliamentarians to endorse, maintain, and advocate for increases in the FP line items in the MOH budget. The MOH will also engage with the MOFPED to ensure that the FP budget line is maintained and not removed or rejected from the sectorial budget.

F2. Donor funding for family planning is increased. The MOH will develop and implement an FP resource allocation advocacy strategy targeting development partners. Budget monitoring of promised financial investments will also be instituted.

F3. Corporations increase FP funding. Non-traditional donors (corporations) from the private sector will be educated about the benefits of investing in family planning as a part of their health benefits to their employees and as part of their corporate social responsibility programming.

F4. Family planning is mainstreamed in district planning and budgeting processes. Advocacy for the creation of budget lines for family planning at the district level will support the prioritisation and integration of family planning into district planning and budgeting processes.

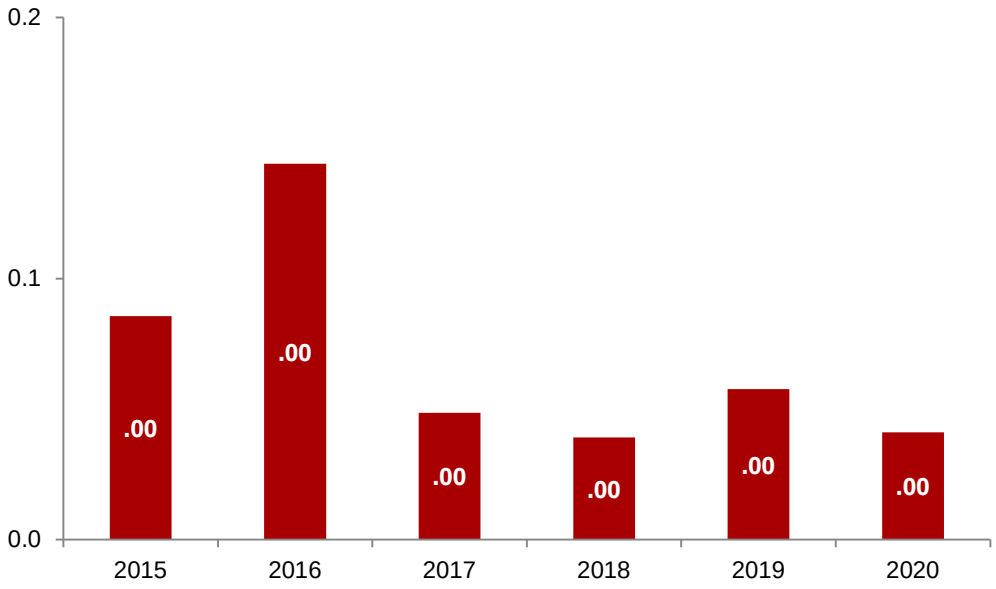
F5. Financial investment in human resources development for health is increased. Advocacy for increased funding for training and support for midwives and nurses at lower-level health facilities will help increase the national financial investment for human resources development for health.

F6. Family planning is included in the national health insurance scheme. The MOH and partners will conduct advocacy to ensure that the health insurance scheme includes coverage for all FP methods in all insurance packages.

F7. MOH and NMS will provide the East Africa Community (EAC) with full information on the costs and benefits of using pooled procurement for RH commodities. EAC pooled funding and procurement will be explored to reduce prices for commodities.

Costing summary

Figure 49: Financing costs, in millions USD



Stewardship, management, and accountability

Strategy

To meet the targeted increase in mCPR and decrease in unmet need by 2020, strong monitoring, management, leadership, and accountability are necessary. Effective management and governance of family planning activities at all levels is needed to ensure FP goals are reached. There are established forums for coordination; however, with numerous implementing partners and stakeholders involved, improved coordination with accountability mechanisms are needed. Better systems are essential to improve collaboration amongst partners and the MOH and to ensure that activities are implemented as a harmonised national effort.

To ensure the effective management of FP priorities and address the staffing challenges, a new MOH FP Coordinator will be hired. The coordinator will manage the FP-CIP's implementation overall, as outlined in the activity matrix. The MOH will also hire a Knowledge Management Officer to assist in tracking data collection and monitoring activities in line with the plan's implementation. These new, dedicated staff members will further increase accountability to keep implementation on track towards achieving the FP goal.

The Family Planning/Reproductive Health Commodity Security Working Group is a crucial body for coordinating partners and managing work at the central and national levels. Efforts will be undertaken to make the working group more effective and efficient. Team-building efforts will be prioritised to foster a working and collaborative environment, enhancing outputs and communication within the group.

An electronic database will be developed to track and monitor progress against the FP-CIP; it will be managed by the MOH. Implementing partners will be required to submit updates to the MOH FP Coordinator and Knowledge Management Officer semi-annually, in order to track progress. Existing data collection, supervision, and monitoring tools to closely track FP indicators will be revisited and revised as necessary.

National coordination is essential, but coordination must also connect national efforts with the decentralised system, particularly districts. The capacity of districts to effectively manage their FP programmes will be strengthened by engaging the DHTs. The teams' capacities will be built, therefore making reporting and outcomes stronger. Further, disseminating data collection tools and training health care workers will improve data quality and ensure more regular reporting on FP indicators.

Mentorship and supervision are key strategies for improving the quality of implementation. Revised supervision tools will include defined FP quality standards. Supervisors will receive training in conducting supportive supervision visits. Mentoring tools for family planning will be developed as part of the training curriculum for use in post-training mentorship sessions. These combined efforts will result in stronger management and accountability of the FP goals in Uganda.

Strategic outcomes

SMA1. Capacity at the MOH to effectively lead, manage, and coordinate the FP programme is strengthened. As the MOH supports implementation of the FP programme, coordination and management resources will be strengthened to ensure the efficient monitoring of FP-CIP activities. Designated MOH staff will monitor the activities semi-annually through an electronic database and track for performance and planning.

SMA2. The MOH effectively tracks and monitors the FP-CIP and provides support to implementing partners to report activities and funding and identify gaps. The MOH will track activities, including financial data outputs and timelines. The ministry will coordinate semi-annual data sharing amongst implementing partners and identify gaps through implementing partner feedback and annual refresher trainings on gap analyses.

SMA3. The capacity of districts to effectively manage their FP programmes is strengthened. By engaging DHTs through training, strengthening reporting mechanisms, and supporting DHTs to develop annual action plans for family planning, district-level FP stakeholder coordination and performance monitoring will be improved. In addition, quarterly district stakeholders meetings to review maternal and neonatal health will be conducted.

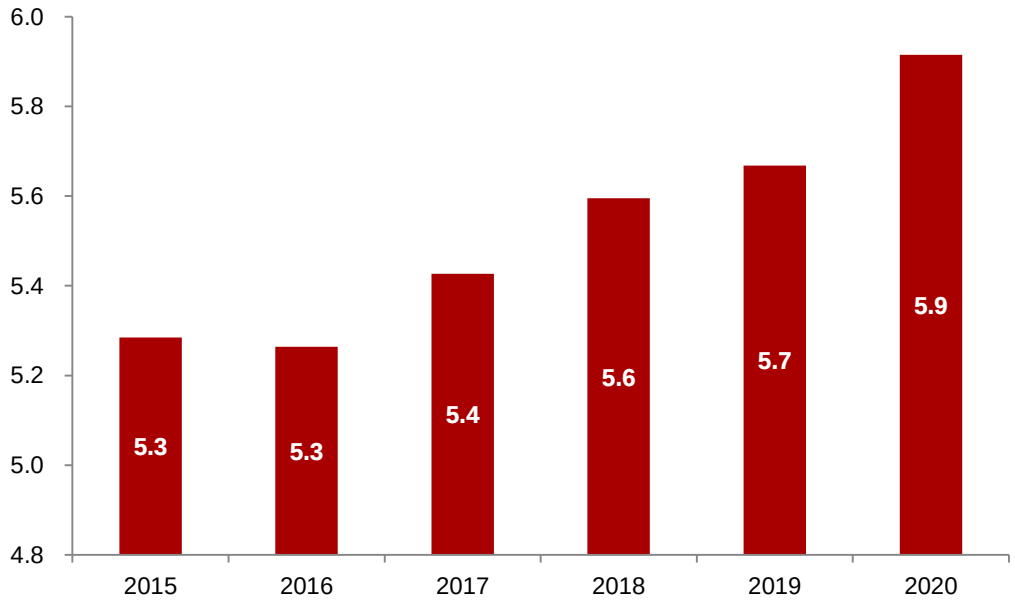
SMA4. Reporting of FP indicators is strengthened. Through training and sharing reporting tools, health care workers will improve their reporting on FP indicators. Accountability for monitoring will increase reporting into the national MOH database.

SMA5. National efforts to collect, analyse, and use data to track FP progress is strengthened. Capacity will be improved for monitoring and supervision of FP programmes. In addition, data collection and analysis will improve to better inform decision making and programme planning. A national FP research agenda will inform tracking activities. In addition, social accountability mechanisms will be implemented to engage clients to provide feedback on the quality of FP services and to effectively monitor procurement processes and financial flows through access to information.

SMA6. The FP-CIP is assessed at mid-term and end-of-plan to inform future FP activities and programming. A mid-term review and final evaluation will be conducted to assess progress and suggest areas of prevention or corrective action and to inform future FP strategy development, planning, and programming. Implementing stakeholders from the National Steering Committee and representation from government, civil society/NGOs, development partners, the private sector, community organizations, including representatives of women organizations, youth-led organizations and groups where marginalized groups express their voice, such as disability organizations will also be invited to participate in assessments at the national and sub-national level.

Costing summary

Figure 30: Stewardship, management, and accountability costs, in millions USD



SECTION 4: COSTING

4.1 Costing Assumptions

Costing elements are described and costed based on specific data from the MOH and partners implementing programmes. Each source for each input is cited in the costing tool; all inputs are also editable in the costing tool. In addition, each activity's costing inputs for both unit costs and quantities can be changed (e.g., the specific input costs for producing a radio programme, the number of programmes to be produced, the cost of broadcasting the programme, and the number of times it will be broadcast, etc.).

Costing inputs have come from a variety of sources and include standards provided by the MOH, the Public Procurement and Disposal of Public Assets Authority (which produces standard cost lists for government procurement), and implementing partners. Where specific costs for items were not available (e.g., if an activity has yet to be implemented in Uganda), the costing data are drawn from an Africa-regional or international source and noted as such in the costing tool.

Contraceptive costs are calculated from 2015 to 2020, using the 2011 Uganda Demographic and Health Survey (UDHS) contraceptive prevalence rate (CPR) and method mix as a baseline for the 2014 method mix.[176] The 2020 objective CPR for all women of reproductive age is then extrapolated for each intermediate year between 2014 and 2020.[177] These inputs can be updated when the Performance, Monitoring and Accountability (PMA) 2020 data are released each year; and the objectives should be updated if these are changed.

Unless otherwise noted, all consumable costs (e.g., salaries, per diem rates, fuel costs, venue hire, etc.) are based on current costs as of September 2014 and have been automatically adjusted for a base rate of inflation of 2.5 percent over time. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in USD dollars and converted to local currency.

Following dissemination of the plan, a gap analysis will be conducted to identify activities that will be supported by partners as the plan is rolled out in 2015 and to identify which activities are still un(or under)-funded. The gap analysis tool can be updated regularly under the guidance of the MOH to track funding for the FP-CIP, as most development partners and implementing partners are unable to report on their funding and activity commitments more than a few years ahead.

In addition, the costing tool is available from the MOH for review, updating, or modification for other programmes.

4.2 Costing Summary

The costs of this plan have been calculated using a tool developed specifically for this purpose, with methodology borrowed from other FP plan costing activities regionally. The tool allows for a calculation of the overall costs of the plan, as well as a disaggregation of the costs by activity area and year. It includes both initial (investment) costs and ongoing or sustainability costs for the duration of the plan.

The total costs of the plan from 2015–2020 are $235 million USD (622 billion UGX).

Overall, $115 million USD or 49 percent of the overall costs are in commodities, including contraceptives and consumables. Another 12 percent are in demand creation; 20 percent in service delivery; four percent in programming for contraceptive security; one percent in policy and enabling environment; less than one percent in financing; and 14 percent in stewardship, management, and accountability.

Costs are spread over the duration of the plan, with commodity costs increasing over time as more women are reached. In addition to commodities, the biggest cost drivers are service delivery, demand creation, and stewardship, management, and accountability activities at $46 million, $28 million, and $33 million USD, respectively. These are priority activities for funding because they directly support the strategic priorities necessary to ensure the plan's successful implementation.

The costs of the plan are comparable to other countries' similar FP costed implementation plans. The cost per woman of reproductive age for activity costs is $2.48 USD per year, which is in line with costs in other countries of about $2–5 USD. The cost per user for FP commodities is $6.95 USD, significantly higher than the costs of $4–4.20 USD seen in other countries.[178] However, this is likely due to the costs being derived from actual national rather than international estimate costs and the inclusion of a variety of additional loaded costs for each commodity (e.g., pre-shipment inspection, wastage, contraceptive procurement fees, clearing fees, freight charges, testing and oversight costs (NDA), insurance, storage fees, distribution fees/ last mile costs), which were not included in the standard costing for commodities for other CIPs.

Figure 31: Summary costs by thematic areas and total, in millions USD

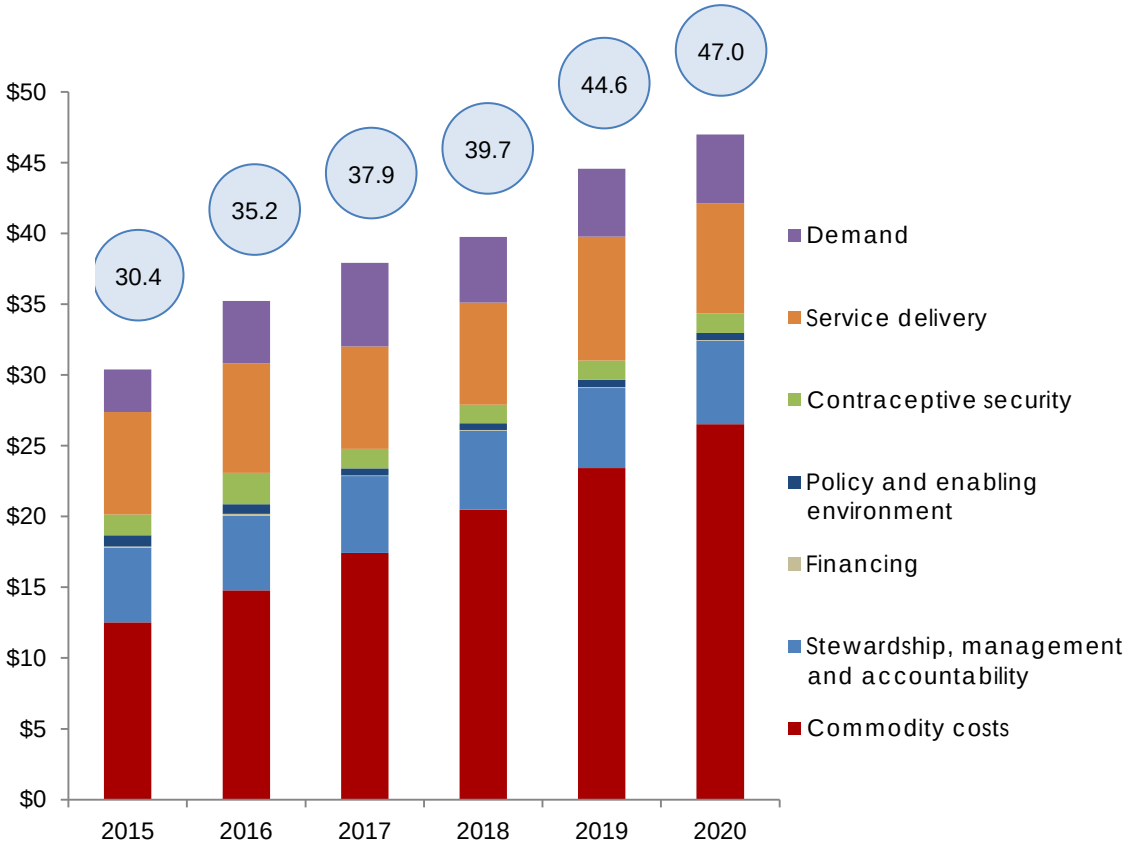


Figure 32: Costs, by category, in millions USD

	2015	2016	2017	2018	2019	2020	Total
Demand creation	3.0	4.4	5.9	4.6	4.8	4.9	**27.6**
Service delivery and access	7.2	7.7	7.2	7.2	8.8	7.8	**46.0**
Contraceptive security (programmes)	1.5	2.2	1.4	1.3	1.4	1.4	**9.3**
Contraceptive security (commodities)	12.5	14.8	17.4	20.5	23.4	26.5	**115.1**
Policy and enabling environment	0.8	0.7	0.5	0.5	0.5	0.5	**3.5**
Financing	0.1	0.1	0.0	0.0	0.1	0.0	**0.5**
Stewardship, management, and accountability	5.3	5.3	5.4	5.6	5.7	5.9	**33.2**
Total	**30.4**	**35.2**	**37.9**	**39.7**	**44.6**	**47.0**	**235.1**

Figure 33: Costs for strategic priorities, by area, in millions USD

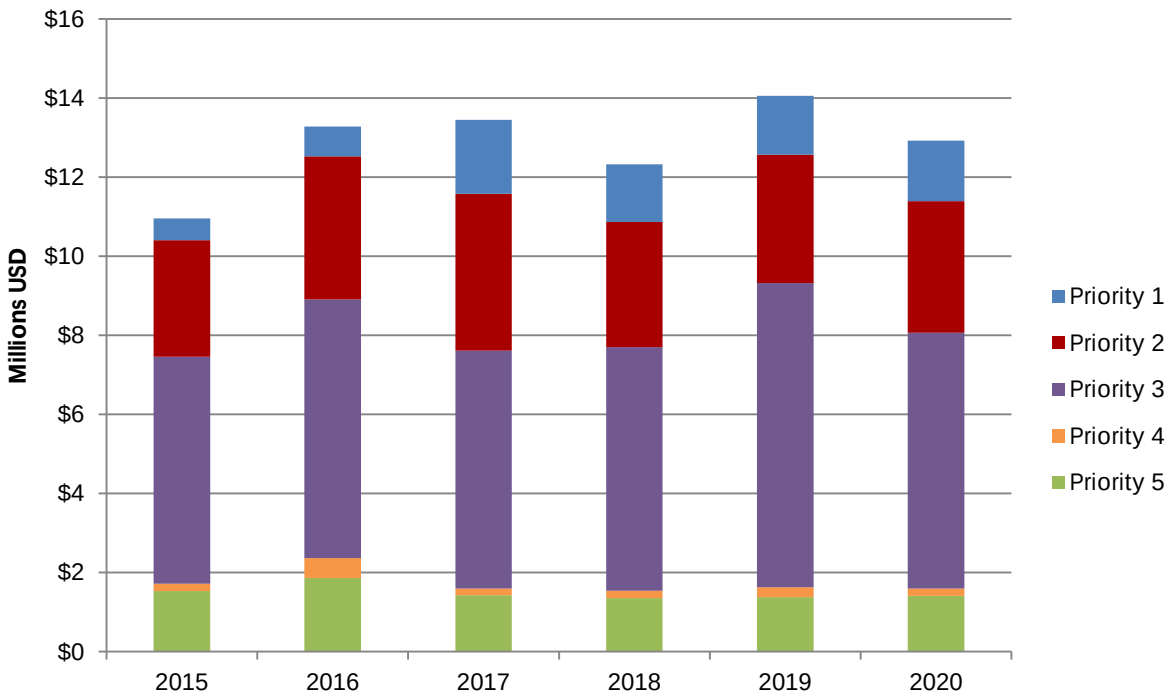


Figure 34: Costs for strategic priorities, by area, in millions USD

	2015	2016	2017	2018	2019	2020	Total
Priority # 1: Increase age-appropriate information, access, and use of FP amongst young people, ages 10–24 years	0.6	0.8	1.9	1.5	1.5	1.5	**7.6**
Priority # 2: Promote and nurture change in social and individual behaviour to address myths and misconceptions and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies	2.9	3.6	4.0	3.2	3.2	3.3	**20.3**
Priority # 3: Implement task sharing to increase access, especially for rural and underserved populations	5.7	6.5	6.0	6.2	7.7	6.5	**38.6**
Priority # 4: Mainstream implementation of FP policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation	0.2	0.5	0.2	0.2	0.3	0.2	**1.5**
Priority # 5: Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors	1.5	1.9	1.4	1.4	1.4	1.4	**9.0**
Total	**11.0**	**13.3**	**13.4**	**12.3**	**14.1**	**12.9**	**77.0**

SECTION 5. PROJECTED METHOD MIX AND CONTRACEPTIVE NEEDS

5.1 Assumptions

The interventions of this FP-CIP will lead to reaching a total CPR of 38 percent for all women of reproductive age in 2020, with married women having a CPR of 50 percent and unmarried sexually active women having a CPR of 68.3 percent.[179] This will lead to a total of 3.7 million women users of contraception in 2020.

The ImpactNow model[180] was used to calculate the impacts that the GOU will benefit from by increasing mCPR to 50 percent by 2020. These demographic, health, and economic impacts include

- Unintended pregnancies averted
- Abortions averted
- Unsafe abortions averted
- Maternal deaths averted
- Child deaths averted (due to improved birth spacing)
- Health care costs saved (in USD)

These calculations estimate that the FP interventions in Uganda will avert more than 4 million unintended pregnancies, more than half a million unsafe abortions, and more than 6,000 maternal deaths between 2015 and 2020. Additionally, the intervention will lead to saving $127 million USD on just maternal and infant health care costs during the six-year plan period.[181]

These impacts were calculated by estimating the current mCPR for all women and inputting method mix assumptions for the baseline year 2014, based on 2011 UDHS data.[182] A target method mix for 2020 was projected for the FP-CIP and considers various factors, including availability of infrastructure, provider capacity, and historical trends. The method mix projections are to be understood as the best-guess projections for future method mix, and are not to be interpreted as reducing user choice for any particular method. As such, the actual forecasting and procurement for FP commodities should be regularly reviewed and adjusted based on new and emerging data, including information on user preference and choice. The method mix projections are based on the following assumptions, which were guided by best practices and recommendations made by members of the stakeholder expert groups:

1. The FP-CIP will be fully implemented by the MOH and its partners and will emphasise reaching underserved populations (e.g., youth, rural populations, and the urban poor) and creating demand and improving access for long-acting reversible contraceptives (LARCs).
2. The method mix changes take into account the recommendations of the MOH and stakeholder groups to shift use, wherever feasible, from less effective to more effective methods, while maintaining the widest possible range of method choices. For example, these projections assume a shift of some users from traditional to modern methods.
3. LARCs will rise at a similar rate to other countries in the region based on similar data for demand and access[183] once LARCs are available at more service delivery points and demand-creation activities for LARCs have begun, with the scale-up of training probable in project activities and as indicated in the National Quantification for Family Planning and Selected Reproductive Health Commodities, July 2013–June 2016.[184] The greatest rise in LARCs will be for implants, accompanied by an increased demand for IUDs, though at a lower rate.
4. Access and use of injectables will increase in line with other countries in the region due to implementation of the policy to allow task shifting for injectable provision by VHTs, as well as in line with historical increases in injectable uptake in Uganda and regionally in Africa.[185]

5. The method mix quantification for the FP-CIP varies from the projections in the National Quantification for Family Planning and Selected Reproductive Health Commodities, July 2013–June 2016,[186] because it is based on variably adjusting CPR method mixes for married and unmarried women. In addition, for the FP-CIP, male and female condoms were only included in the method mix and costed for the amount required for FP usage alone—condoms used for the prevention of HIV and other sexually transmitted infections in addition to another method use by women are not included in this FP costing, although these costs are included in the larger RH commodity costs.
6. Emergency contraception is not included as a percentage of the method mix, as it is not promoted as a regular or consistent method of family planning. It will be procured for public and private sector use as a lifesaving commodity—a contraceptive method to be used when other primary methods are not used or fail.[187]

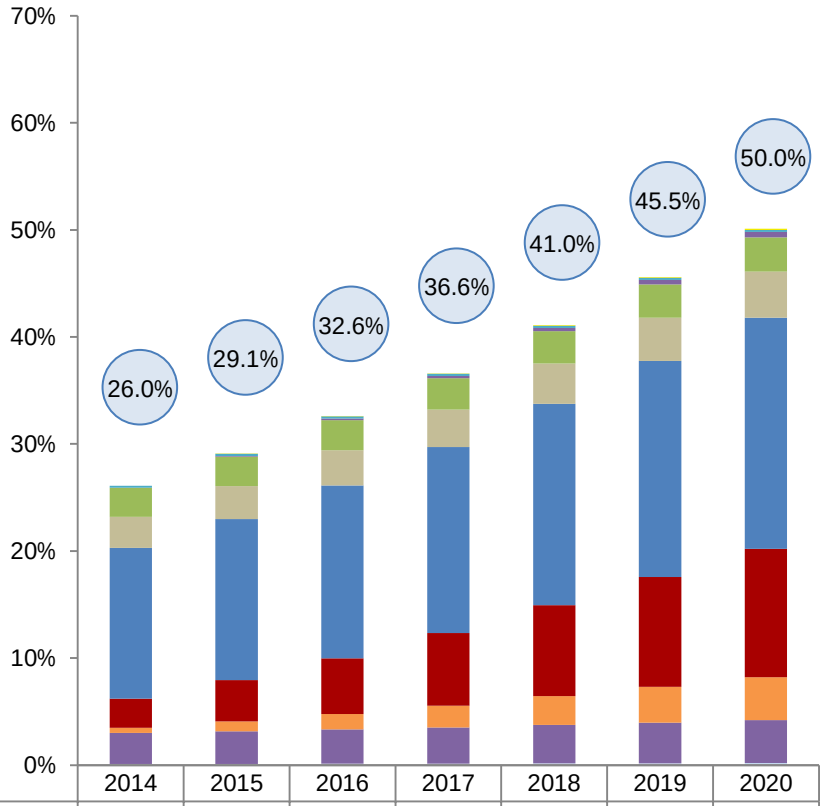
The 2014 baseline method mix and the 2020 objective method mix assumptions, for all women, are outlined below.

Figure 35: Baseline method mix from 2011 UDHS, all women, and projected method mix 2020

Contraceptive method	Method mix	
	UDHS 2011	2020 Projections
Pills	2.21%	3.30%
IUDs	0.32%	2.70%
Injections	10.62%	16.48%
Condoms	3.58%	3.89%
Female condoms	0.00%	0.36%
Female sterilisation	1.87%	2.56%
Male sterilisation	0.06%	0.13%
Implants	1.93%	8.49%
Lactation amennorhea	0.13%	0.13%
Moonbeads	0.00%	0.06%
CPR, all women	**20.71%**	**38.10%**

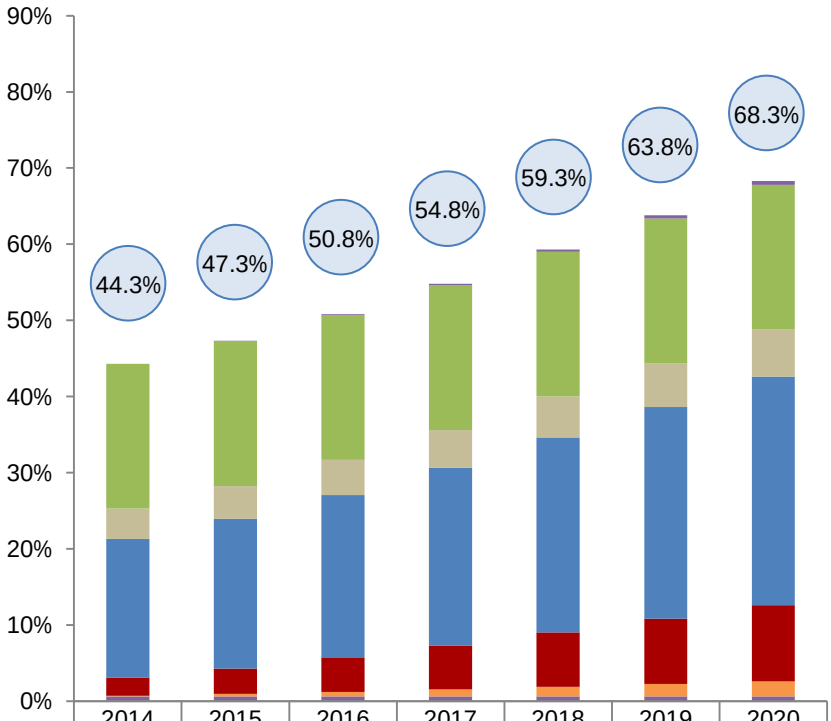
Details of the annual method mix, services/commodities, contraceptive prevalence by methods, and demographic and health impacts are shown in the following figures. Standard global CYP conversion factors and standard units needed for one year of use were used for these calculations.[188]

Figure 56: Contraceptive prevalence by method, married and women in union, 2014 baseline, projected 2015–2020



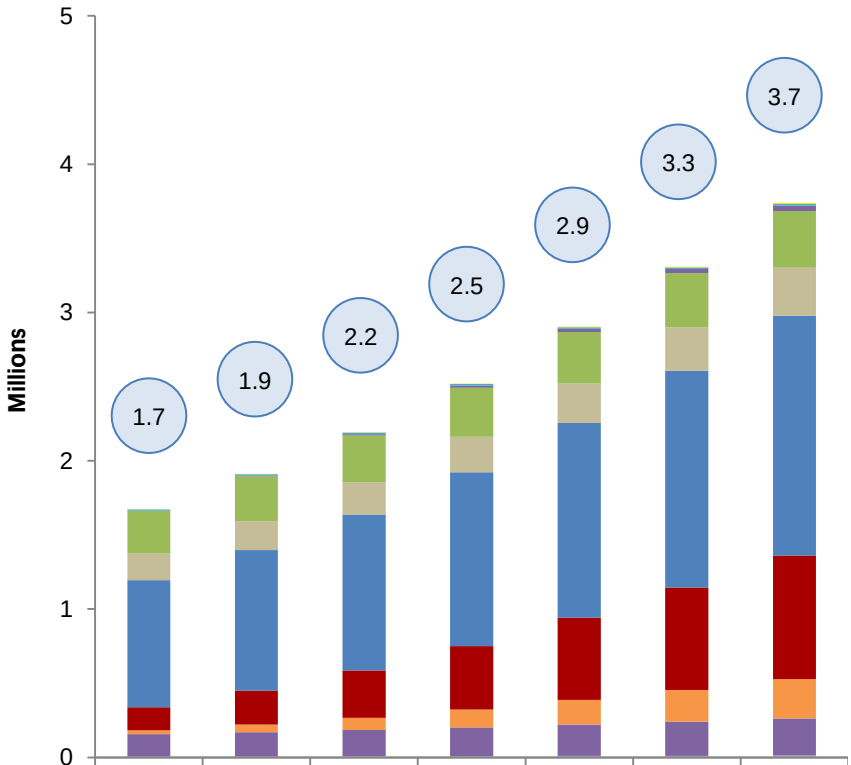
	2014	2015	2016	2017	2018	2019	2020
Moonbeads	0.00%	0.01%	0.03%	0.04%	0.06%	0.08%	0.10%
Lactational amenorrhea	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%
Female condoms	0.00%	0.06%	0.14%	0.22%	0.31%	0.41%	0.50%
Condoms	2.70%	2.76%	2.84%	2.92%	3.01%	3.11%	3.20%
Pills	2.90%	3.08%	3.28%	3.51%	3.78%	4.04%	4.30%
Injections	14.10%	15.04%	16.13%	17.38%	18.79%	20.19%	21.60%
Implants	2.70%	3.86%	5.22%	6.77%	8.51%	10.26%	12.00%
IUDs	0.50%	0.94%	1.45%	2.03%	2.69%	3.34%	4.00%
Female sterilisation	2.90%	3.04%	3.20%	3.38%	3.59%	3.79%	4.00%
Male sterilisation	0.10%	0.11%	0.13%	0.14%	0.16%	0.18%	0.20%

Figure 67: Contraceptive prevalence by method, unmarried sexually active women, 2014 baseline, projected 2015–2020



	2014	2015	2016	2017	2018	2019	2020
Moonbeads	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Lactation amennorhea	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Female condoms	0.00%	0.06%	0.14%	0.22%	0.31%	0.41%	0.50%
Condoms	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%
Pills	4.00%	4.28%	4.60%	4.96%	5.38%	5.79%	6.20%
Injections	18.20%	19.68%	21.40%	23.36%	25.58%	27.79%	30.00%
Implants	2.40%	3.35%	4.46%	5.73%	7.15%	8.58%	10.00%
IUDs	0.10%	0.34%	0.61%	0.93%	1.29%	1.64%	2.00%
Female sterilisation	0.60%	0.60%	0.60%	0.60%	0.60%	0.60%	0.60%
Male sterilisation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Figure 78: Total FP users, married and unmarried 2014 baseline, projected 2015–2020



	2014	2015	2016	2017	2018	2019	2020
Moonbeads	-	652	1,459	2,434	3,592	4,823	6,132
Lactation amennorhea	10,094	10,427	10,771	11,127	11,494	11,873	12,265
Female condoms	-	3,777	8,453	14,105	20,815	27,952	35,538
Condoms	288,739	301,525	315,403	330,447	346,740	363,748	381,500
Pills	178,462	195,754	215,957	239,308	266,060	294,317	324,150
Injections	857,676	947,083	1,051,9	1,173,6	1,313,3	1,461,1	1,617,1
Implants	155,528	229,143	319,238	427,208	554,539	689,808	833,401
IUDs	26,037	51,675	83,242	121,242	166,213	214,019	264,800
Female sterilisation	151,178	163,335	177,365	193,417	211,653	230,881	251,149
Male sterilisation	5,047	5,865	6,844	7,997	9,339	10,760	12,265

Figure 89: Number of FP users provided with services or commodities per year, projected 2015–2020[189]

	2015	2016	2017	2018	2019	2020
Pills	195,754	215,957	239,308	266,060	294,317	324,150
IUDs	36,871	49,663	64,358	81,104	94,332	108,346
Injections	947,083	1,051,978	1,173,631	1,313,394	1,461,102	1,617,130
Condoms	301,525	315,403	330,447	346,740	363,748	381,500
Female condoms	3,777	8,453	14,105	20,815	27,952	35,538
Female sterilisation	24,722	27,673	30,931	34,517	36,989	39,586
Male sterilisation	1,269	1,505	1,768	2,060	2,249	2,448
Implants	145,222	189,856	241,473	300,624	350,834	404,031
Lactation amennorhea	10,427	10,771	11,127	11,494	11,873	12,265
Moonbeads	652	1,459	2,434	3,592	4,823	6,132
Total	**1,667,303**	**1,872,718**	**2,109,582**	**2,380,398**	**2,648,220**	**2,931,126**

Figure 40: Total FP user mix, projected 2015–2020[190]

	2015	2016	2017	2018	2019	2020
Pills	195,754	215,957	239,308	266,060	294,317	324,150
IUDs	51,675	83,242	121,242	166,213	214,019	264,800
Injections	947,083	1,051,978	1,173,631	1,313,394	1,461,102	1,617,130
Condoms	301,525	315,403	330,447	346,740	363,748	381,500
Female condoms	3,777	8,453	14,105	20,815	27,952	35,538
Female sterilisation	163,335	177,365	193,417	211,653	230,881	251,149
Male sterilisation	5,865	6,844	7,997	9,339	10,760	12,265
Implants	229,143	319,238	427,208	554,539	689,808	833,401
Lactation amennorhea	10,427	10,771	11,127	11,494	11,873	12,265
Moonbeads	652	1,459	2,434	3,592	4,823	6,132
Total	**1,909,237**	**2,190,708**	**2,520,917**	**2,903,837**	**3,309,285**	**3,738,329**

SECTION 6. IMPACTS

The figure below forecasts the impacts of increases in FP demand, use, and priorities for 2014–2020 in Uganda. The numbers are drawn from UDHS 2011 data and projected outward based on full implementation of the FP-CIP; they show how the scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health in Uganda.

Demographic impacts. Unintended pregnancies averted refers to the number of births that will not occur, including live births, abortions, miscarriages, and stillbirths. The number of pregnancies, including abortions, averted also affects maternal mortality, given that women sometimes die from abortion complications. As the number of abortions decline due to increased FP use and fewer unintended pregnancies, maternal deaths will also decline.[191]

Health impacts. As a result of full implementation of the FP-CIP, significant numbers of maternal and child deaths will be averted, as well as unsafe abortions, contributing to a healthier population.[192]

Economic impacts. Given the priority on the demographic dividend in Uganda, these numbers hold particular significance. Through the Vision 2040, Uganda has confirmed that increased FP use, reduced unmet need for family planning, and increased contraceptive prevalence result in government savings and economic impacts on a whole, but the below figure shows the specific impacts on maternal and infant health care costs only.

Figure 41: Annual Impacts of the FP-CIP

	2015	2016	2017	2018	2019	2020	Total
Demographic impacts							
Unintended pregnancies averted	503,981	571,828	640,983	711,443	783,211	856,285	4,067,731
Abortions averted	71,805	81,471	91,324	101,363	111,588	121,999	579,550
Health impacts							
Maternal deaths averted	868	938	999	1,051	1,092	1,124	6,072
Child deaths averted	14,707	16,686	18,704	20,761	22,855	24,987	118,700
Unsafe abortions averted	68,760	78,017	87,452	97,065	106,857	116,826	554,977
Economic impacts							
Maternal and infant health care costs saved (USD)	15,693,104	17,805,757	19,959,098	22,153,126	24,387,841	26,663,244	126,662,170

SECTION 7. INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

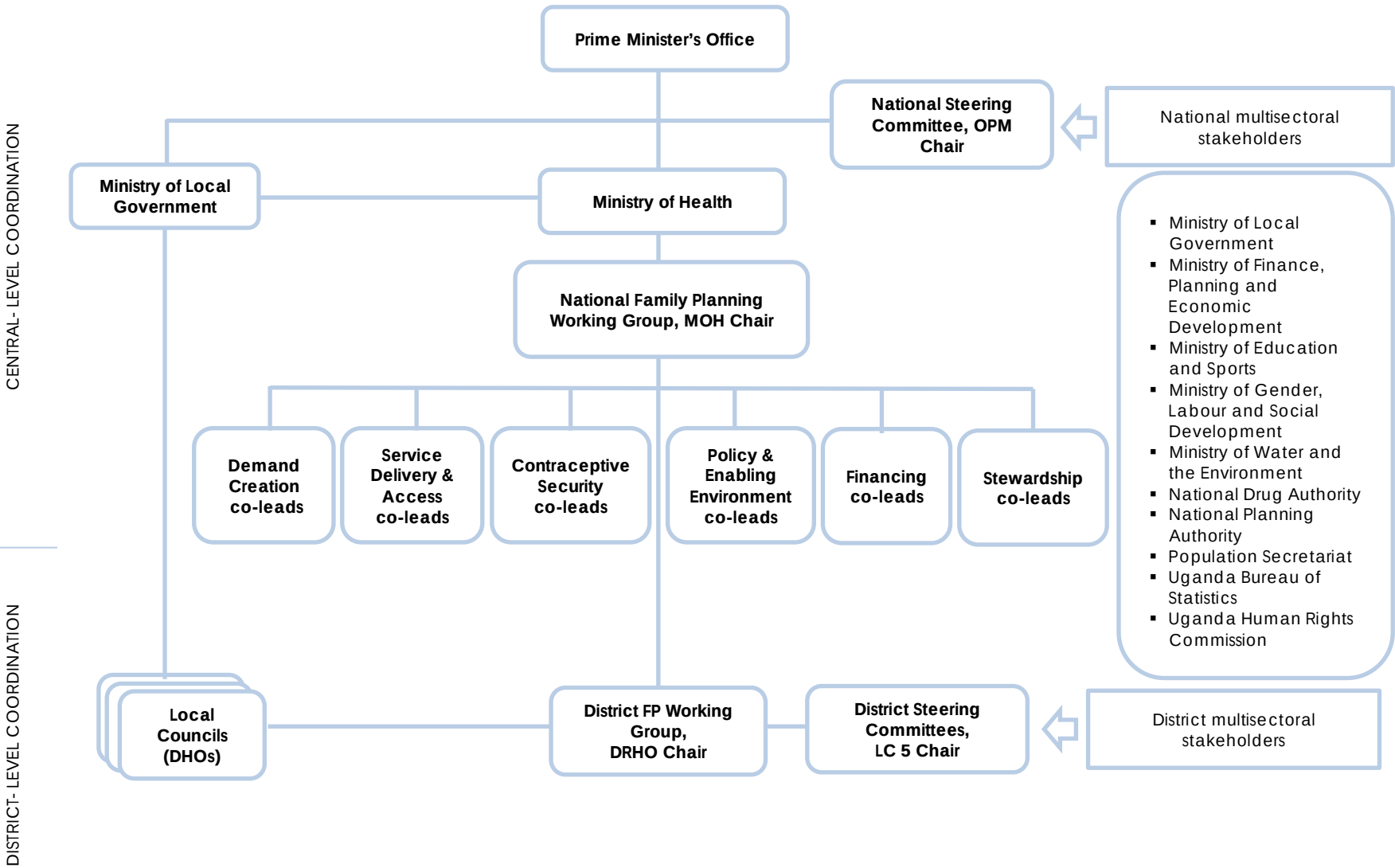
As outlined in the Second National Health Policy,[193] governance responsibility and leadership for ensuring universal access to FP services and meeting the national goals lies with the Government of Uganda. From an operational perspective, implementation of the FP-CIP will require the adoption of multisectoral and decentralised approaches in the coordination and management of the national effort. Such approaches create more opportunities for broad and diverse stakeholder involvement; however, managing multisectoral, decentralised coordination can be complex, challenging, and dynamic. This section describes proposed management structures and institutional coordination arrangements necessary to ensure the results outlined in the FP-CIP. The proposed structure and arrangements will be adapted as they are tested and rolled out operationally.

7.1 Management, Coordination, and Accountability Structure

The FP-CIP reflects a "common" plan for all stakeholders involved in implementing the FP programme at all levels. Following stakeholder consultations, a streamlined management, coordination, and accountability structure was proposed to steer implementation of the FP-CIP, as shown in Figure 42: Proposed coordination structure. The structure

- Recognises that the MOH, in consultation with stakeholders, will be the steward to spearhead the planning, financing, implementation, and performance monitoring of the FP-CIP within existing governance structures.
- Demonstrates that family planning is a key development intervention in harnessing the demographic dividend and accelerating socioeconomic progress towards the Vision 2040; as such, responsibility for implementing the FP-CIP transcends the MOH to include other relevant ministries and institutions.
- Shows that the FP-CIP will be implemented by a broad group of multisectoral stakeholders, including related ministries and agencies, development partners, civil society, community-based organisations, professional associations, faith-based organisations, voluntary agencies, and the private sector, amongst others.
- Designates a National Steering Committee to facilitate a multisectoral partnership forum to coordinate planning, financing, implementation, and monitoring of the FP-CIP. Coordination of the multisectoral effort takes place at the national, district, and community levels. At each level, the coordination structures are multisectoral in nature and draw representation from government, civil society/nongovernmental organisations, development partners, and the private sector.

Figure 42: Proposed coordination structure



7.2 Roles and Responsibilities of Key Actors

Office of the Prime Minister (OPM)

The OPM, in its role to coordinate the implementation of government policies, programmes, and projects, as well as implementation of the National Development Plan 2010/11–2014/15,[194] will be instrumental in coordinating cross-sectoral collaboration efforts described in the FP-CIP. The OPM will chair the National Steering and Coordination Committee, which is key for building cross-sectoral collaboration and facilitating strategic leadership and decision making. The MOH will report to the OPM and take a secretariat role for the steering committee.

Ministry of Health

The MOH is responsible and accountable for providing oversight to effectively and efficiently implement the FP-CIP. Through the Reproductive Health Division of the Community Health Department, the MOH will perform the following key functions: (1) manage, coordinate, and monitor implementation of the plan to ensure attainment of performance targets by a wide range of national and international stakeholders; (2) mobilise, monitor, and ensure efficient use of resources; (3) formulate and implement enabling policies, laws, and regulations; and (4) set guidelines and standards for programme and service delivery. The MOH will recruit new staff, including an FP Coordinator, who will be dedicated to coordinating implementation of the plan, and a Knowledge Management Officer, who will assist in data collection and monitoring activities in line with the plan's implementation.

Senior Top Management Committee (STMC)—The STMC, chaired by the Minister of Health and representing the highest level of governance within the MOH, will foster strong linkages with non-health ministries to realise a multisectoral approach in implementing the FP-CIP. The STMC will also ensure increased resources are directed towards the achievement of plan outcomes, as well as elevate family planning (and the FP-CIP) as a priority area within the MOH.

Top Management Committee (TMC)—The TMC, chaired by the Minister of Health, comprises a broader leadership group, including directors of departments and parastatal institutions, and represents the second highest level of governance within the MOH. The TMC will ensure that there are stronger linkages amongst the different departments and institutions to directly contribute towards implementation of the FP-CIP, as is appropriate with its individual mandate.

Senior Management Committee (SMC)—The SMC of the MOH, chaired by the Permanent Secretary, will provide strategic leadership in overseeing policy development and planning and assuring coordination of the activities and overall functioning of the other relevant departments and institutions within the ministry in support of the FP-CIP. The SMC will give greater attention to the FP-CIP in performing such functions as ensuring the availability and optimal distribution of skilled human resources; performing the inspectorate function of the government; tracking the procurement, delivery, management, and use of contraceptive commodities and equipment; and managing and making available HMIS data to aid in planning and coordination.

National Medical Stores (NMS)—In accordance with its mandate, NMS will procure, store, and distribute medicines and medical supplies to Ugandan public and private health facilities. Specifically, NMS will ensure that procurement, distribution, and warehousing systems for contraceptives and other reproductive health commodities are effective and efficient to foster reproductive health commodity security at all levels of health care. Also, NMS will ensure the proper forecasting, ordering, and distribution of FP commodities.

Other sectoral ministries and institutions

As successful implementation of the FP-CIP requires multisectoral engagement, other key ministries and institutions shall also contribute to the achievement of results in accordance with their respective mandates. Deliberate effort shall also be made to mainstream family planning in sectoral plans and

budgets—for resources to be set aside to promote family planning in respective sectors and provide essential linkages to the health sector for service delivery. Key ministries and institutions include the below.

Ministry of Local Government (MOLG)—The MOLG plays an important role in fostering decentralised implementation of the FP-CIP at the local government level, in accordance with the Local Government Act of 1997. The MOH will liaise with the MOLG to ensure local government authorities have the necessary support and capacity to implement programmes and services, including the allocation of resources, coordination of activities and stakeholders, and management of plan results at the district and sub-county levels.

Ministry of Finance, Planning and Economic Development (MOFPED)—The Ministry of Finance and Economic Development mobilises resources for the GOU and has the overall responsibility of allocating resources to different sectors according to priorities set by the GOU. In accordance with its mandate, the ministry will collaborate closely with the MOH in budget planning, disbursement of funds, and accounting for expenditures. Improved coordination and communication between this ministry and the MOH will ensure the timely disbursement of funds needed for implementation of the FP-CIP. In its role of coordinating implementation of the National Development Plan, the MOFPED will also mobilise and allocate optimal levels of resources towards the FP-CIP, with recognition that these investments will help to achieve the overall goal of the National Development Plan.

Ministry of Education and Sports—The Ministry of Education and Sports will be responsible for the provision of basic education and specialised technical training of health workers in Uganda. It will also foster an enabling policy environment in school systems. Comprehensive sexuality, gender, and health education at primary, secondary, and tertiary levels, as well as outside of school settings, are the primary investments for empowering youth to prevent unintended pregnancies.

Ministry of Gender, Labour and Social Development (MOGLSD)—This ministry is responsible for mainstreaming gender in all government policies and plans, which is an important component of the FP-CIP. The ministry will also address existing social and cultural contexts in the Ugandan society that lead to high-risk unintended pregnancies.

Ministry of Water and the Environment—This ministry is responsible for setting national policies and standards, managing and regulating water and environmental resources, and determining priorities for water and environmental development and management. The ministry will play a key role in advocating to strengthen population-health-environment programming; promoting policies and programming to develop communities' appreciation of the linkages between informed natural resource management and their families' long term well-being; and promoting the importance of family planning and reproductive health in families' efforts to remain resilient to climate change and live within the limits of the natural resources upon which their lives depend.

National Drug Authority (NDA)—In accordance with its mandate under the National Drug Policy and Authority Act Cap 206, the NDA will ensure the quality, safety, and efficacy of contraceptive commodities by regulating their production, importation, distribution, and use. The NDA will also ensure that the national list of essential drugs features an adequate mix of priority contraceptive products according to the established needs of the population, as detailed in the FP-CIP.

National Planning Authority (NPA)—The NPA is responsible for strategic thinking, providing advice to the government on medium- and long-term strategies for socioeconomic development. The NPA will support and institutionalise FP as a key development intervention to harness the demographic dividend to achieve Vision 2040. The NPA will also ensure that the relevant institutions of government (and relevant non-state actors) develop family planning and health indicators consistent with the FP-CIP.

The Population Secretariat (POPSEC)—POPSEC works with the MOH to coordinate implementation of the FP-CIP, with an objective of improving the policy environment for FP/RH. POPSEC will promote the integration of population variables into development policies, plans, and programmes, promote capacity development at national, sectoral, district and lower levels, and support the District Planning Units (DPUs) to allocate resources for implementation of the FP-CIP.

Uganda Bureau of Statistics (UBOS)—UBOS will provide core demographic and health statistics crucial for monitoring and evaluating the FP-CIP. These statistics will be generated through national demographic household surveys and the census.

Uganda Human Rights Commission (UHRC): The Uganda Human Rights Commission (UHRC), as an independent state institution with the mandate to protect human rights, will monitor government efforts to ensure universal access to rights-based family planning; it will produce independent reports and will issue resolutions to promote systemic changes and address the complains of aggrieved individuals. It will also participate as a key stakeholder in monitoring and evaluation of the FP-CIP

Parliamentarians

Parliamentarians will foster general awareness on population issues at all levels in the country, lobby for the inclusion of FP issues in government priority programmes, and advocate for an enabling environment, including promoting investments in FP projects.

Research and academia

Research and academic institutions play an important role in the national effort to increase the use of FP services through technical guidance, research, and training of future professionals. Academic institutions will integrate family planning into a wide range of programmes, especially in pre-service institutions for service providers. Research institutions will be encouraged to generate new research evidence to improve operational performance and quality of service delivery.

Professional associations

Through various professional bodies and technical agencies, the MOH will monitor compliance to the laws and set standards to allow the ministry to concentrate on policy and strategic issues. The bodies include the Medical and Dental Practitioners Council, Pharmacists Council, Nurses and Midwives Council, and Allied Health Professional Council.

Development partners

Development partners and UN agencies are instrumental players in the successful implementation of the FP-CIP through providing the necessary financial resources, technical expertise, and material supplies. Development partners and UN agencies will closely collaborate with the government. Key roles and responsibilities include supporting the modalities of the national response that government partners see as priority challenges with insufficient resources and/or technical expertise; and coordinating their assistance through the multisectoral Health Policy Advisory Committee to avoid duplication.

Civil society and nongovernmental organisations

Civil society includes a diverse group of organisations, including faith-based organisations; cultural, local, and international organisations; media; private sector organisations; and academia. Collectively, civil society plays a crucial role in accelerating access to and use of high-quality FP services and, thus, is a key implementer of the FP-CIP. The alternative distribution system performs a key role in facilitating private sector procurement of FP commodities and thus needs to be strengthened and facilitated to better play that role. Civil society entities will also complement the public sector in delivering services at facility and community levels, mobilise resources, and exercise their role as advocates by playing the role of a “watchdog” to ensure social accountability and responsibility.

Subnational implementation

Consistent with the government policy on decentralisation by devolution, the FP-CIP will place increased responsibilities for scaling up family planning through better planning, resource allocation, implementation, monitoring, and evaluation with local government authorities. The MOH will work with partners to provide guidance and technical assistance to districts to facilitate the translation of FP-CIP results and activities at the district level and ensure that annual budget requests to the Medium Term Expenditure Framework from the district level includes family planning. Particular emphasis will be placed on the district local government and Chief Administrative Officer, as well as other key departments such as planning and education, which are essential to subnational implementation of the FP-CIP.

District health officers and assistant DHOs

As the administrative head of health services in a district, the DHO will oversee district-level implementation of the FP-CIP. The DHO will work with the Chief Administrative Officer to plan and budget adequate financial resources for the FP-CIP within the district health budget. The DHO will translate the FP-CIP into plans of action for the districts and mobilise additional resources to implement the plan. District reproductive health officers will offer technical support to the lower-level health facilities and provide oversight of FP service delivery at the facility and village levels through VHTs. They will also facilitate engagement structures at the community level and convene actors to plan, implement, and monitor activities.

7.3 Coordination Framework

Given the diversity and multitude of stakeholders required to implement the FP-CIP, the harmonisation of resources and activities will be of paramount importance. A clear and active coordination framework at all levels is necessary to prevent duplication of efforts, enhance efficient use of resources, track progress and results, and facilitate knowledge sharing.

The MOH will lead FP-CIP coordination, including stakeholder engagement and the new and existing coordination structures at the central and district levels of the health system described below. Coordination also includes ensuring that the strategic priorities and activities of the FP-CIP are integrated and harmonised with, and supported by, other health and non-health-sector programmes. Resource mobilisation also includes the development of annual budgets in collaboration with the planning department and in the context of the Medium Term Expenditure Framework. It also includes ascertaining resource gaps, aligning available resources to priority results, and lobbying and advocating for increased government and donor support of the FP-CIP.

Central level

National Steering and Coordination Committee for FP-CIP. The national steering and coordination committee is a multisectoral partnership platform chaired by the OPM and supported by POPSEC to facilitate coordination amongst cross-sectoral stakeholders. The committee will strive to achieve efficiencies and the collective effectiveness of different stakeholders by clarifying roles and responsibilities for implementation, creating stronger synergies amongst implementing partner efforts, optimising the flow of information across different stakeholders, and requiring accountability for performance and results from all partners.

Health Policy Advisory Committee (HPAC). The HPAC will continue its mandate to promote the harmonisation of donor investments and address alignment issues with government priorities. It will advise the MOH on policy issues and participate in joint annual review of the performance of the FP-CIP.

Family Planning/Reproductive Health Commodity Security Working Group. All implementing and development partners of the MOH will be convened under the Family Planning/Reproductive Health Commodity Security Working Group, chaired by the MOH and reporting to the Maternal and

Child Health Working Group. The working group is expected to continue to play an important role during the plan's implementation. The group will play an advisory and guidance role to the MOH and FP stakeholders and support effective implementation of the FP-CIP through a variety of strategies, as well as provide a forum for stakeholders to share information and technical updates. The terms of reference and working modalities will be reviewed, and appropriate revisions will be made to ensure that its mandate and priority activities align with the attainment of results of the FP-CIP.

Six **thematic area co-leaders**, reporting to the Family Planning/Reproductive Health Commodity Security Working Group, will be assigned to steer and coordinate efforts for the six investment areas: demand creation, service delivery and access, contraceptive security, policy and enabling environment, financing, and stewardship, accountability, and management. The co-leaders, one nominated from the MOH and another representative of implementing partners, will serve as the lead technical resources for developing the annual objectives and implementation plan for their respective priority area based on the FP-CIP; coordinate the implementation of priority strategies in their investment areas; and report back during the Family Planning/Reproductive Health Commodity Security Working Group meetings on progress and challenges with implementation.

Uganda FP Consortium. Established in 2010, the consortium provides a forum for coordination and advocacy on family planning by stakeholders in the private sector. It will continue to play its role to promote stronger linkages between the government and private non-profit stakeholders. It will also continue to promote the visibility of family planning and play an important role in resource mobilisation.

District level

Similar coordination structures will be replicated at the district council level, including a multisectoral district steering committee, chaired by the Local Council V (LC 5) and a district FP technical working group, chaired by the district reproductive health officer.

7.4 Resource Mobilisation Framework

The success of the FP-CIP hinges on the ability to mobilise a considerable amount of resources within a short time frame and on a continuous basis throughout the implementation period. After the launch of the FP-CIP, a framework will be developed to guide a systematic process for mobilising resources. The framework will be informed by the gap analysis report to identify the country's funding gaps for plan implementation. The framework will explore a number of strategies, including broadening the donor base, enhancing advocacy at the district level for increased allocation of funds to family planning, mobilising resources and support from the private sector (and foundations), and increasing efficiency in the use of funds.

7.5 Performance Monitoring and Accountability

Measuring performance against set targets in the FP-CIP is crucial to generating essential information to guide strategic investments and operational planning. Monitoring and evaluation of the FP-CIP will rely on various systems and data sources (routine and periodic), supported and maintained by numerous stakeholders. Soon after the launch of the FP-CIP, a comprehensive performance monitoring plan and associated monitoring tools will be developed and established.

While service utilisation data will be collected through the HMIS, and from the Track20 and PMA2020 initiatives, a mechanism to collect and review process monitoring data will be established. A system will be developed to collect and report on quarterly data related to financial expenditures, source of funds, geographic location and coverage of implemented activities, and output-level results based on indicators. The information generated from these quarterly data collection efforts will be routinely used by the MOH and working groups to track progress in the mobilisation of financial resources for implementation of the programme and achievement of results against set programme targets. This mechanism will help to ensure that efforts implemented conform to the plan and that

results achieved align with performance targets. Also, process monitoring will allow for corrective and preventive action along the way, including fine tuning of strategies and the planning and coordination process.

Several categories and levels of indicators will be collected. A comprehensive list of output-based indicators is included in the activity matrix in Figure 43: Illustrative list of indicators.

Key performance indicators will hinge on strategic priorities to assess implementation progress and will be presented in a dashboard format to provide a snapshot view of the programme's status.

On a bi-annual basis, the MOH will convene a joint review meeting to assess the progress of FP-CIP implementation against targets and agree on priorities for the upcoming period. The DHOs will also attend these review meetings to share and discuss progress in their districts. The meetings will therefore serve as a key accountability mechanism to assess implementation of the plan and outputs/outcomes. The joint review meeting will also serve to assess the planning and programming process, in time to make recommendations for the next annual work planning cycle or long-term strategic planning.

A formal appraisal of the plan's implementation period will be conducted mid-way to assess progress and areas of preventive or corrective action.

Figure 43: Illustrative list of indicators

Category	Illustrative Indicators		Data Source
Demographic indicators	• mCPR • Percent distribution of users by modern method • Number of additional FP users • Percent of women with an unmet need for modern contraception • Percent of women whose demand is satisfied with a modern method • CYP • Unmet need • Teenage pregnancy rate		Track20, PMA2020, and the UDHS
Service statistics	• Number of women receiving counselling or services in family planning—new acceptors and continuing clients • Number of women receiving FP services, by method • Number of products dispensed, by method • Number of youth receiving counselling or services in family planning—new acceptors and continuing clients • Number of HIV-positive clients using family planning		HMIS
Process indicators	Demand creation	• Percent of non-users who intend to adopt a certain practice in the future • Number of radio and TV spots aired • Percent of audience who recall hearing or seeing a specific message • Availability of accessible, relevant, and accurate information about sexual and reproductive health tailored to young men	• Project reports • Programme surveys • DHS • FP-CIP progress monitoring database

Category	Illustrative Indicators		Data Source
	Service delivery and access	• Number of providers trained on family planning by district • Number of mobile clinic events organised, and number of people reached by district • Number of youth-friendly service clinics established • Availability of accessible, relevant, and accurate information about sexual and reproductive health tailored to young men	
	Contraceptive security	• Contraceptive stock-outs • Actual annual expenditure of government funds on contraceptive procurement for the public sector • Percent of facilities that experienced a stock-out at any point during a given time period • Occurrence of stock-outs for any contraceptive or other identified reproductive health commodity at the central-level warehouse during a specified time period	
	Policy and enabling environment	• Evidence of FP programmes incorporated into national strategic and development plans • Evidence of documented improvement in the enabling environment for family planning, using a validated instrument (e.g., the Family Planning Programme Effort Index and Contraceptive Security Index) • Evidence of targeted public and private sector officials, faith-based organisations, or community leaders publicly demonstrating a new or increased commitment to family planning • Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy	
	Financing	• Annual expenditure on family planning from government domestic budget • Evidence of new financing mechanisms for family planning identified and tested • Evidence of private for-profit sector participation in family planning • Share of contraceptive procurement for the public sector financed by the government	

Category		Illustrative Indicators	Data Source
	Stewardship, management, and accountability	• Evidence of multisectoral structures established or strengthened to promote FP policy • Evidence of data or information used to support repositioning FP efforts • Evidence of government departments or other entities established or strengthened to support the FP agenda	

ANNEX A: IMPLEMENTATION FRAMEWORK WITH FULL ACTIVITY DETAIL

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
DC1. Demand for FP services is increased	Women ages 15–49 years with demand for family planning (met demand and unmet need)	[SP.2] [2020.1]	Gather evidence and data to inform a SBCC strategy to ensure honest, accurate, clear, and consistent FP messaging that targets various audiences (rural/urban youth, married youth, men, people living with HIV, people with disabilities, faith-based, sex workers, etc.)	Meetings to determine the 2 terms of reference (TORs) for the consultants who will develop the communications strategy and evaluate current messaging	• 3 meetings • 1 day • @ hotel in Kampala • 10 people • Transport refund • Printing: 5 pages per person	TORs are developed to hire consultants	2015
				Engage a research consultant to evaluate why the current messaging is not resonating with all groups of people	• Hire research firm for 30 days • Stakeholder meetings: o 4 meetings o @ offices in Kampala o 10 people o Transport refund	Research report evaluating current messaging produced	2015
				Disseminate research findings	• Printing: 500 copies, 50 pages • Disseminate in 10 regions o @ regional hotel o 30 people o Transport refund o Printing: 5 pages per person	Number of research reports printed and disseminated (Target: 500) Number of dissemination meetings held by regions (Target: 10 regions)	2015

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
		[SP.2] [2020.1]	Develop a communications strategy with evidence-based messaging	Engage a consultant to develop a strategy and develop and test key communication messages for all audiences	• Hire firm for 30 days • 3 workshops: o 15 people each o @ hotel in Kampala o Transport refund o 1-day workshop o Printing: 5 pages per person	FP communication strategy developed and approved	2015
				Print and disseminate strategy	• Print 1,000 copies of 20-page communications strategy • Dissemination meeting o 1-day meeting o @ hotel in Kampala o 100 people o Transport refund o Printing: 5 pages per person	Communications strategies printed, distributed, and posted to MOH website (Target: 1,000)	2015
		[SP.2] [2020.1]	Develop and implement a mass media campaign on family planning based on communications strategy	Engage a consultant to develop family planning media scripts (radio, TV, print, etc.)	• Hire consultant for 30 days • Stakeholder meetings: o 2 meetings o 1 day o @ hotel in Kampala o 20 people o Transport refund o Printing 5 pages per person	Number of radio, television, drama, and print media spots developed	2015
				Purchase media space for FP messages	• Buy 30-second ad space to play 3 times a week, quarterly • Buy time to host quarterly discussion sessions on TV and radio	Number of radio and TV spots purchased and aired (Target: 3 times a week, quarterly) Number of quarterly discussion sessions	2015 2016 2017 2018 2019 2020

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
						aired on TV and radio (Target: Quarterly)	
				Orient TV presenters on select FP thematic topics	• 1 workshop • 1 day • @ hotel in Kampala • 10 people • Transport refund • Printing: 5 pages per person	Number of TV presenters oriented on FP message guide (Target: 10)	2015
		[SP.2] [2020.1]	Develop and record soap episodes on family planning to be played in 3 regions	Engage research firm to conduct an evaluation of the current FP environment	• Hire consultancy firm for 90 days	Evaluation of current FP environment completed	2015
				Recruit and hire project director, 36 actors, 10 writers, and 6 producers to write, act, and produce the soap	• Hire: o 1 project director o 36 actors o 10 writers o 6 producers	Number of staff hired (Target: 1 project director, 36 actors, 10 writers, and 6 producers)	2015
				Hold a series of trainings with the actors and writers	• Hold 2 trainings for 2 separate groups • 1 week each • @ hotel in Kampala • 36 actors • 10 writers • Printing: 50 pages per person	Number of trainings held (Target: 2 trainings for 2 groups of 46 people for one week each)	2015
				Host advisory committee meetings to guide the soap	• 10 meetings • 1 day • 20 people • @ hotel in Kampala	Number of review meetings held (Target: 20 person meeting, 10 times	2015 2016 2017

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
				episode development process	• Printing: 5 pages per person	annually to review and support making of soap operas)	
				Promote the soap episodes in the community	• 100 30-second radio spots • 300 hats • 300 shirts • 10 banners	Number of radio spots, hats, t-shirts purchased, aired, and/or distributed (Target: 100 30-second radio spots, 300 hats and t-shirts, and 10 billboards)	2016 2017
				Buy media slots to air the episodes	• Purchase 208 1-hour radio spots	Number of radio spots purchased (Target: 208 1-hour radio spots)	2016 2017
				Host viewing teams to get feedback on the episodes	• 3 regions • 5 districts • @ district meeting room • 20 people • Refreshments • Journals	Number of regional viewing team meetings held and number of participants (Target: 300 participants)	2016 2017
		[SP.2] [2020.6]	Sensitise and orient interpersonal communication agents working in the health and non-health sector to integrate FP SBCC into the communities	Work with implementing partners to engage health and non-health FP champions	• 2 people travelling to regional implementing partner offices • 3 days in each 10 regions • Transport refund • Per diem	Number of interpersonal communication agents trained, per target region	2015 2016 2017 2018 2019 2020

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
		[SP.2] [2020.1]	Orient and sensitise cultural leaders and community leaders working on HIV (voluntary counselling and testing, prevention of mother-to-child transmission, care and treatment, psychosocial groups, etc.), gender-based violence, and maternal health to include FP in their current work	Hold a series of workshops with cultural and community leaders to orient them on FP messaging	• 10 workshops • 1day each • @ hotel in central region • 50 people • Per diem • Transport refund • Printing: 20 pages per person	Number of leaders oriented and sensitized on FP messaging (Target: 500)	2016
		[SP.2] DC3	Develop a package to guide recruitment, orientation, and monitoring of FP champions	Engage a consultant to develop an FP champion package	• Hire consultant for 30 days • Stakeholder meetings: o 4 o @ offices in Kampala o 10 people • Transport refund	Package guide for champion work developed	2015
				Disseminate package	• Printing: 100 copies of 50 pages • Disseminate regionally in 10 UBOS regions o @ regional hotel o 30 people o Transport refund o Printing: 5 pages per person	Number of package guides printed and disseminated (Target: 100 copies of package guide)	2016

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
				Provide support for regional champions	• Buy t-shirts, jackets, and certificates for 30 champions per region	Number of champions supported with FP materials (Target: 300 per year)	2015 2016 2017 2018 2019 2020
DC2. Men support the use of modern contra-ception for themselves and their partners	Number of men who support the use of modern contraception for themselves or their partners is increased	[SP.2] [2020.6]	Conduct community outreach events to engage men in family planning	Conduct men special days	• Hold community outreach event for men in every district • Purchase radio announcement: 30 seconds for 3–4 days • Develop and print 20 advertising posters • Develop promotional materials (T-shirts) • Printing: 100 copies, 1 page	Number of men reached in each district through special events (Target: 800 men)	Quarterly scale-up
				Conduct FP outreach events	• 500 locations • 10–15 people going out • Mobilisation reimbursement • Refreshments	Number of FP community outreach events held	2015 2016 2017 2018 2019 2020 Yearly scale-up Not repeating
DC3. Young people, 10–24 years old, are knowledge-able about family	Young people 10–24 years of age are knowledgeable about FP and are accessing FP services	[SP.1] [SP.2] [2020.8]	Engage peers to educate young people about family planning services	Convene workshops to review and update existing national peer training tools and materials	• 1 meeting • 5 days • @ hotel in Kampala • 100 people • Transport refund • Printing: 200 pages per person	Peer training material updated and adopted (Target: 5-day workshop held with 100 people)	2015

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
planning and are empowered to use FP services				Hold regional youth camps to recruit and orient peer educators	• 1 camp per region • 10 regions • 5 days • @ hotel • 50 people per region • Transport for young people • Printing 10 pages per person • Artists stipend: 2 per region • Technical allowance for 5 facilitators per region	Youth camps held (Target: 50 peer educators oriented per region)	2015 2016 2017 2018 2019 2020
				Supervise youth plans that are developed	• 10 regions o 3 people o SDA • MOH outreach: o Total of 30 people going out once a year o Per diem • Travel	Youth plans supervised (Target: 10 regions annually with 30 MOH staff)	2015 2016 2017 2018 2019 2020 Quarterly
		[SP.1] [SP.2][2020.1]	Create an educational yearly youth magazine that describes youth FP activities, programmes, and services	Write and disseminate youth magazine	• Hire 2 people to write • Printing: 5,000 copies, 20 pages (distributed to youth corners, peer educators, and Chief Administrative Officers)	Youth magazine is produced annually	2015 2016 2017 2018 2019 2020
		[SP.1] [SP.2][2020.1]	Produce youth FP pull-outs for newspapers	Write youth FP pull-out document for newspapers	• 2 consultants (from above) • Printing: 20,000 copies, 1 page	Number of youth newspaper pull-outs disseminated (Target: 20,000 youth newspaper pull-outs, monthly)	2015 2016 2017 2018 2019 2020 Monthly

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
		[SP.1] [SP.2][2020.1]	Create a BlogSpot as a reference point for further feedback from youth	Develop youth BlogSpot hosted by youth to answer common FP questions	• Hire someone to develop BlogSpot: 10 days • Facilitate youth: o 4 youth o 20 days	Youth FP BlogSpot developed as additional reference point	2017
		[SP.1] [SP.2][2020.8]	Support peer educators	Provide monthly peer educator stipends	• 10 regions o 50 stipends per region	Number of peer educators receive monthly stipends (Target: 500 per educators)	2015 2016 2017 2018 2019 2020 Monthly
		[SP.1] [SP.2][2020.1]	Host "edutainment" community events, like dances, music concerts, and sport competitions to provide opportunity for knowledge exchange amongst young people		• 112 districts • Rent a tent • 2 staff per district • Per diem • Transport • Facilitating entertainment group/person	Number of community events held annually (Target: 1)	2015 2016 2017 2018 2019 2020
		[SP.1] [SP.2] [2020.1]	Empower parents, caregivers, and teachers to help their children to	Print Straight Talk parent and teacher training material	• Printing: 3,000 copies, 50 pages	Number of Straight Talk training materials printed and disseminated (Target: 3,000)	2017

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
			avoid teen pregnancy, including improving parent-child communication on sexual issues	Conduct workshops with teachers and parents to orient them on how best to talk to youth about family planning	• 10 regions • 5 per region • 50 people at each • Refreshments • Transport refund • 2 facilitators SDA • Printing: 10 pages per person	Number of teachers and parents trained (Target: 2,500)	2017
				Hold discussion forums on TV and radio about how parents can best communicate with their children about sexual education	• Media buys o 30 seconds per radio and TV o Quarterly o Per region • Presenter facilitation o Print booklet • Develop and print 1 page brief on booklet and what to discuss	Number of quarterly TV and radio discussions (Target: Quarterly discussions)	2017 2018 2019 2020
				Hold community dialogues about how parents can best communicate with their children about sexual education	• 10 regions • 5 per region • 30 parents at each • Refreshments • Transport refund • 2 facilitators SDA • Printing: 15 copies of 50 pages	Number of community dialogues held and participants (Target: 50 dialogues held; 1,500 parents engaged)	2015 2016 2017 2018 2019 2020
DC4. Social marketing of free products and commercial sector increases FP demand	Project to brand free, public-sector condoms initiated and evaluated	[2020.6]	Initiate and evaluate a pilot project to brand free, public-sector condoms to see if overall uptake increases	MOH to partner with social marketing organisation to design and pilot branded free, public-sector condoms	• Hire consultant: 60 days • Purchase 1 million condoms with new branded packaging	New condom packing developed; Number of new branded condoms procured (Target: 1 million)	2017

AREA #1: Demand Creation (DC)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-activities**	**Inputs**	**Output Indicators**	**Timeline**
				Pilot branded free condoms in 3 districts per region	• 10 regions • 3 districts per region • Facilitate 10 distributers per region	Number of new condoms distributed (Target: 1 million to 30 districts)	2017
				Evaluate piloted districts	• Regional hotel venue • 1-day meeting, 2 nights • 20 people per region • Refreshments • Travel • Per diem • Printing five pages per person	Number of districts evaluated and scaled up for effectiveness of new packaging (Target: 30)	2018

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
SD1. Access to FP services is increased	Family planning service delivery points are increased for rural communities	[SP.3] [2020.6] [2020.11]	Pilot mobile clinics	Host a regional meeting with DHOs, ADHOs, and FP focal person to review TOR for piloting mobile clinics	• Regional meeting hotel • 1-day meeting, two nights • 20 people per region • Refreshments • Transport refund • Per diem • Printing: 5 pages per person	TOR produced documenting number of mobile clinics piloted, where they are being piloted, and service to be provided	2015
				Pilot mobile clinics in 10 UBOS regions and 5 districts	• Outreach once a week • 1 location per district • 10 service providers per region • Safari day allowance for 10 service providers • 5 vehicles per region • 5 equipment bags per region • 5 tents per region • 5 collapsible tables per region	Number of mobile clinics established per region(Target: 50 mobile clinics established, 5 per region)	2016
		[SP.3] [SP.6] [2020.11]	Review effectiveness of mobile clinics	Meet with DHOs and ADHOs to review effectiveness of piloted mobile health clinics	• Regional hotel venue • 1-day meeting, two nights • 20 people per region • Refreshments • Transport refund • Per diem • Printing: 20 pages per person • Printing: 3 banners	Documentation of mobile clinics effectiveness captured	2016

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
		[SP.3] [SP.6] [2020.11]	Scale up mobile clinics to all districts	Scale up mobile clinics to all districts	• 112 districts • 1 location • 2 service providers per district SDA per service provider • 5 collapsible tables per region • 5 service bags per region • Outreach at 1 week per district	Number of mobile clinics established (Target: 112 districts receiving mobile clinics)	2017 2018 2019 2020
	FP services are expanded through public-private partnerships	[SP.4] [2020.6] [2020.7]	Sensitise private organisations on the importance of promoting and using FP services	Hold a series of workshops to sensitise private organisations	• 10 regional workshops • 1 day • @ regional hotel • 15 people per region • Transport allowance • Per diem	Number of people from private organisations oriented on provisions of FP services (Target: 150)	2016 2018
SD2. Referral services are strengthened	A uniform FP referral is created	[2020.11]	Develop, disseminate, and train on FP referral forms	Host a stakeholder meeting to develop referral form	• @ hotel in Kampala • 15 people • Transport • Printing 5 pages per person	FP referral forms developed	2015
				Hire consulting firm to translate documents	• Hire consulting firm for 10 days	Referral forms translated into relevant languages for 10 different regions	2015
				Print and disseminate referral forms	• Printing: 600 copies, 1 page • Disseminate at technical working group meeting: o Refreshments	Number of referral forms printed and disseminated (Target: 6,000)	2015

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				Train DHOs and ADHOs in new referral forms for them to take to health care workers	• Train at 10 regions • 1day, 2 nights • @ regional central hotel • 20 people • SDA per health care workers • Printing: 5 pages per person	Number of participants trained on referral forms (Target: 200)	2015
SD3. Motivation for FP health care workers is increased	Performance-based incentives are developed for FP health care workers	[2020.11]	Develop guidelines for performance-based incentives for FP health care workers	Hire consultant to develop guidelines	• Hire consultant for 60 days • Meetings with stakeholders: o 2 meetings, middle and top levels o @ hotel in Kampala o 20 people per meeting o Transport o Printing: 5 pages per person ▪ Printing 200 copies of 50-page document	Guidelines developed for performance-based incentives and printed (Target: 200 copies)	2015
				Hold regional workshops with managers to train them on how to use performance plans	• 30 people per 10 UBOS regions • @ hotel in regions • SDA for 15 people • 1 day, 2 nights • Printing: 5 pages per person	Number of managers trained on developing performance plans with employees (Target: 300)	2015
SD4. Family planning services are integrated into other health services	FP services are integrated into • Cervical cancer screening • Postnatal care • Postpartum care	[SP.4] [2020.11]	Develop FP integration protocols	Host meetings with professional associations to develop protocol	• 1 meeting with professional associations • 1 day • @ Ministry of Health • 20 people • Refreshments • Transport refund	Integration protocols developed and approved	2015

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
	• Sexually transmitted infection screening, treatment, and care • Malnutrition programmes			Print protocols	• Printing: 6,000 copies, 5 pages	Number of copies of 5-page protocol printed (Target: 6,000)	2015
				Train service providers on protocols and FP service delivery	• 2 meetings • 2 days, 2 nights • @ regional central hotel • 25 people • SDA for each participant • Printing: 5 pages per person	Number of providers trained on FP service integration (Target: 500 providers)	2016
SD5. Family planning services are accessible by people with disabilities	FP service delivery guidelines developed for people with disabilities	[2020.11]	Develop clinical guidelines for provision of FP services to people with disabilities	Hire consultant to develop guidelines	• Hire consultant for 30 days • Stakeholder meetings: o 10 meetings o @ hotel in Kampala o 20 people per meeting o Transport o Printing: 5 pages per person	Clinical guidelines developed for FP provision to people with disabilities	2015
				Disseminate and print guidelines	• Printing: 6,000 copies, 5 pages	Number of copies printed (Target: 6,000)	2015
				Train health workers on providing services to FP clients with disabilities	• 10 regions • 2 days, 2 nights • @ central hotel • 25 people per region • SDA per person • Printing: 5 pages per person	Number of providers trained on disability service provision (Target: 250)	2015
		[2020.11]	Sponsor courses for service providers to learn sign language	Sponsor courses for 400 people to learn sign language	• Sponsor 400 people: HC IV and hospitals to have one person who understands sign language	Number of service providers trained in sign language (Target: 400)	2015

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
SD6. Family planning side effects are managed	Counselling guidelines for family planning is re-assessed	[SP.2] [2020.11]	Assess current FP counselling guidelines	Hold meeting to assess current counselling guidelines and re-write new ones with the MOH, and key development partners, key partner organisations	• 2 meetings • @ hotel in Kampala • 50 people • Transport allowance • Printing: 50 pages per person	Meetings held with 50 participants Counselling guidelines developed	2015
		[SP.2] [2020.11]	Train trainers on FP side effects counselling	Train 20 trainers in Kampala	• 4 days, 5 nights • @ hotel in Kampala • 20 people • Per diem • Transport • Printing: 20 pages per person	Number of trainers trained (Target: 20)	2016
		[SP.2] [2020.11]	Print and disseminate reporting tools for pharmacovigi-lance	Hire a consultant to develop reporting tools	• Consultant: 20 days • Printing: 6,000 copies, 50 pages	Reporting tools for pharmacovigilance developed; Number of copies printed (Target: 6,000)	2015
SD7. In-service training is improved to include family planning	Current in-service training guidelines are reviewed to ensure that they include an FP component and a full range of methods	[2020.11]	Review current in-service training guidelines to ensure they include a full and comprehensive FP section	Print newly revised in-service training material	• 3 books • 1,000 pages total • 100 copies	Number of training books printed (Target: 100 copies of 3 books)	2015
				Disseminate and train the trainers on the new components of the training documents	• 5 days • @ hotel in Kampala • 30 people • Transport refund • Per diem	Number of trainers trained (Target: 30)	2015 2017 2020

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				Re-assess current in-service training documents to ensure they include full FP components	• Meeting to develop TOR for consultant: o 1 day o @ hotel in Kampala o 15 people o Transport allowance • Hire consultant for 30 days	In-service trainings re-assessed and updated	2017 2020
				Disseminate new in-service training documents	• 1 day, 2 nights • @ hotel in Kampala • 50 people • Transport allowance • Printing: 100 copies of 10 documents, 100 pages per document	Number of in-service training documents printed and disseminated (Target: 100)	2017 2020
SD8. Family planning in the VHT system is strengthened	Standardised FP training for VHTs is scaled up	[SP.3] [2020.6]	Re-evaluate and re-write VHT training material to include full and thorough FP information	Hire consultant to re-write material	• Meeting to develop TOR for consultant: o 1 day o @ hotel in Kampala o 15 people o Transport allowance • Hire a consultant for 30 days	VHT training material is updated	2015
		[SP.3] [2020.6]	Scale up training of VHTs on FP methods to 112 districts in 5 years with re-training every 5 years	Training-of-trainers for VHTs	• 25 trainers per region • Hotel in region • SDA • Printing: 30 copies per region, 800 pages per document • SDA for trainers to reach 112 districts in 5 years with re-training every 5 years	Number of trainers trained; Number of villages with VHT reach (Target: 250 trainers trained; 50,000 villages with VHTs reached)	2015 2016 2017 2018 2019 2020

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
	Use of Depot Medroxyprogesterone Acetate (DMPA) or Depo Provera® and/or Sayana® Press by VHTs is operationalised	[SP.3] [2020.6]	Meet with lawyers and members of Parliament (MPs)	Hold a series of meetings with lawyers and MPs	• 5 meetings • @ hotel in Kampala • 30 people • Transport • Per diem • Printing: 5 pages per person	Evidence of a decision made on operationalising injectable provision by VHTs	2015
	Benefit packages for VHTs are institutionalised	[SP.3] [2020.6]	Hold meeting with partners to harmonise VHT benefit packages		• 1 meeting • @ hotel in Kampala • 40 people • Printing: 20 pages per person	Number of meetings held (Target: 1) Document depicting how benefit package for VHTs are being implemented by partners produced	2016
SD9. Youth-friendly services are provided in clinics	Youth-friendly corners are established in every clinic	[SP.1] [2020.8]	Establish youth-friendly corners in clinics currently without any	Map current clinics without youth corners	• Hire consultant for 30 days • Print 100 copies, 10 pages • Disseminate at TWG meeting: o Refreshments for 50 people	Document of clinics without youth-friendly corners developed	2015
				Identify space in centres currently without clinics and furnish	• Renovate additional space in health centres • For each youth corner: o Desk o TV and DVD player o 15 chairs • 400 locations • Facilitate 800 peer educators	Number of youth centres established (Target: 400) Number of peer educators facilitated (Target: 800)	2016 2017 2018 2019 2020

AREA #2: Service Delivery (SD)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
	Health workers are trained on youth-friendly services	[SP.1] [2020.8]	Health workers are trained on how to provide youth-friendly services	Train trainers on youth-friendly services	• 25 trainers per region • @ hotel in region • SDA • Printing: 30 documents per region, 200 pages per document	Number of new trainers trained (Target: 25 per region)	2015
				Training of health workers on youth-friendly services	• Training 5 from each district (50 per region) • @ hotel in region • Every district represented • Per diem • Transport • Printing 200 pages per person	Number of people trained on youth-friendly services (Target: 250)	2015
	FP service delivery hours are increased to include outside school hours	[SP.1] [2020.8]	Motivate workers to spend an extra hour working at the clinic	Provide recognition and certification for health care workers who put in the extra hours at a national or regional meeting	• Transport • Per diem • 5 staff per region (10 UBOS regions, 50 staff) • Purchase plaques for all staff people	Number of staff recognised quarterly and annually (Target: 50 quarterly; 200 annually) Number of facilities offering extended hours for FP services	2015 2016 2017 2018 2019 2020 Quarterly

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
CS1. Comprehensive forecasting, quantification, and procurement of FP commodities is implemented	FP commodities are forecasted, quantified, and procured	[SP.5] [2020.3]	Conduct annual quantification, forecasting, and procurement workshops for FP commodities and consumables	Hold annual meeting to review annual contraceptive and consumable needs	• 3 meetings • 1 day • @ hotel in Kampala • 25 people • Transport refund • Printing: 100 documents of 50 pages	Annual review meeting held on contraceptives commodities forecasting and quantification procurement	2015 2016 2017 2018 2019 2020
		[SP.5] [2020.4]	Follow-up with interested partners to determine whether they can further help to fill the financing gap for contraceptives	Hold meeting with partner organisations	• 1 day • @ hotel in Kampala • 25 partners • Printing: 35 pages per person	Documentation of partner commitments made to cover financing gap for contraceptives	2015 2016 2017 2018 2019 2020
		[SP.5] [2020.3]	Write quantification report	Hire consultant to write quantification report	• Hire consultant for 60 days • Consultative meetings in districts: o 10 district visits in 10 regions and 4 facilities o 2 days per region o Transport refund for 60 people per region o Refreshments o Printing: 20 pages per 60 participants	Quantification report produced Number of meetings held (Target: 10 meetings in 10 regions)	2015 2016 2017 2018 2019 2020
				Print quantification report	• Printing: 150 copies, 35 pages	Number of quantification reports printed (Target: 150)	2015 2016 2017 2018 2019 2020

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
		[SP.5] [2020.3]	Monitor contraceptive supply plan		• Hire 1 staff member to monitor • Transport: fuel for daily travel • Procure computer/laptop • Procure desk	New staff member hired to monitor supply plan	2015
		[SP.5] [2020.5]	Hold quarterly FP Reproductive Health Commodity Security (RHCS) meeting with agenda item to review contraceptive stock status	Hold quarterly meeting to review current contraceptive and consumable stock status and predicted needs	• 30 people per meeting • @ MOH • Refreshments • Printing: 20 documents per person	Number of RHCS meetings held annually (Target: 4)	2015 2016 2017 2018 2019 2020 Quarterly
CS2. District staff are able to quantify and forecast FP commodities	Staff are sensitised on forecasting and quantifying of FP methods	[SP.5] [2020.3]	Integrate forecasting and quantification within routine facility and district activities	Hold a series of workshops to sensitise HCWs on how to forecast and quantify FP methods	• 10 regions • 3 days • @ central hotel • 40 people per region • Transport refund • Printing: 10 pages per person • 2 facilitators, technical allowance	Number of HCWs sensitised on how to forecast FP methods (Target: 400)	2015
				Hold field assessments to review capacity of staff to quantify FP methods	• 10 regions • 5 days • 2 staff • Per diem • Transport refund	Number of districts visited by central staff to review staff ability to quantify FP methods (Target: 10)	2015 2016 2017 2018 2019 2020 Twice a year

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
CS3. VHTs and community-based distributors have commodities	Community-based distributors are distributing FP commodities	[SP.5] [2020.3]	Ensure supply chain system provides accurate and timely re-stocking	Develop job aid for logistics managers to quantify and distribute commodities to community-based distributors	• Hire consultant: 30 days • Stakeholder meetings: o 3 meetings o @ hotel in Kampala o 20 people o Transport refund o Printing: 5 pages per person • Printing: 2,000 copies, 30 pages	Evidence of job aid for logistics manager to quantify and distribute commodities to community-based distributors developed	2016
				Train health centres logistics manager on how to quantify and distribute commodities to community-based distributors	• 10 regions • 2 days • @ central hotel • 40 people • 2 facilitators technical pay • Printing: 5 pages per person	Number of logistics managers trained (Target: 400)	2016
CS4. The push system to lower-level facilities is strengthened to increase effectiveness and responsiveness to local needs	Lower-level facilities on the push system receive appropriate products	[SP.5] [2020.5]	Support the regular review of the push kit contents to increase its effectiveness and responsiveness to local needs and develop a capacity-building plan	Hold a series of meetings with MOH, NMS, and key stakeholders to review the push kit contents to increase its effectiveness and responsiveness to local needs	• 5 meetings • @ hotel in Kampala • 40 people • Transport refund • Printing 5 pages per person	Number of dialogue meetings with stakeholders on modifying the push system (Target: 5)	2015
				Hire consultant to continue evaluations of the push system	• Hire a consultant for 30 days • Printing: 150 copies, 50 pages	Evaluation report and capacity-building plan for the push system	2015

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				and develop a capacity-building plan until the transition to the pull system takes place		developed and disseminated	
CS5. Lower-level facilities build capacity to move to a pull system	Lower-level facilities are evaluated on their capacity for implementing a pull system for FP commodities	[SP.5] [2020.3]	Evaluate capacity of lower-level facilities to move to a pull system	Conduct study of the logistical model of the pull system	• Hire a consultant for 60 days • Travel to health facilities in 10 regions and 10 district in each regions with 1 day for 2 facilities • Printing: 150 copies, 50 pages	Documentation of pull system and history of ARV system released	2017
				Disseminate study	• Meeting of 50 people • @ hotel in Kampala • 1 day • Transport refund • Printing: 30 pages per person	Pull system study disseminated to key stakeholders (Target: 50 people)	2017
	Pull system for higher-level facilities strengthened	[SP.5] [2020.3]	Train regional trainers in FP logistics and procurement	Hold regional training-of-trainers for hospital pharmacists, storekeepers, and district managers	• Regional meetings (10 regions) • @ regional hotel • 20 people • Per diem for 3 days • Transport refund • Consultant per diem for two facilitators • Printing: 20 pages per person	Trainers trained in FP logistics and procurement (Target: 20 trainers per region)	2017
		[SP.5] [2020.11]	Facilitate training-of-trainers to roll out the training		• 3-year scale-up to all health facilities • 3-year retraining • 200 trainers	Number of health workers trained (Target: 6,000)	2015 2016 2017 2018

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
			to health workers on how to procure contraceptives		• Per diem • Transport refund • 30,000 stationary books		2019 2020
		[SP.5] [2020.11]	Support supervision of trainers conducting training with health care workers on the pull system	RHCS members go out and review training methods as well as troubleshoot with facilities whose consumption does not match expectations	• 20 people • 5 days travel • Per diem • Transport refund	Number of RHCS members to provide support of trainers (Target: 20)	2015 2016 2018 2019
				Develop, print, and disseminate job aids and posters	• 10,000 copies, 1–2 pages	Number of job aids printed and distributed (Target: 20,000)	2015
CS6. LMIS and HMIS improved	FP logistics management (LMIS/HMIS) improved to increase commodity security	[2020.6]	Investigate whether new technologies (e.g., short message system) would improve real-time stock monitoring and re-supply planning,	Review current stock monitoring practices and determine whether scale-up of system would be feasible and cost-effective	• Hire a consultant for desk review for 30 days	Desk review completed	2016

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
			especially to re-supply VHTs	Disseminate desk review	• 1 day • @ hotel in Kampala • 50 people • Transport refund • Printing: 100 copies, 30 pages	Desk review disseminated	2016
		[2020.5]	Institute real-time stock monitoring system	Procure information, communica-tion, and technology (ICT) equipment	• Procure mobile phones for all health centres II and III • Computers and software for higher health facilities • Hire technical assistance for 1 person to communicate data to DHIS 2	Number of health facilities instituted with real-time stock facilities (Target: 4,884 mobile phones, 193 computers and software procured, 1 additional staff hired)	2016
		[2020.11]	Train staff on use of ICT equipment	Training-of-trainers	• 10 regions • 2 days • @ hotel • 20 people • Per diem • Transport refund • Printing: 5 pages per person	Number of trainers trained on ICT equipment (Target: 200)	2016
				Train staff on ICT material	• 6,000 health facilities and community- based distributors • Refreshments: 5 people per facility • Transport refund 200 people • Per diem 200 people • Purchase 30,000 stationary books	Number of health facilities and community-based distributors trained on ICT equipment (Target: 6,000)	2016
CS7. Challenges with distribution and requisition of FP	Distribution challenges troubleshot through	[SP.5] [2020.3]	Hire consultancy firm to track FP commodities through a short	Hire consultancy firm to track available FP	• Hire a consultancy firm for 30 days • Stakeholder meetings: o 3 meetings	Document explaining available commodities produced	2015

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
commodities proactively identified and addressed	commodity mapping		study	commodities through a short study	o 1 day o @ hotel o 20 people o Transport refund		
				Disseminate document	• 1 day • @ hotel in Kampala • 100 people • Transport refund • Printing 100 documents at 30 pages	Number of participants document is disseminated to (Target: 100)	2015
CS8. Policy and strategies that impact FP commodity security are aligned with the FP-CIP	Policies and strategies align with the FP-CIP	[2020.3]	Review and develop the ADS 2016–2020 and RHCS 2015–2020	Hire consultant to review ADS 2016–2020 and RHCS 2015–2020	• 1 consultant, 30 days • Stakeholder meetings: o 1 day o @ MOH o 20 people o Refreshments o Transport refund o Printing: 10 pages per person	Consultant produces review of ADS 2016–2020 and RHCS 2015–2020	2018
				Disseminate study	• Printing: 100 copies, 30 pages • Dissemination meeting: o 1 day o @ hotel in Kampala o 50 people o Transport refund o Printing: 5 pages per person	Number of participants study is disseminated to (Target: 50)	2018
			Review and update the Uganda clinical guidelines and the essential medicines and	Hire consultant to review and update the Uganda clinical guidelines and the essential	• 1 consultant, 30 days • Stakeholder meetings: o 1 day o @ MOH o 20 people o Refreshments	Review of the Uganda clinical guidelines and the essential medicines and health supply list of Uganda produced	2019

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
			health supply list of Uganda to reflect current practices in family planning	medicines and health supply list of Uganda	o Transport refund o Printing: 10 pages per person		
				Disseminate clinical guidelines and the essential medicines and health supply list	• Printing: 100 copies, 30 pages • Dissemination meeting: o 1 day o @ hotel in Kampala o 50 people o Transport refund o Printing: 5 pages per person	Number of copies disseminated of the clinical guidelines and the essential medicines and health supply list (Target: 100)	2019
CS9. Commodity distribution to private not-for-profits increased	Joint Medical Stores (JMS) includes FP commodities in procurement	[2020.6]	Advocate for JMS to include FP commodities in procurement	Assessment of the unmet need for FP in the faith-based sector service delivery points	• Consultant: 30 days • Stakeholder meetings: o 5 meetings o 1 day o @ hotel o 20 people o Transport refund • Printing: 150 copies, 50 pages	50-page assessment of the unmet need for family planning in faith-based sector produced	2015
				Hold meetings to disseminate findings and advocate with JMS to include FP commodities in procurement	• 3 meetings • @ hotel in Kampala • 40 people • Transport refund • Printing 5 pages per person	Number of meetings held to advocate for JMS to include contraceptives in procurement (Target: 3)	2015
				Update and disseminate JMS operational manuals, product catalogues,	• Consultant: 20 days	JMS operational manuals updated	2017

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				and LMIS			
AREA #4: Policy and enabling environment (PEE)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
PEE1. Family planning is repositioned as a key cross-cutting intervention for national development	FP is seen as a critical element of the national development agenda; as part of the development agenda, family planning is used as a tool to achieve the demographic dividend and is considered a strong component of the health sector strategy	[SP.4] [2020.4]	Advocate for a multisectoral approach so that each ministry includes FP and population issues in their national policy documents, strategic plans, and budget allocations through developing and disseminating technical briefs	Prepare technical briefs to advocate for Budget Framework papers to include family planning as a strategy to improve maternal and newborn health	• Printing: 100 copies, 5 pages • Transport for 1 MOH to go 5 places for 1 day (20 litres fuel)	Number of technical briefs printed (Target: 100 disseminated each year)	2015 2016 2017 2018 2019 2020
		[SP.4]	Engage non-health ministries and department directors to include family planning as part of their policy development	Hold 2-day workshops with ministers and partner staff about how to introduce family planning into their work plans	• @ hotel in Entebbe • 50 people • Transport allowance • Printing: 50 copies of FP-CIP	Number of stakeholders engaged in FP policy discussions (Target: 50)	2016

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				Document all ministry multi-sectorial plans in 1 work plan	• Printing: 1,000 copies, 200 pages • Monitor it with 2 MOH people: o Transport o Per diem	Number of copies of ministry multisectoral plans developed (Target: 1,000)	2016
				Hold meeting with each ministry to review its strategic plan and guide its FP issues	• @ hotel in Kampala • 50 people • Transport refund • Printing: 100 pages per 50 people	Ministry staff review strategic plan	2015 2017 2019
		[SP.4]	Advocate with Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	Hold a series of meetings with the Ministry of Education to encourage a family planning curriculum	• 3 meetings • @ MOH • 15 people • Refreshment • Transport refund • Printing: 10 pages per person	Ministry of Education staff review the use of a school health curriculum, and recommendations are generated on modifications	2015 2016 2017 2018 2019 2020
		[SP.4] [2020.2]	Advocate for acceleration of National Population Council Bill so that the inter-ministerial structure is functional and the necessary budget for	Host 8 meetings with parliamentary sub-committees, private sector, and respective ministries	• 1 day • @ hotel in Kampala • 50 people • Transport refund • Printing: 5 pages per person	Number of meetings hosted with parliamentary sub-committees, private sector, and respective ministries (Target: 8) Documented evidence of the presence of an	2015

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
			support is appropriated			active, functional inter-ministerial structure	
		[SP.4] [2020.1]	Promote family planning as a development tool through public dialogues	Conduct workshops to develop material to train journalists on FP terminology and how to discuss family planning	• 3 days • @ hotel in Kampala • 15 people • Transport refund • Printing: 20 copies, 30 pages	Materials for training journalists developed	2016 2019
				Conduct training workshops with journalists on above developed material	• 4 trainers per diem and transport • 1 day • @ hotel in Kampala • 30 people • Per diem • Printing: 40 copies, 30 pages	Number of journalists trained on FP dialogue (Target: 30)	2015 2016 2017 2018 2019 2020
				Train district health educators and district RH officers on how to host community FP dialogues	• Regionally • 2 days • @ hotel • 40 people • Transport refund • Per diem • 2 facilitators: per diem and transport refund • Printing: 5 pages per person	Number of district health educators and district RH officers trained to host community dialogues (Trained: 400 DHEs and RH people trained)	2015
PEE2. Legal framework and knowledge of	The legal framework that promotes	[2020.11]	Dissemination of the public acts (currently in	Hold dissemination meetings	• 2 meetings: o 1 day o @ hotel in Kampala	Number of people receiving dissemination of	2015

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
policies for family planning improved	FP is better known		revision) including the public health act to help users, health care workers, and policymakers better understand the FP legal framework		o 25 people o Transport refund o Printing 15 pages per person	public acts (Target: 50)	
		[2020.1]	Sensitise different members of society (members of Parliament, health providers etc.) on FP rights, and correct any misconceptions	Orient MPs, DHOs, DHA, and FP point people on SRH rights	• 1 day • @ hotel in Kampala • 150 people • Transport refund • Printing: 10 pages per person • 5 expert facilitators and 1 moderator, technical allowance	Number of MPs and health workers oriented on SRH rights (Target: 150)	2015
				Sensitise and train DHTs so they understand FP rights and correct misconceptions	• 10 regions • 4 trainers, technical allowance • @ hotel • 330 people • Per diem • Transport • Printing: 10 pages per person	Number of DHT members trained on FP rights (Target: 330)	2015
PEE3. The full spectrum of FP commodities is available	Essential Medicines List includes all World Health Organization pre-qualified	[SP.5] [2020.3]	Review/revise Essential Medicines List and include new FP commodities	Hold meeting with MOH, NDA, and key stakeholders	• 1 day • @ hotel in Kampala • 40 people • Transport • Printing: 10 pages per person	Essential medicines list reviewed	2015 2018 2020

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
	FP commodities		that are included in the World Health Organization pre-qualification list				
	Clear guidelines to allow for redistribution of FP commodities between facilities and districts exists	[SP.5] [2020.3]	Formalise and disseminate guidelines to allow for redistribution of FP commodities between facilities and districts	Hire consultant to develop guidelines	• Hire 1 consultant o 15 days • 2 stakeholders meeting: o @ hotel o 40 people o Transport refund o Printing: 10 pages per person	Guidelines for redistribution of FP commodities developed	2016
				Disseminate guidelines	• @ hotel in Kampala • 40 people • Transport refund • Printing: 10 pages per person	Number of guidelines disseminated (Target: 40)	2016
	Comprehen-sive family planning method mix is scaled up nationally through implementa-tion of task-sharing policies	[SP.5] [2020.6]	Support implementation of task-sharing policies, including policy that allows community-based distributors to give injectables throughout the country	Use regular WG meetings to review suggestions on task sharing and address any barriers	• FP/RHCS WG meetings: o Quarterly o Refreshments o Stationary • MCH WG: o Monthly o Refreshments o Stationary	Documented evidence of decisions made on suggestions for task sharing	2015 2016 2017 2018 2019 2020
				Review pre-service curriculum and ensure clinical officers are able to carry out surgical contraceptive	• 3 meetings • 3-day meeting • @ Kampala hotel • Transport refund • 30 people • 4 facilitators paid professional allowance • Printing: 50 copies, 105	Number of revised pre-service curricula for clinical officers reviewed, printed, and disseminated	2015

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				procedures	pages		
		[SP.5] [2020.3]	Include drug outlets as providers of expanded FP method mix	National dialogue with the NDA and MOH to declassify DMPA and emergency contraception	• 8 meetings • 15 people • Refreshments	Documented evidence on recommendations or decisions made to include drug outlets as providers of an expanded FP method mix	2016
	The alternative distribution system is operational and facilitated	[SP.5] [2020.5]	Ensure GOU allocation to alternative distribution system	Hold series of meetings with MPs and ministries to advocate for budget line item allocation to the alternative distribution system	• 3 meetings • @ hotel in Kampala • 40 people • Transport refund • Printing: 5 pages per person	Number of advocacy meetings held (Target: 3) Documented evidence of progress or decisions made on a budget line item allocation to the alternative distribution system	2015 2016 2017 2018 2019 2020
PEE4. Parliament, local, cultural, and religious leaders are supportive of family planning	A national coalition of advocates/ champions to support family planning is established and supported	[2020.1]	Coordinate and support FP advocates/ champions and scale up FP advocacy	Coordinate national prominent FP advocates to share best practices in advocacy and lessons learnt from FP advocacy through a meeting	• 1 two-day meeting • @ hotel in Kampala • 500 people • Transport (350 people) • Stationary • Preparatory meetings: o 30 people o @ MOH offices o Refreshments o Stationary o Transport	Number of advocates coordinated to share best practices (Target: 500)	2015

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				Provide technical support to prominent FP champions	• 5 champions • 3 days • Every quarter • Transport • Per diem	Number of FP champions supported (Target: 5)	2015 2016 2017 2018 2019 2020
		[2020.1]	Support prominent FP champions	Support prominent FP champions to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially, and at the local level	• 2 people • 5 days • Per diem • 1 international trip • 10 national trips (2 days)	Number of prominent FP champions supported to travel internationally and nationally (Target: 2 international trips per year; 10 domestic trips per year)	2015 2016 2017 2018 2019 2020
				Support specific activities of prominent FP advocates, including providing technical support on FP issues, including supporting relevant parliamentary committees to advocate for maternal and	• Printing costs: 50 copies, 50 pages	Number of FP champions provided with technical assistance [Target: 50 per year]	2015 2016 2017 2018 2019 2020

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				neonatal health issues /family planning, the First Lady, business leaders, and relevant councils			
PEE5. Knowledge of FP policies amongst stakeholders and health care workers improved	FP policies widely disseminated and available on MOH website		Upload and print all MOH FP policies	MOH to upload all FP polices and print copies for distribution	• Printing: 2,000 copies • 150 pages each • 10 documents	Number of policies uploaded and printed (Target: 10 policies printed in 2015, ongoing uploading electronically)	2015 2016 2017 2018 2019 2020
	Health care workers (HCWs) are informed of key policies and implications for their work	[2020.11]	Plan for policy/strategy dissemination to include targeted briefs designed for HCWs, etc., that will clearly tell them about what the policies mean for their work	Develop brief for HCWs bi-annually to update them on current policies and implications for their work	• 5 meetings • 1 day • @ MOH • 15 people • Refreshments • Printing 5 pages per person	10-page brief developed for HCWs	2015 2017 2019
				Print and distribute briefs	• Printing 90,000 copies, over 3 years • Dissemination teams: o 2 people o 10 regions o 5 days per region o Transport o Per diem	Number of briefs printed and disseminated to 10 regions and posted to the MOH website (Target: 90,000)	2015 2017 2019

AREA #3: Contraceptive Security (CS)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
PEE6. FP health care workers are retained	Pay for similar cadres is standardised	[2020.11]	Advocate with members of Parliament and the MOH to centralise health care workers and standardise their pay	Hold series of advocacy meetings to centralise FP health care workers	• 3 meetings • @ hotel in Kampala • 30 people • Transport refund • Printing: 5 pages per person	Number of advocacy meetings on health care workers and pay standardisation (Target: 3)	2015 2016 2017 2018 2019 2020
PEE7. The non-health sector integrates FP behaviour change communication into their programmes		[2020.6]	Advocate with interpersonal communication (IPC) agents working in non-health sector to integrate FP SBCC into their programmes	Hold series of advocacy meetings to advocate with non-health sector to integrate FP SBCC into programmes	• 10 regional advocacy meetings • @ hotel • 15 people regionally • Transport refund • Printing: 10 pages per person	Number of stakeholders engaged on integrating SBCC into their programmes (Target: 150)	2015 2016 2017 2018 2019
PEE8. Policymakers are able to advocate for contentious bills on sexual and reproductive health and family planning			Train and orient policymakers on how to advocate for contentious bills on sexual and reproductive health-related policies, including family planning	Hold 3-day workshop to orient policymakers on how to advocate for contentious bills	• Hire a consultant for 10 days to conduct trainings • 3 days • @ hotel venue • 15 people • Transport refund • Printing: 10 pages per person	Number of policymakers oriented on how to advocate for contentious bills (Target: 30)	2015 2016

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
F1. Government funding for family planning is increased	An official budget line for family planning is created in the MOH sector budget and is managed by the MOFPED	[SP.5] [2020.4]	Advocate with parliamentarians to endorse, maintain, and advocate for increases in the FP line items in the MOH budgets	Hold two stakeholder meetings to advocate with MPs for a FP budget line item	• 2 stakeholder meetings • @ hotel • 20 people • Transport refund • Printing: 5 pages per people	Number of stakeholder meetings held (Target: Semi-annual)	2015 2016 2017 2018 2019 2020 Semi-annually
				Develop a policy brief advocating for increases in the FP line items to distribute to the parliamentary committee on health	• 2 people to develop brief • Based on above stakeholder meetings	Policy brief developed	2015
				Print and disseminate policy briefs	• Printing: 10,000 copies, 2 pages	Number of copies of policy brief printed and disseminated (Target: 10,000)	2015
		[SP.5] [2020.4]	Engage MOFPED to ensure that FP budget line is maintained and not removed from the sectorial budgets	3 meetings with MOFPED each year	• 3 meetings • @ MOH • 20 people • Refreshments • Transport refund • Printing: 30 pages per person	Number of people engaged in MOFPED meetings per year (Target: 20) Documented evidence of progress or decisions made to engage MOFPED to maintain or not remove the FP budget line from the sectorial budgets	2015 2016 2017 2018 2019 2020

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
F2. Donor funding for family planning is increased	Resources from donors increased	[SP.5] [2020.4]	Develop and implement FP resource allocation advocacy strategy targeting development partners	Develop advocacy strategy and review strategy at regular meetings of the TWG; prior to the TWG Meeting, the FP team at the MOH will identify any actions in the FP-CIP that have not received financing or an implementation commitment from the GOU	• Created by 2 staff • Printing: 100 copies, 30 pages	30-page advocacy strategy developed and implemented	2015
				Hold a meeting with partners to address advocacy strategy during which an agenda and messaging guide is developed to ensure donor harmonisation	• 1-day meeting • @ hotel in Kampala • 80 people • Printing: 100 pages per person	Number of participants at partner meeting (Target: 80)	2015
		[SP.5] [2020.4]	Draft FP budget line item monitoring and advocacy	Hold a series of workshops with FP partners and key	• 5 workshops • 20 people per workshop • Printing: 200 copies, 30 pages	Number of workshops held to draft guidelines; budget monitoring and	2015

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
			guidelines	government stakeholders to draft monitoring guidelines		advocacy guidelines developed (Target: 5 workshops held; monitoring guidelines developed)	
				Disseminate draft FP budget line item monitoring and advocacy guidelines	• 1-day meeting • @ hotel in Kampala • 50 people • Transport refund • Printing: 5 pages per person	FP budget line item monitoring and advocacy guidelines disseminated	2015
	Level of FP support from development partners is increased through targeted advocacy	[SP.5]	Conduct mapping and monitoring of FP investments amongst development and implementing partners	Hold a meeting with development organisations to identify potential new FP partners	• 1 day • @ hotel in Kampala • 50 people • Transport refund • Printing: 30 pages per person	Mapping meeting held; mapping document produced	2015 2016 2017 2018 2019 2020
				Disseminate final mapping document	• 2 days • @ hotel in Kampala • 200 people • Per diem • Transport refund • Printing 30 pages per person	Mapping document disseminated	2015 2017 2019
		[SP.5]	Improve coordination with regional partners to continue to foster positive financial working relationships	Conduct MOH field visits to regional partner organisations	• 10 people travelling to regions • 5 days for each person • Per diem • Transport refund	Number of meetings to monitor partner commitments (Target: 10 people traveling to 10 regions)	2015 2016 2017 2018 2019 2020

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
		[SP.5] [2020.4]	Organise an FP development meeting to invite FP-CIP commitments from partners	Hold a 1-day advocacy meeting with key FP development partners Invite key partners previously identified as potentially being interested in FP in Uganda	• Meeting @ ministry • 15 people • Refreshments • Printing: 100 pages per person	Meeting with 10 key partners held at ministry Documentation of number and value of commitments made	2015 2016 2017 2018 2019 2020
F3. Corporations increase FP funding	Non-traditional donors (corporations) from the private sector are educated about the benefits of investing in family planning	[2020.7]	Organise an FP advocacy meeting with various corporate officers on corporate social responsibility investments for family planning	Hold a series of FP lunch briefings/ cocktails for chief executive officers, executives, and corporations; have high-level officials host the advocacy briefings, including the Minister of Health and the First Lady	• 1-day meeting • @ hotel in Kampala • 50 people • Printing: 30 pages per person • Printing stock card invitations	Number of corporate representatives briefed on corporate social responsibility investments for FP (Target: 50) Documentation of number and value of commitments made	2016 2019
F4. Family planning is mainstreamed in district planning and	Family planning is prioritised and integrated in district	[2020.4]	Advocate for the creation of a budget line for family planning at the district	Hold MOH outreach visits to districts during the month it is	• 10 regions visited • 2 people per region • 4 days for each region • Transport refund • Per diem per person	Number of regions visited and meetings held as districts plan their budgets (Target: 10)	2015 2016 2017 2018 2019

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
budgeting processes	planning and budgeting processes		level	deciding on its budget to encourage the budgeting for family planning		Number of districts creating a budget line for family planning	2020
F5. Financial investment in human resources development for health is increased	Budget for training and support for midwives and nurses in the health sector is increased	[2020.4]	Advocate for increased funding for training and support for midwives and nurses at lower-level health facilities	Host a series of dialogues/ meetings with MPs and ministry officials to advocate for increased funding for the development of health workers, especially for midwives and nurses at lower-level facilities	• 1 day • @ hotel in Kampala • 50 people • Transport refund • Printing: 30 pages per person	Number of meetings held a year with parliamentarians and ministry officials per year (Target: 2 meetings held annually, 50 members of Parliament and officials per meeting) Documented increases in the funding for training and support for midwives and nurses at lower- level health facilities	2015 2016 2017 2018 2019 2020 Semi-annually
				Produce a document explaining the commitments that were made at the meetings	• Printing: 100 copies, 10 pages	10-page document explaining commitments produced and disseminated via email Documented evidence of progress or decision made on coverage of FP in health insurance scheme	2015 2016 2017 2018 2019 2020

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
F6. Family planning is included in the national health insurance scheme			Conduct advocacy to ensure that the health insurance scheme includes full FP method coverage for all insurance packages	Host a series of dialogues with the MOH and insurers including private insurers	• 1 day • @ hotel • 50 people • Printing: 30 pages per person	Number of meetings held with insurers and officials (Target: 1 meeting annually)	2015 2016 2017 2018 2019 2020
			Produce a small study on the implications of an FP commodities package in different health insurance groups	Hire consultant to produce document on implications of an FP package on different health insurance groups	• Hire 1 consultant for 30 days • Consultative meetings: o 5 meetings o @ hotel in Kampala o 20 people o Transport refund o Printing: 5 pages per person	Document on FP insurance produced Number of stakeholder meetings held (Target: 5)	2015
F7. MOH and NMS will provide the East Africa Community (EAC) with full information on the costs and benefits of using pooled procurement for RH commodities	The costs/benefits for the use of EAC pooled procurement of medicines for RH commodities is understood by MOH, NMS, the five partner countries, and the EAC		Explore the use of EAC pooled funding and procurement for bringing down RH commodity prices	Conduct a study on the feasibility of using EAC pooled procurement of medicines for RH commodities	• Hire a consultant for 60 days • Consultant to travel 4 countries for 1 week each • Stakeholder meetings in country: o 3 meetings o @ hotels in country o 20 people per meeting o Printing: 30 pages per person	Study conducted and recommendations produced	2016
				EAC pooled funding and procurement of RH commodities to help to bring down prices is	• @ Hotel in Kampala • 20 people • 10 international flight tickets • International per diem rates for 10 people for 3 days	International meeting held in Kampala; Advocacy tool produced	2016

AREA #5: Financing (F)							
Strategic outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Output Indicators**	**Timeline**
				investigated by the partner countries	• Printing: 30 copies per person • Advocacy tool produced: print 200 copies of 30-page document		
				Travel to EAC headquarters and other countries to meet with other MOHs to discuss potential processes and mechanisms for using pooled funding and procurement for RH commodities	• 3 international tickets • Per diem for 3 people	Number of advocacy trips to EAC headquarters (Target: 3)	2016 2018 2020

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
SMA1. Capacity at the MOH to effectively lead, manage, and coordinate the FP programme is strengthened	MOH supports coordination and implementa-tion of the FP programme		Hire a coordinator to monitor implementation of the FP-CIP and knowledge management officer to the FP programme	Host meetings at the MOH to develop a TOR for the coordinator and knowledge management officer to include implementing partner reporting	• @ MOH • 15 people • Refreshments • Transport refund	TOR developed and advertised	2015
				Hire coordinator and knowledge management officer	• Hire: o Knowledge manager coordinator for all FP/RH activities o 2 medical officers • Purchase for 4 people: o Office furniture o Computer	Number of new staff hired (Target: 4: coordinator, knowledge manager, and 2 medical officers)	2015
			Engage MOH staff in team-building opportunities to encourage a strong working environment between the departments	Develop team-building exercises	• Hire a consultant for 10 days	Consultant hired to develop team-building exercises	2015
				Host team-building exercises that cut across financing, planning, and RH division who work together	• 3 workshops (movers and shakers training) • 5 days for workshop • @ hotel • 15 people per workshop • Printing: 10 pages per person	Number of people trained on financing and planning (Target: 45)	2015
				Follow up with on job training for those who expressed	• Consultant will follow up with people in the workplace; part of TOR above for first 3 months	Consultant completes job training	2015

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
				interest during the team-building exercises			
	RH has an electronic database for management of the FP-CIP activities		Develop an electronic planning/ performance monitoring mechanism/ system to track progress of the FP-CIP and improve coordination amongst the partners	Hire an outside firm to help develop an FP-CIP reporting component within the MOH intranet	• Hire an outside firm for 60 days	MOH website reorganised with RH component	2015
				Train staff on use of new electronic platform	• 10 people in information technology class • @ hotel in Kampala • Hire a training organisation • Transport refund	Number of people trained on new electronic platform (Target: 10) Number of people engaged with information technology and social media (blogging on MOH website, twitter, facebook, etc. on MOH pages for FP) (Target: 10)	2015
SMA2. The MOH effectively tracks and monitors the FP-CIP and provides support to implementing partners to report activities	MOH tracks and monitors the FP-CIP activities and financial data outputs and timelines		Develop a TOR to include monitoring and tracking of the FP-CIP in the MOH coordinator's role	FP-CIP outputs collected, analysed, disseminated, and shared semi-annually by the MOH coordinator with all relevant stakeholders	• TOR produced to reflect MOH coordinator's role • Updated FP-CIP tracked for progress and gaps semi-annually	TOR adopted; Updated FP-CIP data shared with key stakeholders and implementing partners semi-annually	Semi-annually

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
and funding and identify gaps				and implementing partners			
	MOH identifies gap through implementing partner feedback and refresher training on gap analyses held		Assessment of gap analysis through implementing partner feedback and refresher on gap analysis tool	Disseminate feedback of gap analysis to relevant stakeholders and implementing partner and refresher training on gap analysis tool	• Half-day workshop • @ hotel • 50 participants • Transport • Printing: 20 pages per person	Number of people trained on gap analysis tool (Target: 50) Data generated on the resource gap for FP-CIP execution	2015 2016 2017 2018 2019 2020
SMA3. The capacity of districts to effectively manage their FP programmes is strengthened	DHTs effectively plan for, monitor, and report on FP services	[2020.10]	Conduct annual review meetings of the district work plan	Hold central - level meeting with DHTs	• 1 day • @ hotel in Kampala • 150 people • Transport • Printing: 10 pages per person •	Work plan review meeting held for 150 reviewers	2015 2016 2017 2018 2019 2020
	FP stakeholder coordination and performance monitoring at district level is improved		Improve FP stakeholder coordination and performance monitoring at the district level	Conduct a workshop to orient district management committees and DHTs on the development of an annual action plan for family planning	• Region: 10 regions, 1 per region (UBOS regions) or 13 MOH district hospitals • 2 days • @ hotel • 40 people • Transport refund • Per diem • Printing: 10 pages per person • Use trainers from Ministry of Planning	Number of people trained in training workshop on stakeholder coordination and performance monitoring (Target: 400)	2015 2016 2017 2018 2019 2020

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
				Create and sustain a district task force (implementing partners and government) on FP to strengthen planning	• Refreshments • Transport refund • SDA for 1 facilitator • Printing: 5 pages per person • 10 people	District task force created	2015 2016 2017 2018 2019 2020 Quarterly
				Conduct quarterly district stakeholders meetings to review maternal and neonatal health, with technical support from professional associations; FP is a component	• Meetings: every district • 15 people • Refreshments • Transport • SDA for 1 facilitator • Printing: 5 pages per person	Number of stakeholder review maternal and neonatal health meetings held (Target: Quarterly meetings with 15 participants each)	2015 2016 2017 2018 2019 2020 Quarterly
SMA4. Reporting of FP indicators is strengthened	Health care workers report on FP indicators	[2020.11]	FP reporting tools are widely distributed to health care workers	Print FP reporting tools	• Printing: 6,000 copies, 50 pages	Number of FP reporting tools printed and disseminated (Target: 6,000)	2015 2016 2017 2018 2019 2020
SMA5. National efforts to collect, analyse, and use data to track FP progress is strengthened	National efforts to collect, analyse, and use data to track progress in family planning and	[2020.9]	Monitor and supervise Track20 data for FP programme validation	Conduct bi-annual national-level monitoring and data validation for FP	• 10 regions • 1 day • @ hotel • 40 people • Transport • Printing: 10 pages per person • Transport and per diem for	Number of regions and participants receiving support supervision for FP (Target: 10 regions, 40 people each, receiving supportive supervision for FP)	2015 2016 2017 2018 2019 2020

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
	develop effective programme strategies and plans is supported through Track20				4 facilitators		
	Use of a national FP research agenda is developed and promoted		A national FP research agenda is developed	Engage a consultant to develop the national FP research agenda	• Consultant: 30 days • 3 stakeholder meetings o @ MOH o 15 people o Refreshments o Transport refund	National FP research agenda is developed	2015
				Print and disseminate the research agenda	• Printing: 1,000 copies of 50 pages	Number of copies of research agenda disseminated; Research agenda posted on the MOH website (Target: 1,000)	2015
	FP supervision tools are reviewed for quality	[2020.10]	Conduct workshops to review current supervision tools		• Workshop: 2 days • @ hotel • FP TWG: 20 people • Transport • Printing: 5 pages per person	Current supervision tools reviewed	2015
	Effective quality improvement/ quality assurance (QI/QA) approaches to improve quality of FP		Support districts to conduct QI/QA activities in sample facilities	Perform outreach in 112 districts	• 112 districts • 2–3 people • Transport • Per diem	Number of districts to conduct QI/QA activities (Target: 112)	2015 2016 2017 2018 2019 2020

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
	service provision is designed and implemented at facility and community levels						
	Implement social accountability mechanisms, such as community scorecards, citizen report cards, and social audits to engage clients to provide feedback on the quality of FP services		Ensure that current RMNCH scorecards include FP		• @ FP TWG— already costed	RMNCH score cards assessed to review FP components	2015
SMA6. The FP-CIP is assessed at mid-term and end-of-plan to inform future FP activities and programming	FP-CIP is reviewed and evaluated to inform future FP strategy development, planning, and programming	[2020.9]	Conduct a mid-term review and final evaluation of the FP-CIP	Hire a consultant team to conduct a mid-term review to assess implementation and recommend course corrections	• 2 consultants for 3 months • Travel to 5 districts • 10 Stakeholder meetings: o 1 day o @ hotel in Kampala o 20 people o Transport refund o Printing: 5 pages per person	Number of stakeholder meetings held (Target: 10) Mid-term review completed	2018

AREA #6: Stewardship, Management, and Accountability (SMA)							
Strategic Outcomes	**Expected Results**	**SP and FP2020**	**Activity**	**Sub-Activities**	**Inputs**	**Outputs**	**Timeline**
				Disseminate mid-term review results	• One half-day meeting o 1 day o @ hotel in Kampala o 50 people o Transport refund • Printing: 200 copies, 30 pages	Mid-term review results disseminated	2018
				Hire a consultant team to conduct a final evaluation to inform planning post-2020	• 3 consultants for 3 months • Travel to 5 districts • 10 Stakeholder meetings: o 1 day o @ hotel in Kampala o 20 people o Transport refund o Printing: 5 pages per person	Number of stakeholder meetings held (Target: 10) Final evaluation completed	2020
				Disseminate final evaluation results	• One half-day meeting o 1 day o @ hotel in Kampala o 50 people o Transport refund • Printing: 200 copies, 30 pages	Final evaluation results disseminated	2020

ANNEX B: YEARLY OBJECTIVES FOR CPR AND REDUCTION IN TEENAGE PREGNANCY

To facilitate the monitoring of the plan's success, the national objectives have been translated into yearly objectives. These yearly objectives have been provided for CPR (for modern method use amongst married and women in union and unmarried sexually active women) and teenage pregnancy. The 2011 UDHS was used as a baseline for 2014 for the CPR and teenage pregnancy calculations.

The overall annual growth rate needed for Uganda to increase its mCPR from 26 percent (married) in 2014 to 50 percent (married) in 2020 is 4.0 percent a year on average. However, the annual increase rate has been scaled by year on an S-curve, as it is assumed that uptake will be slower at first and speed up as the plan is further implemented. The mCPR objectives for married women have also been translated into approximate mCPR objectives for all women of reproductive age (with the CPR of unmarried sexually active women also increasing 24 percentage points between 2014 and 2020—the same as the target for married women), as these were needed to calculate the overall contraceptive needs for all women in Uganda.

Similarly to mCPR, the necessary yearly decrease for teenage pregnancy was first calculated as needing to average 4.6 percent per year and then scaled on a sigmoid curve (S-curve), assuming higher uptake of contraceptives and thus lower teenage pregnancy as the plan is implemented. The goal for reducing the percentage of 19-year-old women who have begun childbearing (have had a live birth or who are pregnant with their first child) from the current rate of 57.6 percent[195] in 2011 to 30 percent is drawn from the National Adolescent Health Policy for Uganda, 2004.[196]

Figure 44: Objective for mCPR for married and in-union women in Uganda, by year

	2014	2015	2016	2017	2018	2019	2020
Yearly objectives	26.00%	29.00%	32.50%	36.50%	41.00%	45.50%	**50.00%**

Figure 45: Objective for mCPR for unmarried sexually active women in Uganda, by year

	2014	2015	2016	2017	2018	2019	2020
Yearly objectives	44.30%	47.30%	50.80%	54.80%	59.30%	63.80%	**68.30%**

Figure 96: Objective for reduction in teenage pregnancy (percentage of women ages 19 who have begun childbearing) in Uganda, by year

	2014	2015	2016	2017	2018	2019	2020
Yearly objectives	57.60%	53.00%	48.40%	43.80%	39.20%	34.60%	**30.00%**

ANNEX C: ANNUAL PERFORMANCE TARGETS

Area 1: Demand Creation						
Activity	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
DC1. Demand for FP services is increased						
DC1.1. Gather evidence and data to inform an SBCC strategy to ensure honest, accurate, clear, and consistent FP messaging that targets various audiences (rural/urban youth, married youth, men, people living with HIV, people with disabilities, faith-based organisations, sex workers, etc.)	500 copies of research report printed					
	10 regional dissemination meetings held					
DC1.2. Develop a communications strategy with evidence-based messaging	1,000 copies of communication strategy printed					
	1 dissemination meeting					
DC1.3. Develop and implement a mass media campaign on family planning based on communications strategy *(3 times a week, quarterly)*			121 radio spots	121 radio spots	121 radio spots	121 radio spots
		12 radio spots	120 TV spots	120 TV spots	120 TV spots	120 TV spots
		120 TV spots				
DC1.4. Develop and record soap episodes on family planning to be played in 3 regions		104 radio spots	104 radio spots			
		300 t-shirts	300 t-shirts			
		300 caps	300 caps			
		10 Billboard	10 Billboard			

DC1.5. Sensitise and orient interpersonal communication agents working in the health and non-health sectors to integrate FP SBCC into the communities	20 IPCs trained	20 IPCs trained	20 IPCs trained	20 IPCs trained	20 IPCs trained	20 IPCs trained
DC1.6. Orient and sensitise cultural leaders and community leaders working on HIV (voluntary counselling and testing, prevention of mother-to-child transmission, care and treatment, psychosocial groups etc.), gender-based violence, and maternal health to include FP in their current work		500 cultural and community leaders sensitised			500 cultural and community leaders sensitised	
DC1.7. Develop a package to guide recruitment, orientation, and monitoring of FP champions		100 copies of champion guide printed				
			Champion guide disseminated to 10 regions			
			300 champions supported			
DC2. Men support the use of modern contraception for themselves and their partners						
DC2.1. Conduct community outreach events to engage men in family planning	800 men reached in each district	800 men reached in each district	800 men reached in each district	800 men reached in each district	800 men reached in each district	800 men reached in each district
	10 outreach events	10 outreach events	10 outreach events	10 outreach events	10 outreach events	10 outreach events

DC3. Young people, 10–24 years old, are knowledgeable about family planning and are empowered to use FP services						
DC3.1. Engage peers to educate young people about FP services		10 regional youth camps held	10 regional youth camps held	10 regional youth camps held	10 regional youth camps held	10 regional youth camps held
		10 regional supervision visits	10 regional supervision visits	10 regional supervision visits	10 regional supervision visits	10 regional supervision visits
DC3.2. Create an educational yearly youth magazine that describes youth FP activities, programmes, and services	5,000 copies youth magazine distributed	5,000 copies youth magazine distributed	5,000 copies youth magazine distributed	5,000 copies youth magazine distributed	5,000 copies youth magazine distributed	5,000 copies youth magazine distributed
DC3.3. Produce youth FP pull-outs for newspapers	80,000 youth newspaper pull-outs disseminated	80,000 youth newspaper pull-outs disseminated	80,000 youth newspaper pull-outs disseminated	80,000 youth newspaper pull-outs disseminated	80,000 youth newspaper pull-outs disseminated	80,000 youth newspaper pull-outs disseminated
DC3.4. Create a BlogSpot as a reference point for further feedback from youth			Youth FP BlogSpot developed			
DC3.5. Support peer educators	50 peer educators supported with monthly stipends per region	50 peer educators supported with monthly stipends per region	50 peer educators supported with monthly stipends per region	50 peer educators supported with monthly stipends per region	50 peer educators supported with monthly stipends per region	50 peer educators supported with monthly stipends per region
DC3.6. Host "edutainment" community events, like dances, music concerts, and sport competitions to provide opportunity for knowledge exchange amongst young people	112 events held (1 per district per year)	112 events held (1 per district per year)	112 events held (1 per district per year)	112 events held (1 per district per year)	112 events held (1 per district per year)	112 events held (1 per district per year)
DC3.7. Empower parents, caregivers, and teachers to help their children to avoid teen pregnancy, including improving parent-child			3,000 copies of Straight Talk parent and teacher training material printed			

communication on sexual issues			2,500 teachers/parents oriented			
			40 radio spots	40 radio spots	40 radio spots	40 radio spots
			40 TV spots	40 TV spots	40 TV spots	40 TV spots
			10 community events	10 community events	10 community events	10 community events
DC3.8. Initiate and evaluate a pilot project to brand free, public-sector condoms to see if overall uptake increases			Brand of free, public-sector condoms completed			
			1 million condoms distributed to 30 districts			
				Evaluation of the pilot branding conducted in 30 districts		
Area 2: Service Delivery						
Activity	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
SD1. Access to FP services is increased						
SD7.1. Pilot mobile clinics		50 mobile clinics established (5 mobile clinics per region, 10 regions)				
SD7.2. Review effectiveness of mobile clinics		Knowledge of mobile clinics effectiveness				

		generated and decisions made for scale-up				
SD7.3. Scale up mobile clinics to all districts			112 districts	112 districts	112 districts	112 districts
SD7.4. Sensitise private organisations on the importance of promoting and using FP services		150 representatives from private health organisations sensitised		150 private health providers		
SD2. Referral services are strengthened						
SD2.1. Develop, disseminate, and train on FP referral forms	6,000 copies of referral forms printed					
	200 DHOs and ADHOs trained on referral forms					
SD3. Motivation for FP health care workers is increased						
SD3.1. Develop guidelines for performance-based incentives for FP health care workers	200 copies of guidelines for performance-based incentives printed					
	300 managers trained on developing performance plans with employees					
SD4. Family planning services are integrated into other health services						
SD4.1. Develop FP integration protocols	6,000 copies of the integration protocol printed					
		500 providers trained				

SD5. Family planning services are accessible by people with disabilities						
SD5.1. Develop clinical guidelines for provision of FP services to people with disabilities	6,000 copies					
	250 providers trained on disability service provision					
SD5.2. Sponsor courses for service providers to learn sign language	400 health providers trained in sign language					
SD6. Family planning side effects are managed						
SD6.1. Assess current FP counselling guidelines	Counselling guidelines developed					
SD6.2. Train trainers on FP side effects counselling	20 trainers trained on counselling on FP side effects					
SD6.3. Print and disseminate reporting tools for pharmacovigilance	6,000 copies of reporting tools for pharmacovigilance					
SD7. In-service training is improved to include family planning						
SD7.5. Review current in-service training guidelines to ensure they include a full and comprehensive FP section	3 books, each 100 copies, of in-service training guidelines printed					
	30 trainers		30 trainers			30 trainers
SD8. Family planning in the VHT system is strengthened						
SD8.1. Re-evaluate and re-write VHT training material to include full and thorough FP information	VHT training material updated					
SD8.2. Scale up training of VHTs on FP methods to 50,000	250 VHTs	250 VHTs	250 VHTs	250 VHTs	250 VHTs	250 VHTs

villages in 5 years with re-training every 2 years						
SD8.3. Meet with lawyers and MPs	Evidence of a decision made on operationalising injectable provision by VHTs					
SD8.4. Hold meeting with partners to harmonise VHT benefit packages		Document depicting how benefit package for VHTs is being implemented by partners produced				
SD9. Youth-friendly services are provided in clinics						
SD9.1. Establish youth-friendly corners in clinics currently without any		400 youth-friendly corners established				
		800 peer educators facilitated	800 peer educators facilitated	800 peer educators facilitated	800 peer educators facilitated	800 peer educators facilitated
SD9.2. Health workers are trained on how to provide youth-friendly services	250 trainers trained on youth-friendly services (25 new trainers trained per region, 10 regions)					
		250 health workers trained on youth-friendly services				
SD9.3. Motivate workers to spend an extra hour working at the clinic		50 workers recognised for offering extended hours for FP services	50 workers recognised for offering extended hours for FP services	50 workers recognised for offering extended hours for FP services	50 workers recognised for offering extended hours for FP services	50 workers recognised for offering extended hours for FP services

Area 3: Contraceptive Security (CS)						
Activity	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
CS1. Comprehensive forecasting, quantification, and procurement of FP commodities is implemented						
CS1.1. Conduct annual quantification, forecasting, and procurement workshops for FP commodities and consumables	Annual quantification, forecasting, and procurement workshops conducted	Annual quantification, forecasting, and procurement workshops conducted	Annual quantification, forecasting, and procurement workshops conducted	Annual quantification, forecasting, and procurement workshops conducted	Annual quantification, forecasting, and procurement workshops conducted	Annual quantification, forecasting, and procurement workshops conducted
CS1.2. Follow-up with interested partners to determine whether they can further help to fill the financing gap for contraceptives	Partner commitments made to cover financing gaps	Partner commitments made to cover financing gaps	Partner commitments made to cover financing gaps	Partner commitments made to cover financing gaps	Partner commitments made to cover financing gaps	Partner commitments made to cover financing gaps
CS1.3. Write quantification report	150 copies of quantification report produced and disseminated	150 copies of quantification report produced and disseminated	150 copies of quantification report produced and disseminated	150 copies of quantification report produced and disseminated	150 copies of quantification report produced and disseminated	150 copies of quantification report produced and disseminated
CS1.4. Monitor contraceptive supply plan	1 new staff member hired to monitor supply plan					
		10 regions visited to monitor contraceptive supply	10 regions visited to monitor contraceptive supply	10 regions visited to monitor contraceptive supply	10 regions visited to monitor contraceptive supply	10 regions visited to monitor contraceptive supply
CS1.5. Hold quarterly FP Reproductive Health Commodity Security (RHCS) meeting with agenda item to review contraceptive stock status	4 quarterly contraceptive stock status review meetings convened	4 quarterly contraceptive stock status review meetings convened	4 quarterly contraceptive stock status review meetings convened	4 quarterly contraceptive stock status review meetings convened	4 quarterly contraceptive stock status review meetings convened	4 quarterly contraceptive stock status review meetings convened

CS2. District staff are able to quantify and forecast FP commodities						
CS2.1. Integrate forecasting and quantification within routine facility and district activities	400 HCWs sensitised on forecasting FP methods					
	10 regions visited by central staff to review staff ability to quantify FP methods	10 regions visited by central staff to review staff ability to quantify FP methods	10 regions visited by central staff to review staff ability to quantify FP methods	10 regions visited by central staff to review staff ability to quantify FP methods	10 regions visited by central staff to review staff ability to quantify FP methods	10 regions visited by central staff to review staff ability to quantify FP methods
CS3. VHTs and community-based distributors have commodities						
CS3.1. Ensure supply chain system provides accurate and timely re-stocking	Job aid for logistics manager to quantify and distribute commodities to community-based distributors developed					
		400 logistics managers trained				
CS4. The push system to lower-level facilities is strengthened to increase effectiveness and responsiveness to local needs						
CS4.1. Support the regular review of the push kit contents to increase its effectiveness and responsiveness to local needs and develop a capacity-building plan	Review of push system conducted, and recommendations made to modify the push system					
	Evaluation report and capacity-building plan for the push system developed and disseminated					

CS5. Lower-level facilities build capacity to move to a pull system						
CS5.1. Evaluate capacity of lower-level facilities to move to a pull system			Documentation of pull system and history of ARV system released			
CS5.2. Train regional trainers in FP logistics and procurement			200 TOTs trained			
CS5.3. Facilitate training-of-trainers to roll out the training to health care workers on how to procure contraceptives	200 TOTs conduct trainings in 10 regions	200 TOTs conduct trainings in 10 regions	200 TOTs conduct trainings in 10 regions	200 TOTs conduct trainings in 10 regions	200 TOTs conduct trainings in 10 regions	200 TOTs conduct trainings in 10 regions
CS5.4. Support supervision of trainers conducting training with health care workers on the pull system	100 days of supportive supervision at facility level	100 days of supportive supervision at facility level		100 days of supportive supervision at facility level	100 days of supportive supervision at facility level	
	10,000 copies of the job aid printed					
CS6. LMIS and HMIS improved						
CS6.1. Investigate if new technologies (e.g., short message system) would improve real-time stock monitoring and re-supply planning, especially to re-supply VHTs		Desk review completed and disseminated				
CS6.2. Institute real-time stock monitoring system		4,884 health facilities instituted with real-time monitoring system				
CS6.3. Train staff on use of ICT equipment		200 TOTs				
		6,000 facility- and community-based providers				

CS7. Challenges with distribution and requisition of FP commodities proactively identified and addressed						
CS7.1. Hire consultancy firm to track FP commodities through a short study	Report on a study to track FP commodities developed and disseminated					
CS8. Policy and strategies that impact FP commodity security are aligned with the FP-CIP						
CS8.1. Review and develop the ADS 2016–2020 and RHCS 2015–2020			100 copies of ADS 2016–2020 and RHCS 2015–2020 disseminated			
CS8.2. Review and update the Uganda clinical guidelines and the essential medicines and health supply list of Uganda to reflect current practices in FP		100 copies of the Uganda clinical guidelines and the essential medicines and health supply list printed and disseminated				
CS9. Commodity distribution to private not-for-profits increased						
CS9.1. Advocate for JMS to include FP commodities in procurement	A report on a study to assess the unmet need for FP in faith-based sector produced and disseminated					
Area 4: Policy and Enabling Environment (PEE)						
Activity	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
PEE1. Family planning is repositioned as a key cross-cutting intervention for national development						
PEE1.1. Advocate for a multisectoral approach so that each ministry includes family planning and	100 copies of technical briefs to advocate for Budget Framework	100 copies of technical briefs to advocate for Budget Framework	100 copies of technical briefs to advocate for Budget	100 copies of technical briefs to advocate for Budget	100 copies of technical briefs to advocate for Budget	100 copies of technical briefs to advocate for Budget

	population issues in their national policy documents, strategic plans, and budget allocations through developing and disseminating technical briefs	papers to include FP as a strategy to improve maternal and newborn health developed and distributed	papers to include FP as a strategy to improve maternal and newborn health developed and distributed	Framework papers to include FP as a strategy to improve maternal and newborn health developed and distributed	Framework papers to include FP as a strategy to improve maternal and newborn health developed and distributed	Framework papers to include FP as a strategy to improve maternal and newborn health developed and distributed	Framework papers to include FP as a strategy to improve maternal and newborn health developed and distributed
PEE1.2.	Engage non-health ministries and department directors to include family planning as part of their policy development		50 stakeholders from non-health ministries engaged in FP policy discussions				
PEE1.3.	Advocate with Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	3 advocacy meetings held to encourage Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	3 advocacy meetings held to encourage Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	3 advocacy meetings held to encourage Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	3 advocacy meetings held to encourage Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	3 advocacy meetings held to encourage Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	3 advocacy meetings held to encourage Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy
PEE1.4.	Advocate for acceleration of National Population Council Bill so that the inter-ministerial structure is functional and the necessary budget for support is appropriated	8 meetings conducted to advocate for the presence of an active, functional inter-ministerial structure					
PEE1.5.	Promote FP as a development tool through public dialogues	30 journalists trained on FP dialogue	30 journalists trained on FP dialogue	30 journalists trained on FP dialogue	30 journalists trained on FP dialogue	30 journalists trained on FP dialogue	30 journalists trained on FP dialogue

	400 district health educators and district RH officers trained to host community dialogues					
PEE2. Legal framework and knowledge of policies for family planning improved						
PEE2.1. Dissemination of the public acts (currently in revision) including the public health act to help users, health care workers, and policymakers better understand the FP legal framework	Public acts disseminated to 50 people					
PEE2.2. Sensitise different members of society (MPs, health providers, etc.) on FP rights, and correct any misconceptions	150 people oriented					
	330 DHTs members trained					
PEE3. The full spectrum of FP commodities is available						
PEE3.1. Review/revise Essential Medicines List and include new FP commodities that are included in the WHO pre-qualification list	Essential medicines list reviewed			Essential medicines list reviewed		Essential medicines list reviewed
PEE3.2. Formalise and disseminate guidelines to allow for redistribution of FP commodities between facilities and districts		40 guidelines for redistribution of FP commodities developed and disseminated				
PEE3.3. Support implementation of task-sharing policies, including policy that allows community-based	Evidence of decisions made on suggestions for task sharing	Evidence of decisions made on suggestions for task sharing	Evidence of decisions made on suggestions for task sharing	Evidence of decisions made on suggestions for task sharing	Evidence of decisions made on suggestions for task sharing	Evidence of decisions made on suggestions for task sharing

distributors to give injectables countrywide	50 copies of revised pre-service curriculum for clinical officers printed and disseminated					
PEE3.4. Include drug outlets as providers of expanded FP method mix		Recommendations or decisions made to include drug outlets as providers of expanded FP method mix				
PEE3.5. Ensure GOU allocation to alternative distribution system	Progress or decision made on budget line item allocation to the alternative distribution system	Progress or decision made on budget line item allocation to the alternative distribution system	Progress or decision made on budget line item allocation to the alternative distribution system	Progress or decision made on budget line item allocation to the alternative distribution system	Progress or decision made on budget line item allocation to the alternative distribution system	Progress or decision made on budget line item allocation to the alternative distribution system
PPE4. Parliament, local, cultural, and religious leaders are supportive of family planning						
PEE4.1. Coordinate and support FP advocates/champions and scale up FP advocacy	Annual meeting of 500 advocates to share best practices	Annual meeting of 500 advocates to share best practices	Annual meeting of 500 advocates to share best practices	Annual meeting of 500 advocates to share best practices	Annual meeting of 500 advocates to share best practices	Annual meeting of 500 advocates to share best practices
	5 FP champions provided with technical assistance	5 FP champions provided with technical assistance	5 FP champions provided with technical assistance	5 FP champions provided with technical assistance	5 FP champions provided with technical assistance	5 FP champions provided with technical assistance
PEE4.2. Support prominent FP champions	12 prominent FP champions supported to attend advocacy meetings	12 prominent FP champions supported to attend advocacy meetings	12 prominent FP champions supported to attend advocacy meetings	12 prominent FP champions supported to attend advocacy meetings	12 prominent FP champions supported to attend advocacy meetings	12 prominent FP champions supported to attend advocacy meetings

	50 FP champions provided with technical assistance	50 FP champions provided with technical assistance	50 FP champions provided with technical assistance	50 FP champions provided with technical assistance	50 FP champions provided with technical assistance	50 FP champions provided with technical assistance
PEE5. Knowledge of FP policies amongst stakeholders and health care workers improved						
PEE5.1. Upload and print all MOH FP policies	2,000 copies each of 10 policy documents printed, uploading of policy documents	Uploading of policy documents	Uploading of policy documents	Uploading of policy documents	Uploading of policy documents	Uploading of policy documents
PEE5.2. Plan for policy/strategy dissemination to include targeted briefs designed for HCWs, etc. that will clearly tell them about what the policies mean for their work	Dissemination of policy/strategy documents conducted to HCWs		Dissemination of policy/strategy documents conducted to HCWs		Dissemination of policy/strategy documents conducted to HCWs	
PEE6. FP health care workers are retained						
PEE6.1. Advocate with MPs and the MOH to centralise FP health care workers and standardise their pay	Progress or decision made by MPs and the MOH to centralise health care workers and standardise their pay	Progress or decision made by MPs and the MOH to centralise health care workers and standardise their pay	Progress or decision made by MPs and the MOH to centralise health care workers and standardise their pay	Progress or decision made by MPs and the MOH to centralise health care workers and standardise their pay	Progress or decision made by MPs and the MOH to centralise health care workers and standardise their pay	Progress or decision made by MPs and the MOH to centralise health care workers and standardise their pay
PEE7. The non-health sector integrates FP behaviour change communication into their programmes						
PEE7.1. Advocate with IPC agents working in non-health sector to integrate FP SBCC into their programmes	150 stakeholders engaged on integrating SBCC into their programmes	150 stakeholders engaged on integrating SBCC into their programmes	150 stakeholders engaged on integrating SBCC into their programmes	150 stakeholders engaged on integrating SBCC into their programmes	150 stakeholders engaged on integrating SBCC into their programmes	

PEE8. Policymakers are able to advocate for contentious bills on sexual and reproductive health and family planning						
PEE8.1. Train and orient policy makers on how to advocate for contentious bills on sexual and reproductive health related policies including FP	15 policymakers oriented	15 policymakers oriented				
Area #5: Financing						
Activity	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
F1. Government funding for family planning is increased						
F5.1. Advocate with parliamentarians to endorse, maintain, and advocate for increases in the FP line items in the MOH budgets	Increasing trend in the FP line items in the MOH budgets	Increasing trend in the FP line items in the MOH budgets	Increasing trend in the FP line items in the MOH budgets	Increasing trend in the FP line items in the MOH budgets	Increasing trend in the FP line items in the MOH budgets	Increasing trend in the FP line items in the MOH budgets
	10,000 copies of policy brief printed and disseminated					
F5.2. Engage MOFPED to ensure that FP budget line is maintained and not removed/rejected from the sectorial budgets	Progress or decision made to engage MOFPED to maintain or not remove FP budget line from the sectorial budgets	Progress or decision made to engage MOFPED to maintain or not remove FP budget line from the sectorial budgets	Progress or decision made to engage MOFPED to maintain or not remove FP budget line from the sectorial budgets	Progress or decision made to engage MOFPED to maintain or not remove FP budget line from the sectorial budgets	Progress or decision made to engage MOFPED to maintain or not remove FP budget line from the sectorial budgets	Progress or decision made to engage MOFPED to maintain or not remove FP budget line from the sectorial budgets
F2. Donor funding for family planning is increased						
F2.1. Develop and implement FP resource allocation advocacy strategy targeting development partners	100 copies of a resource allocation advocacy strategy targeting development partners developed and disseminated					

F2.2. Draft FP budget line item monitoring and advocacy guidelines	Budget line item monitoring and advocacy guidelines developed					
F2.3. Conduct mapping and monitoring of FP investments amongst development and implementing partners	FP investments by development and implementing partners mapped and disseminated		FP investments by development and implementing partners mapped and disseminated		FP investments by development and implementing partners mapped and disseminated	
F2.4. Improve coordination with regional partners to continue to foster positive financial working relationships	5 regional visits	5 regional visits	5 regional visits	5 regional visits	5 regional visits	5 regional visits
F2.5. Organise a family planning development meeting to invite FP-CIP commitments from with partners	Financial commitments made by partners for FP-CIP	Financial commitments made by partners for FP-CIP	Financial commitments made by partners for FP-CIP	Financial commitments made by partners for FP-CIP	Financial commitments made by partners for FP-CIP	Financial commitments made by partners for FP-CIP
F3. Corporations increase FP funding						
F3.1. Organise an FP advocacy meeting with various corporate officers on corporate social responsibility investments for family planning		Financial commitments made by corporations for FP-CIP			Financial commitments made by corporations for FP-CIP	
F4. Family planning is mainstreamed in district planning and budgeting processes						
F4.1. Advocate for the creation of a budget line for family planning at the district level	Districts creating a budget line for family planning	Districts creating a budget line for family planning	Districts creating a budget line for family planning	Districts creating a budget line for family planning	Districts creating a budget line for family planning	Districts creating a budget line for family planning

F5. Financial investment in human resources development for health is increased						
F5.1. Advocate for increased funding for training and support for midwives and nurses at lower- level health facilities	Increases in funding for training and support for midwives and nurses at lower-level health facilities	Increases in funding for training and support for midwives and nurses at lower-level health facilities	Increases in funding for training and support for midwives and nurses at lower-level health facilities	Increases in funding for training and support for midwives and nurses at lower-level health facilities	Increases in funding for training and support for midwives and nurses at lower-level health facilities	Increases in funding for training and support for midwives and nurses at lower-level health facilities
F6. Family planning is included in the national health insurance scheme						
F6.1. Conduct advocacy to ensure that the health insurance scheme includes full FP method coverage for all insurance packages	Progress or decision made on coverage of FP in health insurance scheme	Progress or decision made on coverage of FP in health insurance scheme	Progress or decision made on coverage of FP in health insurance scheme	Progress or decision made on coverage of FP in health insurance scheme	Progress or decision made on coverage of FP in health insurance scheme	Progress or decision made on coverage of FP in health insurance scheme
F6.2. Produce a small study on the implications of a FP commodities package in different health insurance groups	Report on study on the implications of an FP commodities package in different health insurance groups developed an disseminated					
F7. MOH and NMS will provide the EAC with full information on the costs and benefits of using pooled procurement for RH commodities						
F7.1. Explore the use of EAC pooled funding and procurement for bringing down RH commodity prices		200 copies of report on a study on the feasibility of using EAC pooled procurement of medicines for RH commodities developed, printed, and disseminated				

		Progress or decision made on pooled funding and procurement		Progress or decision made on pooled funding and procurement		Progress or decision made on pooled funding and procurement
Area #6: Stewardship, Management and Accountability (SMA)						
Activity	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
SMA1. Capacity at the MOH to effectively lead, manage, and coordinate the FP programme is strengthened						
SMA1.1. Hire a coordinator to monitor implementation of the FP-CIP and knowledge management officer to the FP programme	1 FP coordinator, 1 knowledge manager, and 2 medical officers hired					
SMA1.2. Engage MOH staff in team-building opportunities to encourage a strong working environment between the departments	45 staff from financing, planning, and RH divisions participate in team-building exercises					
SMA1.3. Develop an electronic planning/performance monitoring mechanism/system to track progress of the FP-CIP and improve coordination amongst the partners	An online performance monitoring system developed					
	10 MOH staff trained on how to use the performance monitoring system					
SMA2. The MOH effectively tracks and monitors the FP-CIP and provides support to implementing partners to report activities and funding and identify gaps						
SMA2.1. Develop a TOR to include monitoring and tracking of FP-CIP in MOH coordinator's role	Semi-annual review of CIP implementation conducted with stakeholders	Semi-annual review of CIP implementation conducted with stakeholders	Semi-annual review of CIP implementation conducted with stakeholders	Semi-annual review of CIP implementation conducted with stakeholders	Semi-annual review of CIP implementation conducted with stakeholders	Semi-annual review of CIP implementation conducted with stakeholders

SMA2.2. Assessment of gap analysis through implementing partner feedback and refresher on gap analysis tool	Data generated on the resource gap for FP-CIP execution	Data generated on the resource gap for FP-CIP execution	Data generated on the resource gap for FP-CIP execution	Data generated on the resource gap for FP-CIP execution	Data generated on the resource gap for FP-CIP execution	Data generated on the resource gap for FP-CIP execution
	50 people participate in refresher trainings to perform gap analysis	50 people participate in refresher trainings to perform gap analysis	50 people participate in refresher trainings to perform gap analysis	50 people participate in refresher trainings to perform gap analysis	50 people participate in refresher trainings to perform gap analysis	50 people participate in refresher trainings to perform gap analysis
SMA3. The capacity of districts to effectively manage their FP programmes is strengthened						
SMA3.1. Conduct annual review meetings of the district work plan	Annual central - level progress review meeting with DHTs hosted	Annual central - level progress review meeting with DHTs hosted	Annual central - level progress review meeting with DHTs hosted	Annual central - level progress review meeting with DHTs hosted	Annual central - level progress review meeting with DHTs hosted	Annual central - level progress review meeting with DHTs hosted
SMA3.2. Improve FP stakeholder coordination and performance monitoring at the district level	400 DMCs and DHTs	400 DMCs and DHTs	400 DMCs and DHTs	400 DMCs and DHTs	400 DMCs and DHTs	400 DMCs and DHTs
	112 district task forces formed	112 district task forces formed	112 district task forces formed	112 district task forces formed	112 district task forces formed	112 district task forces formed
SMA4. Reporting of FP indicators is strengthened						
SMA4.1. FP reporting tools are widely distributed to health care workers	6,000 copies of FP reporting tools printed and distributed	6,000 copies of FP reporting tools printed and distributed	6,000 copies of FP reporting tools printed and distributed	6,000 copies of FP reporting tools printed and distributed	6,000 copies of FP reporting tools printed and distributed	6,000 copies of FP reporting tools printed and distributed
SMA5. National efforts to collect, analyse, and use data to track FP progress is strengthened						
SMA5.1. Monitor and supervise Track20 data for FP programme validation	Track20 monitoring and supervision in 10 regions conducted	Track20 monitoring and supervision in 10 regions conducted	Track20 monitoring and supervision in 10 regions conducted	Track20 monitoring and supervision in 10 regions conducted	Track20 monitoring and supervision in 10 regions conducted	Track20 monitoring and supervision in 10 regions conducted

SMA5.2. A national FP research agenda is developed	1,000 copies of research agenda printed and disseminated					
SMA5.3. Conduct workshops to review current supervision tools	Supervision tools revised					
SMA5.4. Support districts to conduct QI/QA activities in sample facilities	QI/QA activities conducted in 112 districts	QI/QA activities conducted in 112 districts	QI/QA activities conducted in 112 districts	QI/QA activities conducted in 112 districts	QI/QA activities conducted in 112 districts	QI/QA activities conducted in 112 districts
SMA5.5. Assess current RMNCH score cards to see if FP is included in them	RMNCH score cards assessed to review FP components					
SMA6. The FP-CIP is assessed at mid-term and end-of-plan to inform future FP activities and programming						
SMA6.1. Conduct a mid-term review and final evaluation of the FP-CIP				Report on CIP mid-term review completed and distributed		

ANNEX D: CODING LIST FOR STRATEGIC OUTCOMES

Strategic Priorities [SP.#]

- Priority # 1: Increase age-appropriate information, access, and use of family planning amongst young people, ages 10–24 years [SP.1]
- Priority # 2: Promote and nurture change in social and individual behaviour to address myths, misconceptions, and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies [SP.2]
- Priority # 3: Implement task sharing to increase access, especially for rural and underserved populations [SP.3]
- Priority # 4: Mainstream implementation of FP policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation [SP.4]
- Priority # 5: Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors [SP.5]

FP2020 Commitments [2020.#]

- Commitment 1: Develop and implement an integrated FP campaign [2020.1]
- Commitment 2: Accelerate the passing of the National Population Council Bill into law, immediately making the inter-ministerial structure functional and appropriating the necessary budget support, through a supplementary request [2020.2]
- Commitment 3: Improve RH commodity distribution and effective services delivery, review post shipment testing policy to reduce delays in release of vital RH supplies, including FP supplies from National Drug Authority [2020.3]
- Commitment 4: Finance commitments [2020.4]
- Commitment 5: Strengthen the technical and institutional functionality of Uganda Health Marketing Group and National Medical Stores in a dual private and public sector RH supplies distribution system [2020.5]
- Commitment 6: Scale up partnerships with civil society organisations and the private sector for FP outreach and community-based services, including social marketing, social franchising, and task sharing linked to a comprehensive training programme [2020.6]
- Commitment 7: Partner with appropriate private sector bodies and institutions for the integration of MH/FP/RH and HIV/AIDS information and services for their employees and families [2020.7]
- Commitment 8: Roll out youth-friendly services in all government HC4's and district hospitals [2020.8]
- Commitment 9: Ensure timely completion of the annual house hold panel surveys by UBOS to ascertain progress on health, including FP service delivery. Also carry out a robust evaluation of all FP investments in Uganda [2020.9]
- Commitment 10: Conduct bi-annual joint supervision and bi-annual FP/RH national review meetings [2020.10]
- Commitment 11: Strengthen institutional capacity of the public health facilities and community-based distributors to provide FP services and increase choice and quality of care at all levels [2020.11]

ENDNOTES

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- "The Strategic Plan objectives are: to increase the contraceptive prevalence rate from 23% to 50% and reduce the unmet need for contraceptives from 40% to 5% by 2015. . ." p. vi. Ministry of Health. 2009. Uganda Reproductive Health Commodity Security Strategic Plan 2010–2014. Kampala, Uganda.
- "The unmet need for contraceptives in Uganda is estimated to be 41% while the CPR is estimated at 30% (UDHS, 2011). This supposes a total demand of 71%. In view of this situation, the HSIP targets a CPR of 50% by 2015. In line with the HSIP, MOH developed Contraceptive Procurement Tables (CPTs) where it was projected that the CPR will grow annually by percentage points of 2.5, 3, 3.5, 4 and 4.5 for the years 2011 to 2015 respectively. A key assumption was that the service delivery systems in Uganda will improve at such a rate to hit the 50% CPR mark by 2015." p. 10, Ministry of Health. 2012. Uganda Alternative Distribution Strategy for Contraceptives and Selected Reproductive Health Commodities in Public and Private Sectors 2012-2016. Kampala, Uganda.
- "Given the higher level of investment in reproductive health and family planning anticipated in the coming years, this quantification was based on the more aggressive target set by the RHCS (2009) to achieve a 50% CPR by 2015." P. 1, Ministry of Health. 2013. National Quantification for Family Planning and Selected Reproductive Health Commodities, July 2013–June 2016. Kampala, Uganda.

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