

# Department of Health Promotion, Education and Strategic Communication

# National Family Planning Advocacy Strategy & Costed Implementation Plan 2020/21 - 2024/25

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AGR Annual Growth Rate

A4HU Action for Health Uganda

BCC Behaviour Change Communication

CBD Community-Based Distribution
CBO Community-Based Organisation

CDO Community Development Officer
CIP Costed Implementation Plan

CORP Community Resource Person

COU Church of Uganda

CPR Contraceptive Prevalence Rate

CSO Civil Society Organisation
CSW Commercial Sex Worker
CYP Couple Years of Protection

DFID Department for International Development

DHIM Division of Health Information Management

DHMT District Health Management Team

DLG District Local Government

DMPA Depot Medroxy Progesterone Acetate

DP Development Partner

DSC District Service Commission

EOC Equal Opportunities Commission

FBO Faith-Based Organisation

FP Family Planning

FP-CIP Family Planning Costed Implementation Plan

GOU Government of Uganda
HCF Health Care Facility
HCP Health Care Provider
HCW Health Care Worker

HDP Health Development Partner

HPAC Health Policy Advisory Committee

HPEC Health Promotion, Education and Communication

HPECD Health Promotion, Education and Communication Department

HSC Health Service Commission

HSDP Health Sector Development Plan 2015/16 – 2019/20

HSSP Health Systems Strengthening Project

IEC Information, Education and Communication

IP Implementing Partner

IRCU Inter-Religious Council of Uganda

IUD Intra-Uterine Device

JMS Joint Medical Stores

KII Key Informant Interview

MAAIF Ministry of Agriculture, Animal Industry and Fisheries

mCPR Modern Contraceptive Prevalence Rate

MDA Ministry, Department, Agency

MFPED Ministry of Finance, Planning and Economic Development

MGLSD Ministry of Gender, Labour and Social Development

MOE Ministry of Education and Sports

MOFPED Ministry of Finance, Planning and Economic Development

MOGLSD Ministry of Gender, Labour and Social Development

MOH Ministry of Health

MOICT Ministry of ICT and National Guidance

MOLG Ministry of Local Government

MP Member of Parliament

NACOTHA National Council of Traditional Healers (Herbalists Association)

NDA National Drug Authority

NDP National Development Plan

NGO Non-Governmental Organisation

NHA National Health Assembly
NMS National Medical Stores

NPA National Planning Authority
NPC National Population Council
OPM Office of the Prime Minister
OPM Office of the Prime Minister

PD Planning Division

PHP Private Health Practitioners
PLHA People Living with HIV/AIDS

PNFP Private Not-For-Profit

PPP Public Private Partnership

PPPH Public Private Partnership in Health

PROMETRA The Association for Promotion of Traditional Medicine

PSC Public Service Commission

PSFU Private Sector Foundation Uganda
PWD People/Person with Disabilities

RCC Roman Catholic Church
RH Reproductive Health

RHD Reproductive Health Division

RMNCAH Reproductive Maternal Neonatal Child and Adolescent Health

SBCC Social and Behaviour Change Communication

SMF Samansa Medical Foundation
SRH Sexual and Reproductive Health
SRH Sexual and Reproductive Health

SRHR Sexual and Reproductive Health and Rights

STI Sexually Transmitted Infection

SWG Sector Working Group

SWOT Strengths, Weaknesses, Opportunities and Threats

TAG Thematic Action Group
TBA Traditional Birth Attendant

TCMP Traditional and Complementary Medicine Practitioners

TFR Total Fertility Rate

TMA Total Market Approach
TWG Technical Working Group

UCMB Uganda Catholic Medical Bureau

UCS Uganda Catholic Secretariat

UFPC Uganda Family Planning Consortium
UFPU Uganda Family Planning Consortium
UHRC Uganda Human Rights Commission
UHMG Uganda Health Marketing Group
UIA Uganda Insurance Association

UIRA Uganda Insurance Regulatory Authority

UMA
Uganda Manufacturers Association
UMMB
Uganda Muslim Medical Bureau
UMSC
Uganda Muslim Supreme Council
UNFPA
United Nations Population Fund
UNICEF
United Nations Children's Fund

UNMC Uganda Nurses and Midwives Council

UNMHCP Uganda National Minimum Health Care Package
UNMHCP Ugandan National Minimum Health Care Package

UPC Uganda Pharmaceutical Council

UPHA Uganda Private Health Unit Association
UPMA Uganda Private Midwives Association
UPMB Uganda Protestant Medical Bureau

UPMPA Uganda Private Medical Practitioners Association

VHT Village Health Team

WHO World Health Organisation

# GLOSSARY

Adolescence	A period of transition from childhood to adulthood, characterised by physical, psychological, social, and behavioural changes. <sup>1</sup>				
Adolescent	A person between 10 and 19 years of age. <sup>2</sup>				
Contraceptive prevalence rate	Percentage of women who are using any method of contraception, often divided into those using modern or traditional methods.				
Contraceptive discontinuation rate	Percentage of contraceptive use episodes discontinued within 12 months.				
Demand for family planning	The percentage of currently married women who do not want to have any more children (limiters) or want to wait for two or more years before having another child (spacers), and want to use contraceptives. Total demand for FP includes all women with an unmet need for FP, plus all women who are currently using some method of FP and say they want to have another child or are undecided whether to have another, and women who are using some method of FP and who want no more children.				
Family planning	The conscious effort of individuals or couples to decide for themselves when to start having children, how many children to have, how to space them, and when to stop having children, through artificial and natural methods of contraception. FP connotes contraception control to avoid pregnancy and abortion, but also includes efforts of couples to induce pregnancy.				
Fertility	The actual reproductive performance of an individual, a couple, a group, or a population.				
Long-term and permanent methods	Long-term methods include implants (e.g. Norplant) that provide protection against conception for three to six years. Permanent methods include female sterilisation (tubal ligation) and male sterilisation (vasectomy).				
Modern FP methods	Include male (vasectomy) and female (tubal ligation) sterilisation, injectables, intra-uterine devices, contraceptive pills, implants, female and male condoms, injectables, standard days method, lactational amenorrhoea method, emergency contraception, foam/jelly.				
Natural FP methods	Include standard days method and lactational amenorrhoea.				
Non-hormonal methods	Include methods not containing hormones, e.g. foam/jelly, diaphragm, and condoms, lactational amenorrhoea, and natural methods.				
Population growth rate	The number of persons added to (or subtracted from) a population in a year due to natural increase and net migration expressed as a percentage of the population at the beginning of the time period.				

Population policy	Explicit or implicit measures instituted by a government to influence population size, growth, distribution, or composition.				
Public-Private Partnership	"Describes a spectrum of possible relationships between the public and private actors for integrated planning, provision and monitoring of services. The essential prerequisite is some degree of private participation in the delivery of traditionally public domain services." <sup>3</sup>				
Quality of care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge of best practice.4				
Total fertility rate	The average number of children that would be born to a woman (or a group of women) during her life time if she were to pass through her child-bearing years.				
Traditional methods	Includes periodic abstinence, withdrawal, and other folk methods.				
Unmet need for FP	Proportion of women who (i) are not pregnant and not postpartum amenorrhoeic and are considered fecund and want to postpone their next birth for two or more years or stop childbearing altogether but are not using a contraceptive method, or (ii) have a mistimed or unwanted current pregnancy, or (iii) are postpartum amenorrhoeic and their last birth in the last two years was mistimed or unwanted. (UDHS 2016).				
Village Health Team	Community volunteers who are selected by communities to provide correct health information, mobilise communities and provide linkage to health services. <sup>5</sup>				
Young person	A person between10 and 24 years of age. <sup>6</sup>				

# **FORWARD**

In Uganda, the demand for family planning among currently married women increased from 54% in 2001 to 67% in 2016. Despite greater progress over the past two decades, more than a quarter (28%) of currently married women and 32% of sexually active unmarried women in Uganda have an unmet need for family planning. Although more than 75% of Uganda's households are found in rural areas, the unmet contraceptive need for unmarried women in rural areas is 35.9 percent higher than 24.8 percent in urban areas. Some of the reasons for low family planning service utilization are; services and supplies are not available when they are needed most, limited choices of family planning methods, fear of partner's opposition, worries of side effects while others lack knowledge about contraceptive use.

Reducing unmet need for contraception would prevent around 30% of maternal deaths, reduce child mortality by up to 20%, and avert over one million abortions in Uganda. Investing in family planning would accelerate fertility decline; and increase the ratio of working-age adults relative to young dependents, thus propelling the country to economic growth. Additionally, family planning contributes to universal education, women's empowerment, poverty reduction, and environmental sustainability, making it one of the most cost-effective health and development interventions needed to achieve vision 2040.

Uganda's total fertility, maternal mortality, and teenage pregnancy rates remain among the highest globally. To counter this and other preventable maternal health related challenges, Ministry of Health developed the Family Planning Advocacy Strategy focusing on 14 advocacy issues identified through multi-sectoral consultations and stakeholder engagements. The Ministry of Health is committed to scaling up the use of family planning to ensure that every Ugandan of reproductive age can choose when and how many children to have. This would be achieved through; creating an enabling environment for FP through new policies, legislation, strategies and programs; additional resource allocations; and by strengthening existing structures to match the growing demand, mobilizing public support for initiatives to accelerate and sustain essential actions to improve FP services.

Our efforts to scale up use of modern family planning methods are motivated by the knowledge that family planning helps individuals achieve their human rights to health, education and personal decision making about the number and timing of their childbearing.

Henry G. Mwebesa, MD, MPH

**Director General Health Services** 

# **ACKNOWLEDGMENT**

Given the high fertility rate in the country, coupled with inadequate resources to fully sustain families, developing an advocacy strategy for family planning required having a team of highly competent and well – skilled individuals to undertake the task. This involved conceptualization, analysis of current trend of issues in regard to promotion of family health through well-thought family planning advocacy issues. We acknowledge United Nations Population Fund (UNFPA) and The Foreign, Commonwealth & Development Office (FCDO), United Kingdom, for the financial and technical support towards the development of this strategy. The Ministry of Health senior technical officers from the departments of Health Promotion, Education, and Communication as well as the Reproductive and Child Health department. The contribution of the teams enabled in identifying the key issues and the framing of the strategy. Others include our colleagues from various district local governments particularly the District Health Officers, The District Health Educators and Assistant DHOs in charge of MCH. Further, all religious and a number of cultural institutions, and the academia consulted gave very important inputs to this strategy.

Similarly, we appreciate the contributions of a number of Development Partners, and other government Ministries, Departments and Agencies like Ministry of Gender, Labor and Social Development, Ministry of Local Government, Ministry of ICT and National Guidance among others for the in-put during the development process.

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Richard Kabanda, MPH, MBA, DPHD, F.A.I.P.H

Ag. Commissioner Health Services

Health Promotion, Education and Strategic Communication

### **EXECUTIVE SUMMARY**

### Introduction

According to the Health Sector Development Plan 2015/16–2019/20, the trend of family planning services in Uganda is improving. However, although the adolescent fertility rate, the unmet need for family planning, and the contraceptive prevalence rate are all rising, the rate at which these improvements are happening is too slow to attain the country's targets.

The comprehensive set of family planning interventions the Government of Uganda is pursuing is spurred by the recognition that addressing the current situation requires a multi-pronged approach. For instance, as noted in the Family Planning Costed Implementation Plan, the contraceptive prevalence rate is an outcome of a combination of factors that include: access to information, education, and counseling; family planning commodity security; staff availability and skills; as well as social and cultural influences.

# **Strategy Development Process**

This strategy is the product of a wide-ranging consultative and appraisal process that: (a) took stock of the perspectives of a broad array of stakeholders; (b) assessed the current situation with regard to population dynamics and their ramifications for Uganda's economic development ambitions; (c) scanned the environment for family planning use, policies, and programmes; (d) reviewed the strengths, weaknesses, opportunities, and threats associated with family planning in Uganda; and (e) formulated an updated advocacy agenda to address the challenges of demand for, access to, and delivery of family planning services in Uganda.

The process of developing this strategy involved reviewing and updating the previous National Family Planning Advocacy Strategy 2005-2010. As such, new insights, evidence, and issues that have emerged since the expiry of the old strategy have been taken on board while recognising and retaining relevant elements of the previous strategy and the thinking that undergirded it.

Once this strategy is adopted, a costed operational plan aligned with the current Family Planning Costed Implementation Plan will be developed. The operational plan will refine this strategy into an implementation blueprint including mechanisms for knowledge management, managing risks, monitoring, evaluation and learning, as well as the implementation costs. The operational plan will be the basis for mobilising resources and will guide the execution of the advocacy strategy as applicable to each of the 14 focal advocacy issues.

The stakeholder consultations conducted at the national and district levels including with family planning user communities shed fresh light and generated new perspectives on many of the issues originally reflected in three major reference points and sources of evidence on FP, namely: (i) the *Uganda Family Planning Costed Implementation Plan 2015-2020*; (ii) the *Uganda Demographic and Health Survey 2016*; and (iii) the *National Family Planning Advocacy Strategy 2005-2010*.

# The challenge

Although Uganda is apparently saturated with information about FP – knowledge of contraceptive methods is nearly universal in the sense that 99% of both women and men have heard of at least one method of contraception – there remain acute gaps in and substantial barriers to the actual uptake of services. The demand for FP among married women is high (67%), and a considerable number (64%) of currently married women who are not using contraception intend to use an FP method in the future. Yet only 52% of demand is satisfied by modern contraceptive methods, while 28% of currently married women and 32% of sexually active unmarried women have an unmet need for FP.

The rapid population growth is driven by the high fertility rate, which in turn is caused by sex preference, early marriage, soaring school drop-out rates for girls, and unintended pregnancies due to low contraceptive use. The high growth rate and bottom-heavy age structure of Uganda's population translate in a high child dependency ratio, which undermines the country's efforts towards social transformation and development. Large average family sizes undercut the capacity of households and the nation to invest in education and health, both necessary conditions for the development of quality human capital and enhanced socio-economic development.

As noted by the Family Planning Costed Implementation Plan: "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. Strong national FP programmes also foster environmental sustainability."

According to the Family Planning Costed Implementation Plan, the anticipated benefits from the "demographic dividend" are not a given. Whether, and to what extent, a country earns from the demographic dividend is a function of investments and reforms in FP, education, and economic policy. It requires a steady decline in fertility to shift to a demographic structure dominated by the working-age population. Voluntary family planning programmes are vital in this process.

# Theory of change

Directing advocacy efforts at policy framers, decision makers, power holders, duty bearers, service providers, and influential stakeholders will inspire them to champion, implement, take responsibility, and account for the actions and measures instituted to promote and sustain access to and uptake of family planning. By identifying, spotlighting, mobilising around, and communicating the issues that require action through changes and reinforcements in policies, programmes, resources, and messages, investing in advocacy will contribute to: (i) universal access to family planning to enable Uganda attain middle-income status by 2040; (ii) reduction in the unmet need for family planning to 10%; and (iii) increase in the modern contraceptive prevalence rate amongst married and women in union to 50% by 2020.

# Impact goal

All women, men, and young people actively seek and have ready access to accurate and comprehensive FP information, are provided with high-quality, affordable, and equitable FP services, and do utilise the FP programmes and resources available.

# **Overall objectives**

- 1. To bolster the enabling environment for FP through new policies, legislation, strategies, programmes, and resource allocations, and by strengthening existing ones to match evolving needs and expectations.
- 2. To mobilise public support for initiatives to accelerate and sustain essential actions to improve FP services, and positive changes in reproductive health knowledge, attitudes, and practices.
- To champion the rights of individuals and couples to make informed choices about the use of FP methods.
- 4. To promote conditions for women, men, and young people to decide freely if, when, how often to give birth, and how many children to have.
- 5. To empower the youth and adolescents to make informed and responsible choices about their sexual and reproductive health.

# **Advocacy issues**

To frame the issues and set the family planning agenda, the 14 advocacy issues identified in this strategy are a blend of insights distilled from the stakeholder consultations, evidence gleaned from the latest UDHS, and a consolidation of issues underscored in the old advocacy strategy and the current family planning costed implementation plan. The issues identified that this strategy will focus on are:

- 1. Policy and enabling environment
- 2. Demographic dividend/transition
- 3. Prioritization and Financing
- 4. Stewardship, Management, and Accountability
- 5. Partnerships and Private Sector Engagement
- 6. Access to, delivery and quality of services
- 7. Adolescent and Youth Friendly Services
- 8. Contraceptive and RH Commodity Security
- 9. FP Provider Capacity, Knowledge and Behaviour
- 10. Social norms, culture and religion
- 11. Male Involvement
- 12. Access to information and knowledge management
- 13. Demand Satisfaction and Creation
- 14. Communicating for social and behaviour change

# **Costed implementation plan**

An implementation plan for each of the 14 priority advocacy issues was developed and costed. Many of activities/products for each of the priority areas are cross-cutting. Most of the activities/products for each of the priority areas are cross-cutting and have therefore been addressed and costed as a package. The costed activities/products have come from a variety of sources but include specific data from the MOH and partners implementing programmes. The costing ingredients include standard costs for the government procurement and implementation partners.

The costs of the implementation plan have been estimated using the Ministry and partners' operational rates with a tool developed and linked to an activity framework that is easy to adjust for further revisions. The costs have been estimated for the overall costs of the plan, as well as the costs for each year for the five years.

The total costs of the plan from 2020–2025 are \$21 million USD (77 billion UGX). The calculated total costs of the activities/outputs in the five years are as follows: A total of \$4.4 million USD (16.3 billion UGX) for 2020/2021; \$3.6 million USD (13 billion UGX) for 2021/2022; \$4.4 million USD (16 billion UGX) for year 2022/2023; \$3.9 million USD (14.3 billion UGX) for year 2023/2024; \$4.7 million USD (17.3 billion UGX) for year 2024/2025.

# 1.0 INTRODUCTION AND BACKROUND

The trend of FP services in Uganda is improving, according to the HSDP 2015/16 – 2019/20. But while the adolescent fertility rate, the unmet need for FP, and the CPR are all on an upward curve, the improvements are happening "too slowly to achieve country targets." <sup>1</sup>

FP services are crucial in efforts to reduce and prevent maternal, infant, and child mortality, and have both direct and indirect links and contributions to broader health, social, and economic outcomes. Trimming down the incidence of unintended pregnancies could avert maternal deaths, for example.

Access to FP programmes has the potential to lessen poverty, enhance gender equity, check the spread of HIV, drive down unwanted teenage pregnancies, and reduce infant deaths. Investment in FP could generate savings for households and countries on health, housing, water, and public services generally.<sup>2</sup>

According to WHO, the vast majority of births by adolescent mothers aged 15-19 occur in developing countries, and many are unplanned and unwanted. Factors that account for these unplanned and unwanted pregnancies in adolescence include: social pressure to marry and bear children early; absence of or limited education and employment opportunities; lack of information and education on contraception and how to avoid pregnancy; lack of access to condoms and contraceptive commodities; and inability to reject unwanted or coerced sex. Besides, adolescents are less likely than adults to obtain skilled prenatal, childbirth, and postnatal care. The negative repercussions and complications of adolescent childbearing equally affect the health of their babies.<sup>3</sup>

The comprehensive set of FP interventions the GOU is pursuing is spurred by the recognition that addressing the current situation requires a multi-pronged approach. For instance, as noted in the FP-CIP, the CPR rate is an outcome of a combination of factors: access to information, education, and counseling; FP commodity security; staff availability and skills; as well as social and cultural influences.

Boosting the CPR rate therefore requires improving access to contraceptive information especially for adolescents and young people, as well as expanding the range of contraceptive options available to users. Yet, the use of condoms and IUDs and FP as a whole are afflicted by certain myths and misconceptions not only in the general population but also among health workers. In addition, the delivery of FP services in Uganda as in East Africa generally is constrained by the shortage of skilled providers and frequent stock-outs of contraceptive commodities.<sup>4</sup>

Yet the challenges notwithstanding, the MOH reports that based on the CYP as a measure of FP use, Uganda recorded an 18% increase in the CYP from 2,156,240 in 2016/2017 to 2,540,251 in 2017/2018. There was a noteworthy rise in the use of IUDs and implants but a decline in the number of users of all other methods.<sup>5</sup>

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## **Key Demographic and Socio-Economic Statistics**

### According to 2014 National Population and Housing Census:

- Uganda's population was projected to be 40.3 million by mid-year 2019
- ◆ Annual population growth rate between 2002 and 2014 censuses was 3.03%
- Population density was 174 persons per square kilometre
- Sex ratio was 94.5 percent in 2014

### According to the 2016 Uganda Demographic and Health Survey:

- → Total fertility was 5.4 children per woman
- Infant mortality rate was 43 deaths per 1,000 live birth
- Under-five mortality rate was 64 deaths per 1,000 live birth
- ⇒ Life expectancy at birth was 63.7 years.

Source: 2019 Statistical Abstract. Uganda Bureau of Statistics.

Innovation is considered a cross-cutting domain in this strategy. The scaling up of innovative FP products and methods of delivering services such as the Sayana Press self-injectable, voucher scheme, postpartum IUD, and postpartum FP are elevating the levels of access to FP. Operational innovations such as task shifting and task sharing can increase access to and availability of FP services. According to WHO, "family planning services and methods can be safely and effectively provided by different health worker cadres, under specified circumstances." Training and continued educational support, for example, are essential for the successful implementation of task shifting and task sharing.

Given the broad range of actors involved in the provision of health services, the government puts a premium on building and consolidating partnerships among public and private healthcare providers in their various service categories. Yet, in describing the magnitude of the problem with partnership engagement, the HSDP points out that:

Most of the existing structures for partnership engagement are largely moribund, and not providing the needed forums for sector engagement. Some partners are therefore sidestepping these structures, and providing support that is not coordinated and harmonized. The SWAp process and the Health Policy Advisory Committee (HPAC) functionality are therefore compromised, with current focus primarily on statutory actions (e.g. endorsing proposals) as opposed to being forum for dialogue. The Technical Working Groups (TWGs) and Intersectoral coordination functionality are sub optimal, and there is limited real engagement of some stakeholder groups. Merit however needs to be given to the tenacity of the partnership and coordination structures, like HPAC and Health Development Partners (HDPs) forum which have largely continued to exist in spite of this environment."

Partnership engagement will be a success factor for advocacy under this strategy. While it has been framed as an advocacy issue in its own right with specific messages and actions devised to promote it, partnership engagement is fundamental to all elements of advocacy as proposed in this strategy.

# 1.1 Rationale, Vision, and Mission of the Advocacy Strategy

### **Rationale**

### The National Family Planning Advocacy Strategy 2020-2025 aims to:

- 1. Increase the demand for FP services across the country.
- 2. Strengthen political commitment to and the enabling policy environment for FP programming at all levels.
- 3. Improve the availability of equitable high quality FP services and information.
- 4. Raise awareness of population dynamics among policy and decision makers.
- 5. Strengthen the supply chain for availability of a range of contraceptive methods for informed choice.

### **Vision**

### The vision of the National Family Planning Advocacy Strategy 2020/21-2024/25 is:

- ➡ That all men and women will have access to accurate family planning information and high-quality family planning services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have.
- ➡ That young people and adolescents will have access to accurate information and high-quality services that will enable them to make informed choices about their sexual and reproductive health.

### Mission

The mission of the National Family Planning Advocacy Strategy 2020/21-2024/25 is to create an enabling environment that supports:

- → Improved access to accurate information about family planning.
- Improved access to high-quality family planning services.
- The rights of individuals and couples to make informed choices about use of family planning methods.

# 1.2 Approach to the Development of the Updated Strategy

This strategy is the culmination of a consultative and appraisal process that: (a) took stock of the perspectives of a broad array of stakeholders; (b) assessed the current situation with regard to population dynamics and their ramifications for Uganda's economic development ambitions; (c) scanned the environment for FP use, policies, and programmes; (d) reviewed the strengths, weaknesses, opportunities, and threats associated with FP in Uganda; and (e) formulated an updated advocacy agenda to address the challenges of demand for, access to, and delivery of FP services in Uganda.

This purpose of undertaking this exercise was to review and update the National Family Planning Advocacy Strategy 2005-2010. For that matter, new insights, evidence, and issues that have emerged since the expiry of the old strategy have been taken on board while recognising and retaining relevant elements of the previous strategy and the thinking that undergirded it.

Once this strategy is adopted, a costed operational plan aligned with the current FP-CIP will be developed. The operational plan will refine this strategy into an implementation blueprint including execution costs and mechanisms for knowledge management, managing risks as well as monitoring, evaluation and learning. The operational plan will be the basis for mobilising resources and will guide the implementation of the advocacy strategy as applicable to each of the 14 focal advocacy issues.

As a starting point to facilitate the design of the operational plan, for each of the 14 advocacy issues the following fundamental features have been identified:

- Framing the issue
- Objective
- Core messaging
- Priority audiences
- Calls to action and policy asks

# 1.3 Implementation of the Strategy

An implementation plan has been prepared and costed as the basis to operationalize the strategy. The strategy will be implemented by advocacy issue. The response to and interventions on each of the 14 priority issues identified will be led and overseen by respective thematic action groups (TAGs) composed of individual experts and representatives of organizations and agencies who are engaged with the given issue. Under the oversight of the MOH (HPECD and RHD), the TAGs will technically support and advise on the design of detailed implementation guides for the advocacy issues they are responsible for or interested in. The implementation guides will lay out the modalities of execution including, for instance, conceptual elaboration of the advocacy issue (e.g. formative research as the basis of an authoritative policy brief), updated stakeholder analysis, a work plan with a mechanism to track performance of the plan annually per objective, and a result framework to enable monitoring and evaluation of the strategy.

# 2.0 FP PROGRAMMING IN UGANDA

# 2.1 FP Costed Implementation Plan

The FP-CIP (promulgated in November 2014 for the period 2015 to 2020) is the GOU's guiding policy instrument for FP programming to which all sectors, development partners, and IPs are bound. As stated:

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.<sup>8</sup>

Accordingly, the *National Family Planning Advocacy Strategy 2020/21-2024/25* is anchored on, and seeks to contribute to, the vision and goal<sup>9</sup> of the FP-CIP.

### **FP-CIP Vision**

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

### **FP-CIP Goal**

To reduce the unmet need for family planning to 10% and increase the modern contraceptive prevalence rate amongst married and women in union to 50% by 2020.

The FP-CIP is designed to:10

- Ensure one, unified country strategy for family planning is followed
- Define key activities and an implementation roadmap
- Determine impact
- Define a national budget
- Mobilize resources
- Monitor progress
- Provide a framework for inclusive participation

The FP-CIP identifies five strategic priorities for the GOU to focus on in order to deal effectively with the gaps in FP. Each of these priorities is an arena for advocacy:

- **Priority 1:** Increase age-appropriate information, access, and use of FP 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 FP 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 multi-sectoral 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.

The FP-CIP is aligned with key international principles enshrined in FP2020, the SDGs, and *Committing to Child Survival: A Promise Renewed*;<sup>11</sup> and with established national frameworks notably Vision 2040 and NDP II. This section reflects on some of these principles and frameworks to set the context for zeroing in on the FP issues that the advocacy strategy will respond to.

### 2.2 FP2020

Uganda is a party to FP2020 – born out of the 2012 London Summit – which is motivated by the principle that "All women, no matter where they live, should have access to lifesaving contraceptives." At the London Summit, Uganda made a broad set of commitments towards FP2020 and followed up to actualize them through the FP-CIP. These commitments aim at: 12

- Attaining universal access to FP.
- Reducing the unmet need for FP.
- Increasing the annual government allocation for FP supplies.
- Improving accountability for procurement and distribution.
- Developing and implementing a campaign for integration of FP into other services.
- Partnerships with the private sector by supporting alternative distribution channels.
- Scaling up innovative approaches such as community-based distribution, outreaches, social marketing, social franchising, and youth-friendly services.
- Strengthening institutional capacity of the public and community-based service delivery points.
- □ Increasing choice and quality of care at all levels through staff recruitment, training, motivation and equipment.

# 2.3 Sustainable Development Goals

The SDGs have direct and indirect implications for FP programming, including: advocacy on actions at the policy and institutional levels; interventions to transform social (cultural and gender) norms; measures to scale up and improve provision of and access to services and commodities; and support mechanisms to sustain behaviour change in all spheres that have an influence on the uptake of FP. Of particular import are SDGs 3 and 5.

SDG 3	Ensure healthy lives and promote well-being for all at all ages.
Goal 3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
Goal 3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

SDG 5	Achieve gender equality and empower all women and girls."
Goal 5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
Goal 5.3	Eliminate all harmful practices, such as child, early and forced marriage and female Genital mutilation.
Goal 5.6	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 and the Beijing Platform for Action and the outcome documents of their review conferences.

# 2.4 Committing to Child Survival

The survival and health of children is critically associated with birth spacing, defined as "the interval between the birth of one child and the birth of the next to the same mother." According to UNICEF, there are risks of prematurity and low birth weight due to short birth spacing. For mothers in low-and lower-middle-income countries, birth spacing of at least two years is recommended as it would reduce infant mortality (children less than one-year-old) by 10% and child mortality (children ages 1 - 4 years old) by 21%. "Access to contraceptives and family planning services thus has significant potential to improve child survival through increasing birth spacing." 13

# 2.5 Second National Development Plan

Uganda's high fertility rate is a matter of concern, and NDP II attributes it, among other factors, to "early onset of marriage and childbearing, religious and cultural beliefs, and preference for large family sizes as a source of sustenance and social security." Although the use of modern contraception has increased over the years, it remains too low to significantly bring fertility levels down.<sup>14</sup>

To harness the demographic dividend, the GOU set out in its development strategy to considerably decelerate the fertility rate through a range of interventions that include improving access to FP services.<sup>15</sup> Uganda could then reap from the demographic dividend given that "countries with shrinking numbers of children due to fertility decline and large shares of working-age people can raise their rates of economic growth and standards of living."<sup>16</sup>

Another key intervention under NDP II is in the area of human capital development focusing on 13-17-year-olds. The intention is to ensure that "all children of this age group are retained in school with a special focus on the girl child, till completion of secondary school as a strategy to reduce early marriage and teenage pregnancies [...] and providing adequate and appropriate sexual and reproductive health information and services; and promoting male involvement in family planning and safe motherhood."<sup>17</sup>

# 2.6 Uganda Vision 2040

### **National Vision**

A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years.

The Vision 2040 target is to reduce the population AGR from 3.2% (the third highest in the world in 2010) to 2.4% by 2040.

Uganda's demographic profile, comprising one of the youngest populations in the world, could make or break the country's prospects of attaining Vision 2040. Due to the high fertility rate, the age structure of the population is dominated by young people below 15 years. These make up practically half of the population. "This has resulted in an unfavorable demographic profile made up largely of dependants. These dependants are either too young to work, and yet they consume the bulk of public services. In addition, the high growth rates arising out of the high fertility are putting pressure on delivery of services such as education and health."

# 2.7 Health Sector Development Plan 2015/16 - 2019/20

### **Goal of HSDP**

To accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life.

Way back in 2015 when the current HSDP<sup>19</sup> was being written, access to FP was improving as were the rates of adolescent fertility, the unmet need for FP, and contraceptive prevalence. However, then, as now, the pace of these improvements was too slow to achieve the country's targets.

Under specific objective 1 of the HSDP – to contribute to the production of a healthy human capital for wealth creation – one of the focal areas is health promotion across the life course. Key interventions for RMNCAH include implementing the FP-CIP at all levels of care and empowering male partners with knowledge about RMNCAH care services.

# 3.0 KEY FP AND ASSOCIATED INDICATORS

These indicators discussed in this section are derived from the latest (2016) UDHS<sup>20</sup> except where specifically credited to a different source.

# 3.1 Population Dynamics

Uganda's population is estimated at 40,308,000 in 2019. From 34,634,650 in 2014, the population is projected to grow to 69,746,400 by 2040 at an average AGR of 3.0%. Women of reproductive age 15-49 years constitute 48% of the population, and teenagers 13-19 years make up 17.3%.

### 3.2 Use of FP

The CPR stood at 39% among currently married women age 15-49 (from 23% in 2000/2001) and 51% among sexually active unmarried women age 15-49 who use FP of any method. Among married women age 15-49, considered the reproductive stage of the life course, the use of any modern method of FP (35%) exceeded that of traditional methods (4%). Among sexually active unmarried women in the same age group, 47% used any modern FP method and 4% used a traditional method.

The use of modern FP methods among married women varied by residence, region, education, and wealth. It was higher in urban areas (41%) as compared to rural areas (33%). It was lowest in Karamoja (7%) and West Nile (19%) and highest in Kigezi and Bugisu (43%), North Central (42%), Lango (41%), and South Central (40%) regions. Women with at least a secondary education were almost twice as likely to use modern FP methods (43%) as were women without an education (23%). Usage of modern methods of FP was higher among women in the wealthiest households (42%) than it was in the poorest (22%).

# 3.3 Sources of Modern Contraceptive Methods

Fifty-nine percent of 15-49-year-old women who used a modern contraceptive method last obtained it from the public sector – 42% got it from a government health centre and 39% from the private sector. There were differences in access to methods between the public and private sectors. The public sector was the most common source for female sterilisation (86%), IUDs (70%), and implants (83%); while 93% of women who used pills and 62% who used condoms had a socially marketed brand.

### 3.4 Demand for FP

The total demand for FP among married women stood at 67%. Forty percent wanted to delay childbearing – by either delaying their first birth or spacing another birth – for at least two years, and 27% did not want any more children or wanted to limit births. Just 39% of married women were already using contraception. If all married women who desired to space or limit their children used an FP method, the CPR would shoot up from 39% to 67%. By 2016, only 58% of the FP needs of married women were being met and just about half (52%) of the demand for FP was satisfied by modern methods.

### 3.5 Unmet Need for FP

The unmet need for FP<sup>23</sup> among married women stood at 28%, having declined from 35% in 2000/2001. Eighteen per cent wanted to delay childbearing while 10% wanted to stop. The high unmet need was attributed to poor access to FP services. With few skilled providers and inadequate commodities, FP service seekers had limited or no choice of methods. Consequently, men and women who needed the services were constrained in their capacity to freely determine the number, spacing, and timing of their children. The high unmet need for FP was likewise a factor in the prevalence of unplanned pregnancies, considering that 41% of all pregnancies were unplanned because they were either mistimed (32%) or unwanted (9%).

### 3.6 Informed Choice

In general, just about half (53%) of users<sup>24</sup> of modern contraceptive methods were fully informed about FP, having been told about all three critical factors involved in the use of FP, namely: side effects of the method used, what to do if they experienced side effects, and alternative FP methods available. Most women (two-thirds) were given information on possible side effects or problems of their method; 57% were informed about what to do if they experienced side effects, and 74% were informed of other available FP methods.

# 3.7 Fertility Rate

Although Uganda's TFR had declined by 1.5 since 2001 to 5.4 children per woman by 2016, there were notable variations by residence, region, education, and socio-economic status. In rural areas, women on average had 5.9 children in comparison to 4.0 children by their urban counterparts. Kampala had the lowest fertility rate of 3.5 children per woman while Karamoja had the highest at 7.9. Besides, women without an education had an average of 6.4 children compared to those with at least a secondary education who had an average of 3.6 children. Fertility also dropped with increases in the wealth of the household a woman lived in: women living in the poorest households had an average of 7.1 children, whereas those in the wealthiest households had an average of 3.8 children.

# 3.8 Knowledge of the Fertile Period

Very few women (22%) age 15-49 had correct knowledge of their fertile period during the ovulatory cycle. Among those using the rhythm method, 34% knew that a woman was more likely to conceive midway between two menstrual periods.

# 3.9 Discontinuation of Contraceptives

The contraception discontinuation rate<sup>25</sup> was high. Close to half (45%) of all instances of contraceptive use during the five years preceding the survey in 2016 were discontinued within the previous 12 months. Discontinuation was highest for pills (67%) and injectables (52%) and lowest for implants (21%). Health concerns or side effects (35%) were the most common reasons for discontinuation in addition to the desire to become pregnant (26%), conceiving while using a given method (10%), and infrequent sex or absence of the husband (9%).

# 3.10 Decision Making about FP

For the majority (62%) of married women using FP, the decision to use contraception was usually made jointly with their husbands; for 31% it was mainly their own decision; and for 7% it was primarily their husbands' decision. Forty-four percent of married women who were non- users of FP mainly made the decision to not use contraception jointly with their husbands; for 41% it was largely their own decision; and for 12% it was mainly a decision by their husbands.

# **3.11 Future Use of Contraception**

Sixty-four percent of married women who were non-users of contraception intended to use FP in the future whereas 33% did not. Intention to use contraception in the future by non-users of FP ranged from 56% among women with no children to 73% among those with two children. However, among women with four or more children who were non-users of FP, 58% intended to use contraception in the future.

# 3.12 Exposure to FP Messages in the Media

Radio was the most common source for FP messages among women and men age 15-49, with 65% of women and 69% of men having heard a FP message on the radio during the previous few months. Twenty percent of women and 23% of men had seen an FP message on TV, while 11% of women and 20% of men had seen one in a newspaper or magazine. Three percent of women and 6% of men had been exposed to an FP message on a mobile phone, while 31% of women and 26% of men had not been exposed to FP messages through any of these media in the previous few months.

### 3.13 Non-User Contact with FP Providers

Seventy-two percent of women age 15-49 who were non-users of a contraceptive method had not discussed FP with a health worker in the previous 12 months. Only 7% had discussed FP with a health worker. Twenty-five percent had visited a health facility in the previous 12 months and reported discussing FP with a health worker. Forty-one percent had visited a health facility but not discussed FP. Non-users in rural areas (27%) were more likely to have discussed FP during a health facility visit than were those in urban areas (20%). The proportion of FP non-users who had not discussed contraception either with a fieldworker or at a health facility ranged from a low of 38% in Karamoja to a high of 87% in Kampala. More educated and wealthier non-users of FP were less likely to discuss FP with a health worker than were the least educated and poorest women.

# 3.14 Sex, Marriage, and Birth

Women tend to start sexual activity earlier than men. The median age at first sexual intercourse for 25-49-year-old women was 16.9 years and 18.5 years for men in the same age bracket. Women who had attained secondary education and beyond initiated sex generally four years later (at 19.8 years) than did women with no education (at 16.0 years). Twenty percent of women begun sexual activity before they were 15 years old, while 64% had sex before they were 18. Uneducated women married more than six years earlier (at 17.5 years) than did those with a secondary education and beyond (at 23.8 years). Far more women (43%) were married by the age of 18 than were men (10%). Women had their first birth within 0.5 years of marriage, the median age at first birth being 19.2 years. More than 35% of women gave birth by the age of 18.

# 3.15 Teenage Pregnancy and Childbearing

Evidence from 2016 indicated that Uganda had a high teenage pregnancy rate, with 25% of adolescents aged 15-19 already mothers or pregnant with their first child. There were more teenage pregnancies in rural areas (27%) than there were in urban areas (19%), ranging from 16% in Kigezi to 31% in Teso. Moreover, adolescents in the poorest households were twice more likely to have begun childbearing (34%) than were those in the wealthiest households (15%). More educated teenagers were less likely to bear children (11%) than were uneducated young women (35%).

# 4.0 ADVOCACY AGENDA SETTING

Wide-ranging stakeholder consultations at the national and district levels were conducted with policy framers, decision makers, power holders, duty bearers, frontline health workers and service providers, and FP user communities. The consultations shed fresh light and generated new perspectives on many of the issues originally reflected in three major reference points and sources of evidence on FP, namely: (i) the *Uganda Family Planning Costed Implementation Plan 2015-2020*; (ii) the *Uganda Demographic and Health Survey 2016*; and (iii) the *National Family Planning Advocacy Strategy 2005-2010*.

To frame the issues and set the agenda going forward, the advocacy issues sketched out in this section are a blend of insights distilled from the stakeholder consultations, evidence gleaned from the last UDHS as well as a consolidation of issues underscored in the old advocacy strategy and the current FP-CIP.

# 4.1 Policy and Enabling Environment

FP is recognised in national policies and strategies as an important vehicle for improving health, socio-economic, and overall development outcomes. Yet the enabling environment for FP is undercut by scanty political will and commitment. Policy implementation and coordination are also undermined by lack of a clear and cohesive voice and message from leaders. Consequently, stakeholders and implementers of FP programmes often go about their work unaware and without an appreciation of the policy implications of their activities. This is compounded by poor policy dissemination whereby messages sometimes sound contradictory, ill-timed, misdirected, or complex. Advocacy for FP across different levels and sectors of the GOU will ensure that the appropriate policies are not only in place and but are fully implemented, enforced, monitored, and evaluated for impact.

# 4.2 Demographic Dividend/Transition

The demographic dividend is defined as "accelerated economic growth that arises when the birth rate declines rapidly and the ratio of working-age adults significantly increases relative to dependents." Since 2014, harnessing the demographic dividend has been the central and rallying message about the relationship between FP and socio-economic development in line with Uganda's ambition of becoming a high middle-income nation under Vision 2040. A rapid drop in the fertility rate is one of the critical paths towards this goal because the dual burden of a high population growth rate and a high child-dependency ratio are bottlenecks on the road to socioeconomic transformation.

As the guiding policy instrument on the linkage between population dynamics and development, the Demographic Dividend report is the prime advocacy and messaging platform on the value and contribution of FP to socioeconomic transformation. In fact, since the launch of the Demographic Dividend report in 2014, according to UNFPA: "Government commitment to family planning budget increased by 30 percent and its allocation for family planning supplies grew from US \$3.3 million to US \$5 million projected for five years." <sup>27</sup>

# 4.3 Prioritisation and Financing

The health, social, and economic costs to the country arising from the proliferation of unintended and teenage pregnancies are under-appreciated. The role of FP in preventing and mitigating these costs is poorly understood by some of those who should know better, such as politicians and other influencers who ignore evidence to publicly de-campaign FP, condom use, and contraception generally. Consequently, FP has not received maximum commitment and support at the national and sub-national levels. Other programmes such as HIV/AIDS and malaria benefit from a more generous share of health resources largely through targeted donor funding, while budgets for FP (and reproductive health in general) pale in comparison.

Without reasonable dedicated funding, managers at the national and sub-national levels lack the means to undertake critical countrywide and community-based FP and RH initiatives. In the districts, health managers and service providers are faced with multiple competing priorities for limited funds. Coupled with staff shortages at many health facilities, <sup>28</sup> FP ends up being sidelined in favor of better-resourced programmes and uncontroversial health needs. Yet another troubling phenomenon is the disconnect between the overall positive policy environment for FP in Uganda and the level of national financial resources allocated to adequately respond to the demand for FP services. Advocacy will be crucial in efforts to increase allocations for FP by the central and local governments. To provide the necessary evidence to support advocacy around financing, it will be necessary to introduce and institutionalize the tracking/monitoring of FP financing at the district level. At the same time, it will be crucial to intensify efforts to sustain the current funding by development partners and to improve value for money within family planning programmes.

# 4.4 Stewardship, Management, and Accountability

There are numerous players active in FP policy, oversight, knowledge management, and service delivery in its multiple dimensions. Attaining the set goals and targets requires harmonising and coordinating the functions and interventions of the various actors through effective monitoring, management, leadership, and accountability at all levels.

While the MOH plays the lead role in FP coordination, the fact that there are many and diverse stakeholders involved in the sector calls for improved and strong mechanisms for collaboration and synchronization of plans so that FP programmes at the central, inter-ministerial, and decentralised levels, and by the public, private, not-for-profit, and civil society sectors are approached as a collective effort trained on common goals. It cannot be overemphasised that, "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." 29

# 4.5 Partnerships and Private Sector Engagement

Access to a variety of service delivery points to obtain commodities from is as critical to the success of FP as having a variety of methods to choose from. The Common African Position (CAP) of the African Union includes partnerships as a priority area, with emphasis on the promotion of PPP for health as one of the means to achieve universal and equitable access to quality healthcare. One of

the key programme areas of the HSDP is PPP and one of the key interventions is to develop a PPP advocacy strategy targeting both internal and external stakeholders of the Ministry of Health. The government's policy is to partner with private sector stakeholders and service providers in order to improve the overall health status of the population and to expand geographical access to health care.

The government enacted the National Policy on Public Private Partnership in Health<sup>30</sup> as a vehicle through which to effectively partner and coordinate with the private sector in the delivery of health services. The purpose of the policy is "to provide guidance to mainstreaming, establishing, implementing, coordinating, monitoring and evaluating partnerships between the Government of Uganda and the private health sector within existing laws, policies and plans."<sup>31</sup> The policy, and its attendant implementation guidelines, elaborates the strategies that public and private sector stakeholders are expected to follow to contribute to achieving the goals of the national health system. The policy categorises Uganda's varied and diverse private health sector as follows: (i) Private Not For Profit; (ii) Private Health Practitioners; and (iii) Traditional and Complimentary Medicine Practitioners. However, there is also a significant informal sector of health providers who often have no formal training and are unregulated. These exist outside the legitimate private sector. Regularizing their operations requires that they comply with the laws, regulations and standards that apply to their practices.

# 4.6 Access to, Delivery and Quality of Services

A mix of factors conspire to restrain potential and current users' access to FP services. Basic health facilities are unavailable in many areas. Where they do exist, a good number have no qualified RH service providers. In many cases, the providers who are available have not been equipped with upto-date FP knowledge and skills. With limited training, time, supplies, and equipment, health care workers are constrained in executing their duties including counselling and advising clients on contraceptive options. In short, the current staffing, levels of skill, and service structure within the country's health care system do not provide sufficient and equitable FP services.

FP is yet to be fully integrated with other health services, which is not helped by the fact that community-based FP services are barely accessible in many communities. To make matters worse, FP commodities and supplies are not consistently available at service delivery points. For instance, many communities are served by health facilities operated by the Catholic Church, yet their services are restricted to natural FP methods. Often times, people in these communities have no alternative providers to benefit from the full range of FP services. Similarly, there is an urgent need to address issues of equity by confronting obstacles to access and use of FP due to poverty (the poorest in rural and urban areas), HIV/AIDS, gender, age, marital status, education, geography (rural and hard-to-reach populations), and religious disposition, among other things.

# 4.7 Adolescent and Youth Friendly Services

Family planning services for adolescents, youth, and young people at large are starved of funding and lack custom-designed delivery mechanisms. This partly explains why adolescents and young people are more likely to seek services for common illnesses such as malaria than to use SRH services. The reluctance by adolescents to seek SRH services including FP also has to do with long waiting times and queues, unsatisfactory quality of care such as lack of privacy and confidentiality, and encounters with service providers who are rude and have poor communication skills. Early plus unwanted pregnancies and unsafe abortions are but some of the many health challenges that adolescents have to contend with, often leading to dropping out of school and early or forced marriages.

The MOH recommends that: "Adolescents and young people need to be reached with Adolescent-Friendly Services (ADFHS) to mitigate the multiple health challenges and behavioral risks that they are faced with. This has to be done in a manner that ensures availability and accessibility by all young people including those in conflict and hard to reach environments." <sup>32</sup>

# 4.8 Contraceptive and RH Commodity Security

The health system both at central and service delivery levels is plagued by recurrent stock-outs of some commodities and over-stocks of others. Maintaining a robust and reliable supply of high-quality contraceptive and RH commodities and related supplies is important to meet the needs and choices of FP users across the country. Provision of a complete method mix to respond to clients' changing needs and expectations is important. People's needs evolve throughout their reproductive lives and having access to a range of options increases clients' overall levels of contraceptive use and empowers them to fully exercise their rights so they can attain their reproductive aspirations. It is anticipated that the use of the more effective modern methods will rise and that of the less effective traditional methods will shrink as a share of the overall method mix.

According to the FP-CIP: "The method mix available influences not only successful client use and satisfaction, but also has implications for provider skills confidence and competence." As a measure to increase the market size of FP services and commodities, the FP TMA strategy highlights the urgency of addressing "the high cost for registration of new products, high supply chain markups and a long registration process for FP product/commodities including branding products for the public sector and social marketing." It recommends advocacy to engage NDA to waive and shorten the registration process for FP products and especially new products supplied by WHO-prequalified manufacturers.

# 4.9 FP Provider Capacity, Knowledge and Behaviour

Frontline FP providers who interface directly with service seekers perform a critical enabling role for the uptake of FP services. Yet negative provider attitudes and behaviour often turn users, including adolescents and young people, away from FP. As noted by the National Family Planning Social Behaviour Change Communication Strategy (2016-2021), providers "especially those in community settings lack the necessary knowledge, information and skills to provide adequate information and counseling on family planning for the above different audiences. For a long time, providers deliver family planning information to adolescents, young women, old women and men in the same way with no differences to cater for the unique needs of each audience category"<sup>35</sup> (page 7). The range of problematic behaviours, tendencies, and situations observed among service providers includes: providing limited FP information while paying only slight or no attention to possible side effects; prioritising women; inadequate skills and tools to deliver FP information, counselling, and services particularly for the benefit of men, adolescents, and young people; poor attitudes towards FP generally; impatience with FP clients; rushing through counselling sessions as a way of coping with the heavy workload; personal biases that result in offering a limited range of contraceptive options even when all methods are available; and drawing on personal experiences with FP in disregard of the uniqueness of the clients seeking services. Through continuous medical education, for instance, health workers and FP providers need to be equipped with the knowledge, skills, and tools to tailor the way they convey FP messages to different user groups or service seekers such as adolescents and male partners. This includes, for example, addressing the providers' own attitudes and professional

practices to focus on the importance of confidentiality, being non-judgmental, counselling that promotes individual efficacy, and constructive communication about the side effects of different contraceptive options.

# 4.10 Social Norms, Culture and Religion

Women's reproductive choices are influenced in significant ways by social norms, including gender and cultural values, and religious beliefs. The pervasive early and frequent childbearing and large family sizes have a lot to do with some of the age-old norms, values, and beliefs. Men report 5.4 children as their ideal family size compared to women whose ideal family size is 4.8 children. Family size norms vary across regions. Women in Kampala region want 4.1 children, while women in Karamoja want 7.2 children. Also, education is a stronger predictor of desire for a smaller family size than wealth. The majority of women (62%) who use FP typically make the decision to use contraception jointly with their husbands. By the same token, spouses do play a role in women's decision to discontinue contraception. In FGDs with women, many said they preferred more discreet methods to implants because the former can be used without the knowledge of their spouses.

### 4.11 Male Involvement

Although men are to a large extent involved in decisions on the use of FP (62% of married women made the decision to use contraception jointly with their husbands), the high unmet need for FP implies that men are similarly involved in deciding that their partners should not use, or should opt out of, FP. Moreover, 44% of married women who were non-users of contraception made the decision against using FP jointly with their husbands. The fact that 45% of all cases of contraceptive use were discontinued within the 12 months prior to the UDHS of 2016 equally points to the role of men in decisions to discontinue FP use. One study of male knowledge and use of FP concluded that: "An opportunity lies in providing men with accurate family planning information, especially about highly effective methods. As men are not accessing the hospital or clinics often or getting their information from healthcare workers, the venue for such education should include settings outside of healthcare facilities, but staffed with trained healthcare workers." There are male involvement strategies in other sectors that FP can use to benchmark its own, such as *The National Male Involvement Strategy for the Prevention and Response of Gender Based Violence in Uganda.* 

# 4.12 Access to Information and Knowledge Management

Although almost all respondents surveyed in the UDHS have heard about at least one method of contraception, few know about the various other FP options. Misconceptions also abound in regard to the effects of contraception due to unfounded health concerns and fears of side effects. Many lack information about sources of contraceptive commodities. And the failure to vigorously target men with information about FP exacerbates the myths, misconceptions, inaccuracies, and half-truths circulating about FP.

On the other hand, the available data or evidence on FP and RH is neither sufficiently optimised nor extensively and constantly disseminated in user-friendly and digestible formats to help feed into and inform public debates and the national conversation on FP at all levels. There is need to build and strengthen capacity to promptly process and manage the existing and new evidence for the benefit of stakeholders. This is especially crucial for stakeholders at the lower levels and at the frontlines of service delivery who are far removed from the technical arenas where routine discourses on FP happen and where policies are mooted and formulated. One of the key programme

areas of the HSDP 1915/16 – 2019/20 is knowledge translation and use for decision-making and one of the key interventions is to develop a comprehensive knowledge management framework for Uganda.

### 4.13 Demand Satisfaction and Creation

The fact that numerous women who want to delay or limit childbearing are presently not using any FP method is manifested in the high level of unmet need for FP. What is required is to deepen people's knowledge about contraception beyond elementary awareness and to challenge myths, superstitions, misconceptions, and disinformation through proactive and vibrant advocacy and communication. This will go a long way to satisfy current and to generate new demand for FP.

Knowledge is a well-known determinant of FP use. To sustainably expand knowledge and grow the demand for FP, consistent dissemination of accurate, comprehensive, as well as properly targeted and packaged information is essential. Equally important is an approach based on inventive promotion, visibility, branding, social marketing, coalition-building, and stakeholder engagement techniques, all guided by sound evidence and best practices in SBCC. The ultimate aim, according to the FP-CIP, is to "increase demand for family planning within communities, producing a supportive environment; reducing social, cultural, and religious barriers; and mobilising community support." 38

# 4.14 Communicating for Social and Behaviour Change

One of the results expected from advocacy is positive change in RH beliefs and behaviours among communities. In that regard, the *National Family Planning Social and Behaviour Change Communication Strategy (2016-2021)* was developed "to operationalise key elements of Uganda's FP-CIP (2015-2020) by guiding the design and implementation of high-impact communication interventions that address key barriers including the knowledge-use gap, cultural and religious beliefs, myths and misinformation, fear of side effects and health concerns that impede seeking, adoption and continuous use of modern family planning methods in Uganda."<sup>39</sup>

The objectives of the SBCC strategy are: (i) Increased knowledge and empowerment for adolescent girls (10-19) and young women (20-35) to seek contraceptive information and services (met demand and unmet need); (ii) Increased number of men (15-49) who take up and support the use of modern contraception for themselves and their partners; and (iii) Increased number of women and men (15-49) with favourable attitudes/beliefs/norms towards family planning generally, and modern contraceptives in particular. The underlying theoretical framework for the SBCC strategy – the Socio-Ecological Model – draws attention to the importance of interventions to influence change and address barriers in the FP enabling environment including policies and legislation, politics and conflict, economics, religion, technology, and the natural environment.

# 5.0 ADVOCACY PARTNERS

NATIONAL									
Government		NGOs / CSOs		Private Sector		Cultural Institutions		Faith-Based Organisations	
2.	Cabinet	2. CARE International in Uganda		Association	2.	Tieng Adhola (The Padhola		Uganda	
3.	National Population	3. Aid Information Centre (AIC)	2.	Uganda Association of University		Cultural Institution)	2.	Catholic Secretariat	
	Council	4. The AIDS Support Organisation (TASO)		Women	3.	Iteșo Cultural	3.	Uganda Catholic	
4.	Professional Councils	5. Elizabeth Glaser Foundation	3.	Uganda Association of Women	4.	Union Buganda	4	Medical Bureau	
5.	Public Service Commission	6. Marie Stopes Uganda (MSU)		Medical Doctor		Kingdom	4.	Uganda Muslim Supreme Council	
6.	Uganda AIDS	7. Marie Stopes International (MSI)	4.	Federation of African Women	5.	Bunyoro Kitara Kingdom	5.	Uganda Muslim	
	Commission	8. PATH Uganda		Educationists	6.	Buruli Chiefdom		Medical Bureau	
7.	GFATM Country Coordination	9. Pathfinder	5.	Media – newspapers	7.	Bunyala	6.	Church of Uganda	
	Committee	10. PSI Uganda	6.	Media – radio		Chiefdom	7.	Uganda Protestant	
8.	Parliament: Social Services	11. Straight Talk Foundation	7.	Media – TV	8.	Busoga Kingdom		Medical Bureau	
	Committee; Finance	12. Uganda National	8.	Media - Online	9.	Uganda Kings and Cultural	8.	Aga Khan Foundation	
	Committee; HIV/ AIDS Committee	HealthConsumers Organisation (UNHCO)	9.	Rotary and Rotaract Clubs	10	Leaders' Forum  Nkore Cultural	9.	Uganda Orthodox	
9.	Ministry of Finance, Planning	13. Mercy Corps	10.	Lions Club	10.	Trust		Church	
	and Economic Development	14. National Union of Disabled Persons of Uganda (NUDIPU)	11.	Uganda Manufacturers Association	11.	Inzu Ya Masaaba	10.	Hindu Union	
10.	Ministry of Health	15. Uganda Local Authorities Association (ULAA)		Association	12.	Obwa Kamuswaga Bwa Kooki			
11.	National Curriculum	16. CUAMM			12				
	Development Centre	17. FHI360				Alur Kingdom			
12.	Health Training Institutions	<ol> <li>Johns Hopkins University Center for Communication Programs (JHU-CCP)</li> </ol>				Ker Kwaro Acholi Obwa Ikumbania Bwa Bugwere			
13.	Ministry of	19. Caritas Uganda			16	J			
	Gender, Labour and Social	20. Samaritan's Purse			10.	Busongora Kingdom			
	Development	21. Save the Children			17.	International			
		22. Straight Talk Foundation				Community of Banyakigezi -			
		23. Uganda Family Planning Consortium				Uganda Chapter			
		24. Reproductive Health Uganda							
		25. CEHURD							
		26. Coalition for Health Promotion and Social Development Uganda (HEPS)	a						
		27. Uganda Health Marketing Group (UHMG)							
		28. Action for Health Uganda (A4HL	)						
		29. Samasha Medical Foundation (SMF)							

# INTERNATIONAL AND DEVELOPMENT ORGANISATIONS

DANIDA, DFID, EU, Global Fund (GFATM), Irish Aid, UNFPA, Enabel, UNICEF, USAID, WHO, World Bank

# 6.0 UPDATED ADVOCACY STRATEGY FRAMEWORK

# 6.1 The Challenge

Although Uganda is apparently saturated with information about FP – knowledge of contraceptive methods is nearly universal in the sense that 99% of both women and men have heard of at least one method of contraception – there remain acute gaps in and substantial barriers to the actual uptake of services. The demand for FP among married women is high (67%), and a considerable number (64%) of currently married women who are not using contraception intend to use an FP method in the future. Yet only 52% of demand is satisfied by modern contraceptive methods, while 28% of currently married women and 32% of sexually active unmarried women have an unmet need for FP.<sup>40</sup>

The rapid population growth is driven by the high fertility rate, which in turn is caused by sex preference, early marriage, soaring school drop-out rates for girls, and unintended pregnancies due to low contraceptive use. The high growth rate and bottom-heavy age structure of Uganda's population translate in a high child dependency ratio, which undermines the country's efforts towards social transformation and development. Large average family sizes undercut the capacity of households and the nation to invest in education and health, both necessary conditions for the development of quality human capital and enhanced socio-economic development.<sup>41</sup>

As noted by the FP-CIP: "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. Strong national FP programmes also foster environmental sustainability." <sup>42</sup>

According to the FP-CIP, the anticipated benefits from the "demographic dividend" are not a given. Whether, and to what extent, a country earns from the demographic dividend is a function of investments and reforms in FP, education, and economic policy. It requires a steady decline in fertility to shift to a demographic structure dominated by the working-age population. Voluntary FP programmes are vital in this process. As observed by the FP-CIP:

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 national development plan.<sup>43</sup>

# **6.2 Theory of Change**

Directing advocacy efforts at policy framers, decision makers, power holders, duty bearers, service providers, and influential stakeholders will inspire them to champion, implement, take responsibility, and account for the actions and measures instituted to promote and sustain access to and uptake of FP. By identifying, spotlighting, mobilising around, and communicating the issues that require action through changes and reinforcements in policies, programmes, resources, and messages, investing in advocacy will contribute to: (i) universal access to FP to enable Uganda attain middle-income status by 2040; (ii) reduction in the unmet need for FP to 10%; and (iii) increase in the modern contraceptive prevalence rate amongst married and women in union to 50% by 2020.

# 6.3 Impact Goal

All women, men, and young people actively seek and have ready access to accurate and comprehensive FP information, are provided with high-quality, affordable, and equitable FP services, and do utilise the FP programmes and resources available.

# 6.4 Overall Objectives

- 1. To bolster the enabling environment for FP through new policies, legislation, strategies, programmes, and resource allocations, and by strengthening existing ones to match evolving needs and expectations.
- 2. To mobilise public support for initiatives to accelerate and sustain essential actions to improve FP services, and positive changes in reproductive health knowledge, attitudes, and practices.
- 3. To champion the rights of individuals and couples to make informed choices about the use of FP methods.
- 4. To promote conditions for women, men, and young people to decide freely if, when, how often to give birth, and how many children to have.
- 5. To empower the youth and adolescents to make informed and responsible choices about their sexual and reproductive health.

# **6.5 Advocacy Issues**

**Priority Audiences 1.1** 

#### **ISSUE #1: POLICY AND ENABLING ENVIRONMENT**

**Framing the Issue:** While Uganda has developed various policies, guidelines, and strategies, implementation remains a challenge to reaching the country's goals as reflected both in national and international obligations and frameworks. The policy environment for FP is conducive, with strong political will at the highest level of government as exemplified by the President's commitments on behalf of the GOU and his public pronouncements. However, beyond recognising RH as a key driver of social, economic, and environmentally sustainable development, measures should be taken to mainstream, including budgeting for, FP in all relevant sectors, government MDAs, health care/outreach services, and livelihood programmes in agricultural, income generation, and wealth creation projects, among others.

Objective	Core Messaging		
By 2025, FP is integrated as a cross-cutting intervention for national development and policies that promote access to services in accordance with human rights and quality of care standards are enacted and implemented.	1. Although FP has been recognised in policy as a key element in improving national health and development, the enabling environment for policy implementation still needs improvement and strengthening.		
	2. Build and demonstrate political will and commitment to ensure the appropriate FP decisions, policies, strategies, and measures are not only present but also fully implemented.		

MOH | DLGs | Central Government MDAs | National Coalition of FP Advocates and Champions

- Secure commitment and support to develop, implement, and monitor decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into health services at all levels.
- 2. Reposition FP as a cross-cutting intervention and fundamental element of national development including as a key contributor to the demographic dividend, environmental sustainability, and the health sector strategy.
- 3. Disseminate information to popularise and improve public and stakeholder understanding of Uganda's FP programme and its legal and policy frameworks.
- 4. Disseminate and avail FP policies on the MOH website and knowledge management portal.
- 5. Promote initiatives to ensure that the full range of FP commodities and contraceptive methods is available: i.e. inclusion of all WHO pre-qualified commodities in The Essential Medicines List; review of the contraceptive testing policy; implementation of task-sharing policies; facilitating the operationalisation of the alternative distribution system for providing commodities to NGOs.
- 6. Promote measures to operationalise task-sharing in the provision of FP services.
- 7. Equip decision makers and duty bearers with knowledge and skills to advocate for contentious policies, bills, laws, and decisions on SRH and FP (e.g. approval of clinical officers to perform surgical contraceptive methods) so they can help to strengthen the FP policy environment through informed and evidence-based dialogue and deliberation.
- 8. Conduct advocacy training and orientation on FP- and RH-related policies.
- 9. Engage political, civic, local, cultural, religious, and business leaders, celebrities and social influencers to coordinate and scale up public and community outreach on the benefits of FP.
- 10. Secure commitment and support to develop, implement, and monitor decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into district health services and into the activities and programmes of non-health sectors at all levels of decentralisation.
- 11. Secure commitment and support to develop, implement, and monitor decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into the activities and programmes of non-health sectors.
- 12. Promote measures to embed FP in broader development issues and to address it on a multisectoral level across line ministries.

#### **Priority Audiences 1.2**

IPs | NGOs | CSOs | Private Sector

#### **Calls to Action and Policy Asks**

- 1. Secure commitment and support to develop, implement, and monitor decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into the activities, programmes, and core businesses of non-governmental and private sector partners.
- 2. Improve knowledge and appreciation of FP policies and programmes among health care workers at all levels of service delivery and among duty bearers in non-health sectors impacted by FP and RH outcomes.
- 3. Produce and disseminate customised information products addressing the role of HCWs, DHTs, and non-health sector duty bearers in policy implementation with particular focus on education about the provision of FP services in accordance with human rights and quality of care standards.

#### **Priority Audiences 1.3**

#### **Parliament**

#### **Calls to Action and Policy Asks**

- 1. Secure commitment and support for the development, implementation, and monitoring of decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into relevant government programmes and services at all levels.
- 2. Support measures to increase the retention of FP HCWs by standardising the salary scales for similar cadres of HCWs.
- 3. Develop and provide messages/talking points on how FP relates to the mandate of MPs and the interests and welfare of their constituents.

# **Priority Audiences 1.4**

**HDPs** 

#### **Calls to Action and Policy Asks**

1. Secure commitment to support measures by the GOU and its partners to provide efficient FP services that meet the needs of all segments of the population.

# ISSUE #2: DEMOGRAPHIC DIVIDEND / TRANSITION

**Framing the Issue:** The role of FP as a driver of the demographic dividend is not well understood by policy- and decision-makers, implementing partners, and the public. To reap the dividend and to achieve middle-income country status by 2040, Uganda needs to implement policies that will engender rapid declines in fertility and mortality. Similarly, the country needs to pursue measures to ensure that the population age structure does not burden the economy and society with a high dependency ratio, and that the resultant surplus labour force and youthful population are well educated, skilled, healthy, and economically productive.

# Objective Core Messaging

By 2025, the centrality of FP in harnessing the demographic dividend is visible in dialogue on population matters and better appreciated by policy stakeholders and the public.

- 1. Uganda's aspirations for socio-economic transformation and transition to an upper middle income country by 2040 can be enhanced considerably by adopting policies that will harness a maximum demographic dividend, including accelerating fertility decline by enhancing investments in family planning.
- 2. Uganda's population presents both challenges and opportunities for the country's development. The combination of a high but slowly declining fertility rate and steadily declining child mortality implies that the population is very youthful, has a high child-dependency ratio, and is growing at a rapid rate.
- 3. Uganda's high child dependency ratio is a major hindrance to social transformation and sustainable development, given that one working-age person (age 15–64) supports 1.9 people in the dependent age groups.
- 4. A large average family size is a constraint on the ability of households and the government to invest in education and health, which are critical drivers of socio-economic and human capital development. Parents and the government have limited savings because they spend most of their income on meeting the basic needs of children.
- A speedy demographic transition from the current high rates of child mortality and fertility to low child mortality and fertility rates will reduce the dependency ratio and stimulate development.
- 6. If the birth rate declines steadily, Uganda's age structure will change, resulting in a population that has more working-age people relative to dependent children. This shift in the age structure has tremendous potential to accelerate the socio-economic transformation envisaged in Uganda's Vision 2040.

#### **Priority Audiences 2.1**

The Executive & Cabinet | Central Government MDAs | DLGs | NGOs | CSOs | Private Sector | Religious Leaders | Cultural Leaders | MPS | NPA | NPC

- 1. Promote and popularise among FP stakeholders the interventions rolled out by the GOU to enable the country accelerate the demographic transition.
- 2. Demonstrate the contribution of FP to outcomes associated with the demographic dividend including: rapid declines in fertility and mortality; improvements in child survival; and retention of children, especially girls, in school to completion (Senior 4) in order to delay childbearing and marriage and to prevent teenage pregnancy.
- Leverage the political will to commit resources to FP to generate funding for interventions to accelerate fertility decline and set the country on the path to harnessing the demographic dividend.
- 4. Promote the policy options and programme interventions recommended to accelerate fertility reduction in order "to open the demographic dividend window of opportunity in Uganda."
- 5. Reinforce political will and investments in FP at the national and sub-national levels, building on the commitment to FP2020.
- 6. Reinforce evidence-based advocacy, monitoring, and accountability mechanisms to ensure FP is prioritised and commitments are operationalised.
- 7. Address barriers to demand, access, and use of FP among married and unmarried couples by strengthening the delivery of high-quality FP services through health facilities, community outreach programmes, and other outlets.
- 8. Intensify educational campaigns through the media and other formats to enable couples to realise the benefits of smaller family size for both their own economic well-being and national development.
- 9. Delay the onset of childbearing by promoting school progression and access to contraception for sexually active adolescents and young women.
- 10. Declare FP a key development intervention to ensure that non-health sectors contribute to promoting voluntary contraception and fertility decline.

#### **ISSUE #3: PRIORITISATION AND FINANCING**

**Framing the Issue:** Uganda is heavily dependent on donors for health care funding, with donors providing more than half of the MOH budget for drugs and services. **D**onor fatigue has inevitably set in. Yet, while demand for FP is growing, funding is not increasing at the same pace to complement the increase in the population's needs. There is a grave shortage of funding for youth FP services, in particular. There is a recognition that recent advocacy has helped to increase financing for RH commodities and the momentum built up through previous and ongoing efforts must be maintained. Nonetheless, advocacy efforts need to be intensified to persuade the district and lower-level local governments to earmark more resources for FP.

Objective	Core Messaging
By 2025, funding for FP programmes within the national budget and by local governments, partners, and the private sector increases.	1. The generally positive policy environment for and political commitment to FP and RH need to be translated into sustained allocation of national resources to meet the demand for services, commodities, equipment, supplies, and personnel.

#### **Priority Audiences 3.1**

#### MOH | MOFPED | NPA | HDPs

#### Calls to Action and Policy Asks

- Increase government funding to close the gap between the overall positive policy environment for FP and the low allocation of national financial resources to fully meet the need for FP services
- 2. Demonstrate the value for money derived from financial investments in FP in order to sustain financing by development partners.
- 3. Mobilise to ensure that the national health insurance scheme includes coverage for all FP methods in all insurance policies.

# **Priority Audiences 3.2**

#### **Parliament**

#### Calls to Action and Policy Asks

1. Endorse, maintain, and push for increases in the FP line items in the MOH budget.

#### **Priority Audiences 3.3**

#### DLGs

#### **Calls to Action and Policy Asks**

- 1. Increase the allocation of financial resources by districts and lower level local governments for FP services and commodities.
- 2. Promote the creation of FP budget lines at the district level to support the prioritisation and integration of FP into district planning and budgeting processes.

# **Priority Audiences 3.4**

MOFPED | HDPs | NPA | DLGs

#### Calls to Action and Policy Asks

- 1. Engage with the MOFPED to ensure that the FP budget line is maintained and not removed or rejected from the sectoral budget.
- 2. Engage with development partners to make a case for allocating resources to FP programmes.
- 3. Promote the case for increased investment in training and support for midwives and nurses at lower-level health facilities to help increase the overall level of human resource development funding for health.

#### **Priority Audiences 3.5**

**Private Sector** 

1. Educate non-traditional donors especially the private sector about the benefits of investing in FP as a part of the health benefits package offered to their employees and as part of their corporate social responsibility programming.

#### ISSUE #4: STEWARDSHIP, MANAGEMENT, AND ACCOUNTABILITY

Framing the Issue: FP has to be repositioned in the context of the current multi-sectoral environment. Advocacy will promote the urgency of measures and actions to ensure clear leadership responsibility and authority to address bottlenecks in supervision, monitoring, coordination, and staffing. Advocacy efforts will also emphasize the need for effective mechanisms to oversee the government and partners' policy positions and programmatic activities at the national and subnational levels. Effective leadership at the decentralised level is especially critical. Given their proximity to the FP services frontline, local leaders are best placed to neutralise conflicts that could arise due to differences in public policy and religious values, and to mitigate risks that could obstruct the overall management of the country's FP programme.

Objective	Core Messaging

in the overall management and governance of Uganda's FP programme.

- By 2025, there is demonstrable improvement | 1. FP is a fundamental health, population, and socio-economic development issue for Uganda.
  - 2. Effective management and governance of FP activities at all levels are needed to meet the targeted increase in mCPR and decrease in unmet need by 2020.
  - 3. The management of FP activities in Uganda will improve by upgrading the systems and processes in place for supervision, monitoring, tracking, and coordinating government and partner activities at the national and decentralised levels.

#### **Priority Audiences 4.1**

The Executive & Cabinet | MOH | Parliament | DLGs | Religious Platforms and Networks | Cultural Platforms and Networks | Youth Platforms and Networks

#### Calls to Action and Policy Asks

1. National leaders in all walks of life actively promote FP as a national economic and social development priority and support increased resource allocations for RH.

#### **Priority Audiences 4.2**

**DLGs** 

- 1. District and local councils adopt pro-FP resolutions and actively support increased resource allocations for FP as a priority health, population, and socio-economic development intervention.
- 2. Promote and follow up on measures to strengthen the capacity of districts to effectively manage their FP programmes.

#### **Priority Audiences 4.3**

MOH | OPM | Central Government MDAs | SWGs | IPs

#### Calls to Action and Policy Asks

- 1. Strengthen the coordination of inter-ministerial efforts to improve stewardship.
- 2. Strengthen the involvement of civil society in monitoring to improve accountability at policy and programme levels.
- 3. Improve coordination, collaboration, and accountability among the numerous partners and stakeholders involved in FP.

#### **Priority Audiences 4.4**

MOH

#### Calls to Action and Policy Asks

- 1. Promote the inclusion of FP indicators in the policies and programmes of related sectors.
- 2. Promote measures to strengthen skills for the supervision and management of health staff.
- 3. Promote and follow up on measures to strengthen capacity at the MOH to effectively lead, manage, coordinate, monitor, and track performance of the country's FP programme under the FP-CIP.
- 4. Promote and follow up on measures to strengthen national efforts to collect, analyse, and use data to track FP progress.

#### **ISSUE #5: PARTNERSHIPS AND PRIVATE SECTOR ENGAGEMENT**

**Framing the Issue:** The HSDP notes that "effective and sustainable partnerships are important for optimal health system functionality, to improve service coverage, access, quality, safety, and financial risk protection." Partnerships involve MDAs, development partners, the private sector, CSOs, and households, from community to national levels through appropriate governance and partnership structures as well as public private partnerships and coordination. "The MoH desires to increase access to health services by exploiting private sector geographical reach, efficiency, work ethic, financial mobilization expertise, personnel and physical facilities." In that respect, a PPPH Coordination Unit was established in the ministry to coordinate all resolutions by the PPPH TWG and HPAC that concern public-private collaboration in health.

#### **Objective**

By 2025, partnerships among and between health development partners, line ministries, departments and agencies, and private sector stakeholders and providers are robust and fully functional.

#### **Core Messaging**

- 1. Through partnerships, the government aims to provide an enabling environment for effective coordination of efforts among all partners, to increase efficiency in resource allocation, to achieve equity in the distribution of available resources for health, and to ensure effective access by all citizens to the UMHCP.
- 2. The government's vision is to achieve universal access to affordable health care for all Ugandans through efficiently integrated public-private partnerships in health.
- 3. The government's goal for public-private partnership in health is to contribute to strengthening the national health system with the capabilities and full participation of the private health sector to maximise attainment of the national health goals.
- 4. Private health sector inputs in the service delivery systems and structures are a cost saving to the public sector.
- 5. "Private sector providers contribute to sustainability by maintaining complementary networks of facilities and services that c¹³an withstand social, political and economic shocks that may adversely affect the public sector. By working in partnership with government, the mixed system of public and private services thus created is stronger and can compensate for short-comings in either provider. The private sector health infrastructure represents a valuable national asset that needs to be preserved."

# **Priority Audiences 5.1**

MOH | HDPs | PNFPs | PHPs | TCMPs

- 1. Establish a clear institutional and legal framework to effectively build and utilise the full potential of PPP in Uganda's national health development.
- 2. Establish a functional integration and support the sustained operation of a pluralistic health care delivery system by optimising the equitable use of available resources.
- 3. Invest in comparative advantages of the partners in order to sustain scope, quality, and volume of services to the population.
- 4. Promote and showcase the role of private providers and organisations in building capacity at different levels of the health system.
- 5. Demonstrate the benefits of supporting provision of the UNMHCP through private sector providers in terms of increasing the proportion of the population that can access quality services including FP.
- 6. Support the efforts including those by PNFPs, PHPs and TCMPs to provide equitable access to quality services by ensuring geographical access and adequate human resources and infrastructure and by addressing the economic, social, cultural, and gender barriers to services.

## ISSUE #6: ACCESS TO, DELIVERY AND QUALITY OF SERVICES

Framing the Issue: The market share for FP services is split among the public sector (50%), private hospitals/clinics (for-profit and not-for-profit) (45%), and VHTs (5%). The current FP service delivery system needs to be strengthened and scaled up, and new approaches are needed to expand availability and accessibility. Geography and income remain significant barriers to access, with rural and distant communities as well as poor people both in rural and urban areas experiencing comparatively lower levels of access and greater gaps in service. Nearly 41% of women report that distance to health facilities is a barrier to accessing FP services. Tackling the various inequalities requires targeted policies, programmes, and financing that measure up to the scale of the needs of the under-served populations.

Objective		Core Messaging
By 2025, clients in every region of Uganda have access to the widest choice of contraceptive methods and more equitable access to high-quality FP services.	1.	The current staffing, skill level, and service structure of Uganda's health care system does not provide adequate and equitable FP services to the population.
	2.	Health care workers are unable to effectively perform their duties and to provide services – e.g. counselling clients on contraceptive methods – because of inadequate training, time, supplies, and equipment.
	3.	Inequities due to geography, income/poverty, HIV status, gender, age, and marital status are hampering access to and use of FP.
	4.	Performance-based incentives will increase HCWs' motivation to counsel clients on full, free, and informed choice, without introducing method-specific bias.
	5.	FP services should be integrated into other health services e.g. cervical cancer screening, post-natal care, post-partum care, prevention, care, and treatment of STIs including HIV, and malnutrition programmes.

#### **Priority Audiences 6.1**

#### MOH | MOFPED | OPM | PSC | DLGs | Parliament | HDPs

#### **Calls to Action and Policy Asks**

- 1. Support integration of FP into other health services by ensuring that relevant protocols are developed, service providers trained, and specific efforts made to ensure that outreach is tailored to address the needs of key populations.
- 2. Promote plans to increase the number and deployment of appropriately qualified and skilled service providers to offer a full range of quality static and outreach FP services that are male-friendly, disability-friendly, and adolescent-friendly.
- 3. Engage the PSC and MOFPED to initiate and approve incentive schemes to attract and retain qualified service providers for rural and hard-to-reach districts and locations.
- 4. Engage the PSC to revise staffing norms to provide for adequate numbers of qualified FP/RH providers at all levels of service delivery.

#### **Priority Audiences 6.2**

#### MOH | DLGs | IPs | Development Partners

#### **Calls to Action and Policy Asks**

1. Strengthen the existing service delivery system and initiate new approaches to optimise availability and accessibility commensurate with need through targeted policies, programming, financing, and high-impact strategies.

## **Priority Audiences 6.3**

#### MOH | DLGs | IPs

- 1. Engage district health and health facility managers to deploy qualified FP/RH providers at all facilities and service delivery points.
- 2. Support and implement initiatives to provide a full range of FP services in all areas served by Catholic-run health facilities.

# Priority Audiences 6.4

MOH | DLG | IPs

#### **Calls to Action and Policy Asks**

1. Engage the responsible duty bearers within the MOH, the DLGs, and IPs to develop, implement, and commit funds to support a comprehensive national in-service training programme on FP at all health facilities.

# **Priority Audiences 6.5**

MOH | Private Sector | IPs | DLGs

#### **Calls to Action and Policy Asks**

- 1. Support the scaling up of the PPP initiative for training service providers in public and private HCFs in the provision of long-acting FP methods.
- 2. Support the scaling up (beyond pilot basis) of innovations in service delivery e.g. community-based distribution of injectable contraception by VHTs, tubal ligation by trained clinical officers, and provision of long-acting FP methods by midwives.
- 3. Expand access to FP services by increasing service delivery points, including community-based distribution, for rural communities e.g. through mobile clinics and PPP initiatives.
- 4. A uniform FP referral system will be created to strengthen referral services, including appropriate referral forms and training of DHOs and ADHOs to implement the system.

#### **Priority Audiences 6.6**

NGOs | CSOs | Parliament | IPs | EOC | UHRC

#### Calls to Action and Policy Asks

- 1. Monitor the implementation of measures to increase access of PWDs to FP services, including development and dissemination of FP clinical service delivery guidelines to ensure the provision of FP services in accordance with human rights and quality of care standards, and training of HCWs in provision of services to FP clients with disabilities.
- Monitor the commitment to improve the management of FP side effects through reassessment of FP counselling guidelines, training of trainers on side effects, and production and dissemination of reporting tools.
- 3. Monitor the commitment to improve in-service through the inclusion of FP, production and dissemination of the revised training manual, and induction of trainers in the new components of the manual.
- 4. Monitor the commitment to strengthen FP in the VHT system through revision of the VHT training manual, scaling up of VHT training, operationalisation of the use of DMPA (or Depo Provera®) and/or Sayana® Press by VHTs, and harmonisation of the benefits package for VHTs.
- 5. Increase access for PWDs to FP services in accordance with human rights and quality of care standards, including training of HCWs in providing services to FP clients with disabilities.

#### **ISSUE #7: ADOLESCENT AND YOUTH-FRIENDLY SERVICES**

**Framing the Issue:** Young people especially adolescents are a key population for FP. They have unique needs that require tailor-made mechanisms to reach and offer them the services they need, and in environments designed to encourage them to come forward and seek RH services. This entails dedicated funding for youth FP programmes at the sub-national and sub-national levels, equipping primary health care providers with sexual health knowledge and specialised sexual communication skills, and creating spaces that welcome young people into health care facilities. Advocacy on this issue will focus on promoting recognition and implementation of measures and actions to enable compliance with the recommended standards for adolescent/youth-friendly services in terms of provider and health facility characteristics and service components.

#### **Objective**

# By 2025, more young people benefit from FP and RH services that meet the standards for adolescent/youth-friendly services.

#### **Core Messaging**

- 1. While it is easy for adolescents to seek services for common illnesses such as malaria, they are less likely to use services for SRH complaints due to factors such as long waiting time, long queues, and poor quality of services (e.g. lack of privacy, rude service providers).
- 2. Many adolescents drop out of school because of the many health challenges they face including RH such as early/unwanted pregnancies and unsafe abortions.
- 3. Adolescents and young people need to be reached with Adolescent-Friendly Health Services (ADFHS) to mitigate the multiple health challenges and behavioural risks they face; this has to be done in a manner that ensures availability and accessibility to all young people including those in conflict and hard-to-reach environments.

#### **Priority Audiences 7.1**

MOH | IPs | MGLSD | Youth Platforms and Networks | MOES

#### Calls to Action and Policy Asks

1. Promote measures to increase the knowledge and empowerment of young people e.g. engaging and supporting peer educators; engaging youth through targeted media, messaging, and outreach.

#### **Priority Audiences 7.2**

DLGs | IPs | NGOs | CSOs | MGLSD | Youth Platforms and Networks

#### Calls to Action and Policy Asks

 Monitor the commitment to provide adolescent- and youth-friendly services in clinics through establishment of youth-friendly corners, training of HCWs in youth-friendly services, and extension of FP service delivery times beyond school hours to accommodate more adolescents and youth.

#### ISSUE #8: CONTRACEPTIVE AND RH COMMODITY SECURITY

Framing the Issue: Commodity security is about ensuring that all women, girls, men, and boys - including those in humanitarian situations - have access to RH commodities of their choice whenever they need them. Commodity security is to a large extent a function of the interactions among a diversity of actors at different levels of operation. The system that drives the process to ensure commodity security cascades downwards from the MOH/UFPC and development partners through the NMS, the UHMG as an alternative warehouse, IPs and regional warehouses, private and public health facilities, VHTs, and clients/users. Advocacy will: (i) showcase the progress of measures to strengthen the effectiveness of the commodity supply chain through such interventions as diagnosis of the system, redesign of or adjustments to the supply chain including storage and distribution, forecasting, procurement, and improvements in staffing, training, financing, and information about inventory; (ii) highlight the benefits and outcomes of the TMA as expected in four key market variables – size, accessibility, sustainability, and equity; (iii) promote collaboration among the numerous participants in the commodity market to guarantee efficiency and value for money; and (iv) increase the visibility of initiatives to leverage private and public sector expertise and resources and to ensure seamless integration of FP into other health services at all levels of health care.

#### Objective

By 2025, FP commodities and supplies are consistently available in the quantities, in the varieties, in the places, and at the times they are needed to meet demand.

#### **Core Messaging**

- Providing a full FP method mix is essential to meet the changing needs of clients throughout their reproductive lives, to increase the overall levels of contraceptive use, and to enable clients to fully exercise their rights and meet their reproductive goals.
- Shifting users from the less effective traditional FP methods to the more effective modern methods while maintaining the widest possible range of method choices will enable women and families to best fulfil their reproductive intentions.
- 3. Significant distribution challenges are limiting the availability of high-quality FP services at all levels of care especially in the remote, hard-to-reach, and currently underserved areas.

# **Priority Audiences 8.1**

MOH | Family Planning/Reproductive Health Commodity Security Working Group | DLGs

- 1. Secure commitments and action from the GOU and districts to strengthen systems for quantification, procurement, and logistics to reduce stock-outs of FP commodities and supplies.
- 2. Promote efforts to strengthen real-time reporting of consumption and stock status at facility level.
- 3. Track progress on the commitment to implement comprehensive forecasting, quantification, and procurement of FP commodities.
- 4. Ensure contraceptive security by maintaining a robust and reliable supply of commodities to meet clients' needs and to prevent stock-outs.
- 5. Ensure that contraceptive commodities and supplies are adequate and available to meet the needs and choices of FP clients.
- 6. Ensure that the contraceptives available in the country are of high quality.
- 7. Ensure that contraceptives are delivered through the *last mile* to HCFs throughout the country.
- 8. Secure commitments from districts to eliminate stock-outs and wastage of FP commodities and supplies at service delivery points.
- 9. Promote efforts to increase commodity distribution to not-for-profits by seeking common ground with JMS, the second major supplier of EMHS, to persuade it to include FP commodities in procurement to improve FP access for non-Catholic clients in facilities supplied by JMS.
- 10. Declassify the contraceptive injection DMPA or Depo Provera® and/or Sayana® Press and emergency contraceptives so as to include drug shops as providers of an expanded FP method mix.

#### **Priority Audiences 8.2**

#### DLGs | MOFPED

#### Calls to Action and Policy Asks

1. Secure commitments and action from the GOU and districts to allocate adequate funding for procurement and distribution of FP commodities and supplies.

# **Priority Audiences 8.3**

#### MOH | IPs | Private Sector

#### Calls to Action and Policy Asks

- 1. Secure commitments and action from the GOU and its partners in the non-governmental and private sectors to increase the promotion and availability of the full range of FP methods.
- Promote efforts to strengthen private sector involvement in supply planning and commodity tracking.

#### **Priority Audiences 8.4**

#### MOH | DLGs | IPs

#### Calls to Action and Policy Asks

- 1. Track progress on the commitment to ensure that district staff are able to accurately quantify and forecast FP commodities.
- 2. Track progress on the commitment to strengthen the supply chain system by ensuring that VHTs and CBDs have commodities through accurate and timely re-stocking and distribution and that supplies are available at the lower levels.

#### **Priority Audiences 8.5**

**HDPs** 

#### Calls to Action and Policy Asks

1. Secure commitments and action from development partners to support the efforts of the GOU, the districts, and their partners to strengthen the supply chain for FP commodities.

#### ISSUE #9: FP PROVIDER CAPACITY, KNOWLEDGE AND BEHAVIOUR

**Framing the Issue:** The demand for FP services has a lot to do with the quality of care that people expect and get. However, the knowledge, attitudes and behaviour of FP service providers has in some cases been found to negatively affect interest in and willingness to seek FP services. Providers are not always up to date with practical knowledge of the latest developments, practices, and resources in the FP field. Some do let their personal preferences get in the way of objective determination of clients' needs. Some are judgmental and ill-equipped to communicate effectively, often leaving clients with confused and mixed messages about the side effects of the recommended contraceptive options, for example. HCWs need to be supported through supervision, facilitation, and continuous education to ensure they are equipped with the knowledge, skills, and tools to provide FP services that address the varying needs and contexts of their clients.

Objective	Core Messaging		
By 2025, there are measurable improvements in FP service providers' knowledge, attitudes, and practices when dealing with clients.	<ol> <li>Provide and facilitate opportunities for continuous medical education.</li> </ol>		
	2. Equip HCWs and FP providers in particular with the knowledge, skills, and tools to respond to the unique needs different groups of FP service seekers.		
Priority Audiences 9.1			

#### Priority Addiences 7.1

MOH | DLGs | Professional Associations | Training Institutions | IPs | HCFs

- 1. Address the FP service providers' own attitudes and professional practices emphasising confidentiality, being non-judgmental, counselling that empowers individuals, and objective information about the side effects of different contraceptive methods.
- 2. As recommended by the FP-CIP, motivate HCWs who provide FP services through performance-based incentives so they can counsel clients on full, free, and informed choice without recourse to method-specific bias.
- 3. Include FP in in-service training to improve the knowledge and capacities of FP HCWs.

#### **ISSUE #10: SOCIAL NORMS AND RELIGIOUS VALUES**

**Framing the Issue:** The uptake of modern contraception is undermined by myths, misconceptions, misinformation, and in certain instances outright disinformation all of which in some cases manifest as misinterpreted side effects. Some cultural and religious beliefs are formidable barriers to FP. Gender inequalities and power relations have a bearing on women's ability to make decisions in households including the use of contraception. Men, even when not opposed to contraception, tend to treat FP as a women's issue. It is as crucial to pragmatically confront, isolate, and change the negative norms and values as it is to creatively maintain, amplify, and showcase the positive ones.

ones.				
Objective		Core Messaging		
By 2025, fewer Ugandans express harmful social norms and negative religious influences towards FP and more men are supportive of contraception and involved in FP.	1.	Whereas negative social norms steeped in religion and culture are prevalent, they are related to and reinforced by real and perceived gaps in the quality of FP services. As such, negative norms cannot be addressed in isolation without paying attention to service quality.		
	2.	Religion is a greater force for good in FP than it gets credited for. There is some evidence to suggest that religion ranks low among the barriers to or negative influences on FP use; and that it has the potential to significantly impact behaviour in a positive way and to increase contraceptive use because of the power that religious leaders have to change and shape FP perceptions and practices among their communities.		
	3.	Parenting norms and associated skills play an important role in preventing teenage pregnancy and child marriage. Parenting styles and norms are driven by other factors such as socioeconomic status and cultural beliefs that need to be taken into account.		
Priority Audiences 10 1				

#### Priority Audiences 10.1

MOH

- 1. Increase demand for and uptake of FP by expanding knowledge of FP and addressing myths and misconceptions.
- 2. Invest in and supporting high-impact demand generation activities designed to address social/cultural norms and religious/spiritual beliefs that negatively affect FP uptake and utilisation.
- Support efforts to close the knowledge-use gap through initiatives designed to address myths, misinformation, fear of side effects, and health concerns that impede adoption and continuous use of FP.
- 4. Promote efforts to motivate men to support the use of modern contraception for themselves and their partners.
- 5. Strengthen the strategy for male involvement in SRHR by supporting the roll-out of male action groups throughout the country beyond the selected districts where they were introduced.

#### **Priority Audiences 10.2**

DLGs | IPs | HCWs | VHTs | CDOs

#### **Calls to Action and Policy Asks**

- 1. Mobilise community support to increase demand for FP by helping to foster a supportive environment and to reduce social, cultural, and religious barriers.
- 2. Promote demand creation initiatives that focus on men with strategies to dispel myths and misconceptions that militate against male involvement in FP.

# **Priority Audiences 10.3**

FBOs | Religious Platforms and Networks

#### **Calls to Action and Policy Asks**

1. Embrace and routinely communicate policy statements and positions in support of FP and promote it as a fundamental health, population, and socio-economic development issue.

#### **Priority Audience 10.4**

Cultural Platforms and Networks

#### Calls to Action and Policy Asks

1. Embrace and routinely communicate policy statements and positions in support of FP and promote it as a fundamental health, population, and socio-economic development issue.

#### **ISSUE #11: MALE INVOLVEMENT**

**Framing the Issue:** In 2014 Uganda launched the National Male Involvement Strategy and Guidelines to ensure the participation of men in FP and all other aspects of health including ante-natal and post-natal care, nutrition, sanitation, immunisation, malaria, and HIV/AIDS. There is a recognition that there is a gap in knowledge of RH issues among men in particular. A 2014 MOH survey of 388 men aged 18 years or more (with a median age of 32) whose spouses were attending ante-natal care at Mbale Regional Referral Hospital revealed a low male involvement index. For instance, only 5% of men accompanied their spouses to the ante-natal clinic. Uganda. Men with secondary education were more likely to have a high male involvement index than men with primary or no formal education.

men with primary or no formal education.			
Objective	Core Messaging		
By 2025, more men have comprehensive knowledge of contraception and regularly contact health care providers to seek FP information and services.	1. Men's knowledge about pregnancy is crucial to their lifesaving role during pregnancy and childbirth.		
	2. Male participation has a cultural background that affects uptake and utilisation of health services in Uganda.		
	3. The role of men in promoting positive health outcomes in households and communities is important and must be addressed at all levels.		
	4. Health care providers should adopt innovative approaches to have couples attend ante-natal care together.		
	5. There is a growing number of programmes engaging men in RH in Uganda and this reflects exciting changes in the field.		

#### **Priority Audiences 11.1**

MOH | MGLSD | HCWs | IPs | Cultural Platforms and Networks | DLGs

#### **Calls to Action and Policy Asks**

- 1. Promote efforts to motivate men to support the use of modern contraception for themselves and their partners.
- 2. Strengthen the strategy for male involvement in SRHR by supporting the roll-out of male action groups throughout the country beyond the selected districts where they were introduced.
- 3. Promote men's shared responsibility and active involvement in responsible parenthood.
- 4. Encourage men to take part in sexual and reproductive health including FP and maternal and child health, in prevention of STIs including HIV/AIDS, and in prevention of unwanted and high-risk pregnancies with special emphasis on prevention of violence against women and children.
- 5. Promote demand creation initiatives that focus on men with strategies to dispel myths and misconceptions that militate against male involvement in FP.

#### ISSUE #12: ACCESS TO INFORMATION AND KNOWLEDGE MANAGEMENT

Framing the Issue: Whereas most Ugandans are aware of at least one method of contraception, significant FP knowledge gaps exist notably among the youth, and parental engagement in sexuality education of children is limited. The sexual health concerns of clients are also inadequately addressed in primary health care contexts where providers lack training, knowledge, and skills in sexual health care and sexuality communication. Moreover, while evidence on the demographic, health, and economic impacts of Uganda's FP programme is available, it needs to be translated into compelling narratives that advocates can use to mobilise resources and to make the case for prioritising FP and RH. In addition, strengthening and mainstreaming the FP knowledge management policy and plan will facilitate sharing of information and monitoring of its dissemination and reach, as well as gathering, analysing, and responding to feedback on a regular basis.

Objective	Core Messaging
By 2025, there is improvement in the scale of information dissemination and utilisation and support for initiatives that address knowledge gaps in FP.	1. Knowledge is a vital condition for and determinant of the adoption of FP.
	2. Lack of accurate information limits the use of FP. Informed personal decision-making is dependent on users being aware of and knowledgeable about the whole range of available contraceptive options.

## **Priority Audiences 12.1**

MOH | DLGs | IPs | HCWs | VHTs | CDOs | Private Sector | Cultural Platforms and Networks | Religious Platforms and Networks | HDPs

#### **Calls to Action and Policy Asks**

- 1. Prioritise and commit increased budget allocations and resources to support programmes to provide quality and consistent information about FP at all levels.
- 2. Popularise the legal framework for the promotion of FP through dissemination of the revised public acts and sensitisation of MPs, DHTs, and health providers.
- Develop and disseminate, via the MOH and partner websites and digital platforms, specific briefs addressing the role of HCWs in FP policy implementation including knowledge about the provision of FP services in accordance with human rights and quality of care standards.

#### **ISSUE #13: DEMAND SATISFACTION AND CREATION**

**Framing the Issue:** There have been significant investments in generating demand for FP through financing, capacity building, promotional and marketing initiatives, and policy development at the national and sub-national levels. The momentum and advocacy initiatives undertaken to make this happen need to be sustained. The districts and communities remain areas for further attention, for example, by canvassing to replicate and extend the model of national champions to these levels; rolling out the model of male action groups across the country beyond selected districts as part of implementing the male involvement strategy for supporting SRH and rights; and scaling up the policy for community-based distribution of injectables and taking it beyond the pilot. The rate of discontinuation of contraception use is unacceptably high as 45% of women who start using contraceptives stop within 12 months. The causes and implications of, as well as solutions to, this threat to the coverage of FP services and the goal of raising the mCPR to 50% by 2020 should be communicated.

Objective	Core Messaging
By 2025, 75% of the FP needs of married women are met and 65% of the demand for FP is satisfied by modern methods.	<ol> <li>Uganda has a high unmet need for FP. Many women who want to delay or limit childbearing are currently not using any FP method.</li> </ol>
	2. Encouraging FP use will improve the health of women and their families.

#### **Priority Audiences 13.1**

MOH | DLGs | HCWs | VHTs | CDOs | IPs | FP Champions | Local Leaders

#### **Calls to Action and Policy Asks**

- 1. Promote public dialogue from the highest national to the lowest community levels to sustain support for FP and recognition of its role in the health, wellbeing, and development of the nation.
- 2. Generate support for and participation in on-the-ground community outreach and mobilisation efforts to increase demand for FP.
- 3. Increase knowledge of, and demand for, FP by disseminating accurate information about FP methods and their availability.
- 4. Scale up the policy for community-based distribution of injectables beyond the pilot phase.
- 5. Strengthen the national champions programme by supporting its extension to the district and community levels.

#### ISSUE #14: COMMUNICATING FOR SOCIAL AND BEHAVIOUR CHANGE

**Framing the Issue:** SBCC programming needs to be integrated and harmonised across interventions, so that communications to the public are evidence-based and properly targeted through messaging and campaigns to increase demand for FP.As such, redoubled and sustained investment in SBCC are essential to fully operationalise the FP-CIP priority actions that invoke and require direct communication interventions: (i) to increase age-appropriate information, access, and use of FP amongst young people ages 10–24 years; and (ii) to promote and nurture change in social and individual behavior to address myths, misconceptions, and side effects and improve acceptance and continued use of FP to prevent unintended pregnancies.

Objective	Core Messaging		
By 2025, the GOU and its partners intensify communication to promote social and behaviour change among FP users and service providers.	1.	A guided and systematic approach to the design and implementation of high-impact communication interventions will facilitate efforts to address key barriers that impede seeking, adoption, and continuous use of modern FP methods in Uganda, including the knowledge-use gap, cultural and religious beliefs, myths and misinformation, fear of side effects, and health concerns.	
	2.	Investing in SBCC will increase knowledge and empower adolescent girls (10-19) and young women (20-35) to seek contraceptive information and services, increase the number of men (15-49) who take up and support the use of modern contraception for themselves and their partners, and increase the number of women and men (15-49) with favourable attitudes/beliefs and norms towards FP and modern contraception.	

# **Priority Audiences 14.1**

MOH | DLGs | IPs

#### **Calls to Action and Policy Asks**

- 1. Invest in and support measures to ensure that SBCC campaigns and efforts are harmonised across interventions, accurately targeted with evidence-based messages, and use market segmentation to increase demand.
- 2. Ensure and support the development and dissemination of tailored, honest, objective, non-judgmental, accurate, clear, and consistent information packages and messages on FP with a multi-sectoral dimension (e.g. FP as a development intervention).

#### **Priority Audiences 14.2**

Non-Health Sector Duty Bearers | DLGs | NGOs | CSOs | Private Sector

#### **Calls to Action and Policy Asks**

- 1. Engage stakeholders in the non-health sectors e.g. environment, agriculture, gender, labour and social development, and livelihood to integrate FP SBCC into their programmes and activities in order to address the holistic and full needs of communities.
- 2. Promote efforts to lessen the burden on HCWs by encouraging non-health sector duty bearers and service providers to incorporate FP messages in their programmes.
- 3. Engage managers of livelihood and human welfare programmes to integrate FP BCC into the activities and programmes of sectors such as education, environment and natural resources, agriculture, water and sanitation, gender, labour and social development, etc.

#### **Priority Audiences 14.3**

DLGs | IPs | HCWs | VHTs | CDOs

1. Support and facilitate the development and dissemination of FP information packages and messages targeting all critical FP users i.e. rural and urban youth, adolescents in and out of school, married youth, men, PLHAs, key populations at risk, PWDs, CSWs, etc.

ADVOCACY ISSUE 1	POLICY AND ENABLING ENVIRONMENT					
FRAMING THE ISSUE	Whereas Uganda has a conducive policy framework and enabling environment as well as strong political will for family planning and reproductive health, implementation remains a challenge to reaching the country's goals. Measures are needed to mainstream, including budgeting for, FP across all health services and in all sectors and programmes.					
ADVOCACY GOAL	By 2025, FP is integrated as a cross-cutting intervention for national development and policies that promote access to services in accordance with human rights and quality of care standards are enacted and implemented.					
LEAD AGENCIES &	Lead Agencies:					
KEY PARTNERS	MOH [HPECE	), RHD, DHIM, PD]; C	PM			
	Key Partners:					
	UFPC; HDPs [UNFPA, WHO, UNICEF, USAID, DFID]; NUDIPU; MOLG; Bilateral agencies/embassies; NGOs; Religious Institution; FBOs; Youth Platforms and Networks					
ADVOCACY	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS		
OBJECTIVES				AND PRODUCTS		
<b>1.1</b> Package	• MPs	Publicise the	Lobbying and	Implementation guide		
and disseminate information	• MDAs	national FP programme	negotiating	Policy briefs		
to popularise Uganda's FP	• DLGs	among stakeholders and	<ul> <li>Policy dialogue</li> </ul>	<ul> <li>Factsheets</li> </ul>		
programme and	NFP HCPs	the public.	• Public	Messaging briefs		
its legal and policy frameworks.	<ul><li>Private HCPs</li><li>Public</li></ul>		Ps	CPs	information dissemination	IEC materials (tailored to the mandates and interests of the different targets)
	<ul> <li>Media Gatekeepers</li> </ul>	Secure commitment		In-person briefings		
	• PSFU	from HDPs as		Information sessions		
	. 5. 5	well as the private and non-profit	private and non-profit		Roundtable meetings	
		health sectors to support measures by the GOU to provide efficient FP services that meet the needs of all segments of the population.				

1.2 Secure commitment to develop, implement, and monitor decisions, policies, strategies, and measures for effective integration of FP into health service delivery at all levels.	MOH DLGs	Ensure that guidelines and service standards are reviewed and updated to include specific guidance on providing FP information and services through programmes such as integrated management of childhood illnesses, immunisation, malaria control, ante-natal care, post-abortion care, adolescent sexual and reproductive health, emergency obstetric care, HIV/AIDS, disabilities and rehabilitative health, etc.	•	Technical support  Capacity building  Policy monitoring  Policy dialogues	•	Implementation guide Policy briefs Factsheets Information sessions In-person briefings Roundtable meetings
1.3 Secure commitment to develop, implement, and monitor decisions, policies, strategies, and measures for effective integration of FP services in the activities and programmes of non-health sectors.	<ul> <li>MDAs</li> <li>UFPC</li> <li>National Coalition of FP Advocates and Champions</li> </ul>	Promote measures to embed FP in development programming and to address it on a multi- sectoral level across ministries.  Identify opportunities and develop costed plans for integrating FP information and services in non-health sector programmes.  Mobilise resources for orienting and training service providers in non- health sectors to provide FP information and services.	•	Lobbying and negotiating Policy monitoring Policy dialogue Research and analysis	•	Implementation guide Policy briefs Messaging briefs Stories of change (videos, digital, and printed formats using most significant change approach) Training manual User manual

1.4 Secure commitment to develop, implement, and monitor decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into district health services and into the activities and	<ul><li>DLGs</li><li>HCFs</li></ul>	Develop and support programmes and activities to integrate FP information and services in community health programmes.	<ul> <li>Lobbying and negotiating</li> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Research and analysis</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Stories of change (videos, digital, and printed formats using most significant change approach)</li> </ul>
programmes of non-health sectors at all levels of decentralisation.		Mobilise resources for orienting and training service providers in HFs to provide FP information and services.  Develop, produce, and disseminate training and IEC/ SBC materials including guidelines for integrating FP information and services in HFs.	<ul> <li>Lobbying and negotiating</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Training manual</li> <li>User manual</li> <li>Factsheets</li> </ul>

ADVOCACY ISSUE 2	DEMOGRAPHIC DIVIDEND/TRANSITION
FRAMING THE ISSUE	Family planning is not well understood as a driver of the demographic dividend. Yet, to benefit from the dividend and to achieve middle-income country status by 2040, the country needs to pursue policies and measures that will bring about rapid declines in fertility and mortality and reduce the current high dependency ratio with its negative impacts on the economy.
ADVOCACY GOAL	By 2025, the centrality of FP in harnessing the demographic dividend is visible in dialogue on population matters and better appreciated by policy stakeholders and the public.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	NPA; NPC; MOH [RHD, HPECD]
	Key Partners:
	HDPs (UNFPA, USAID, WHO, DFID); OPM; MOFPED; MOGLSD; MOLG; UFPC

ADVOCACY	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS
OBJECTIVES				AND PRODUCTS
2.1 Reposition FP as a cross-cutting intervention and fundamental element of national development including as a key contributor to the demographic dividend, environmental sustainability, and the health sector strategy.	<ul> <li>Cabinet</li> <li>MPs</li> <li>MDAs</li> <li>DLGs</li> <li>Public</li> <li>Media Gatekeepers</li> </ul>	Promote the policy options and programme interventions recommended to accelerate fertility reduction in order "to open the demographic dividend window of opportunity in Uganda."  Declare FP a key development intervention to ensure that nonhealth sectors contribute to promoting voluntary contraception and fertility decline.	<ul> <li>Lobbying and negotiation</li> <li>Research and analysis</li> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Public information dissemination</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>National stakeholder conference</li> <li>Regional stakeholder conferences</li> <li>Roundtable meetings</li> <li>In-person briefings</li> <li>Policy statement</li> <li>Messaging briefs</li> <li>Mass media</li> </ul>
2.2 Leverage the political will to commit resources to FP to generate funding for interventions to accelerate fertility decline and set the country on the path to harnessing the demographic dividend.	<ul><li>Cabinet</li><li>MPs</li><li>MDAs</li><li>DLGs</li></ul>	Reinforce political will and investments in FP at the national and sub-national levels, building on the commitment to FP2020.		<ul> <li>campaign</li> <li>IEC materials</li> <li>Digital media campaign (targeted online and social networking platforms)</li> </ul>
2.3 Promote and popularise among FP stakeholders the interventions rolled out by the GOU to enable the country accelerate the demographic transition.	<ul> <li>FP NGOs</li> <li>PSFU</li> <li>DLGs</li> <li>Religious Institutions and Organisations</li> <li>FBOs</li> <li>Cultural Institutions, Organisations, Platforms and Networks</li> </ul>	Demonstrate the contribution of FP to outcomes associated with the demographic dividend including: rapid declines in fertility and mortality; improvements in child survival; and retention of children, especially girls, in school to completion (Senior 4) in order to delay childbearing and marriage and to prevent teenage pregnancy.		

	Hadional Family Flamming Advocacy Strategy Costed implementation Flam 2020 2025			
ADVOCACY ISSUE 3	PRIORITISATIO	N AND FINANCING		
FRAMING THE ISSUE	services. Where at the same rational increased budg	as the demand for fan e to meet the populat	ion's needs. More has t	g, funding is not increasing
ADVOCACY GOAL	By 2025, fundin		within the national bu	dget and by local
LEAD AGENCIES &	Lead Agencies:			
KEY PARTNERS	MOH [RHD;	HPD; HRDD]		
	Key Partners:			
	NPA; UIA; U	IRA; PSFU		
ADVOCACY	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND
OBJECTIVES				PRODUCTS
government funding to close the gap between the overall positive policy environment for FP and the low allocation of national financial resources to fully meet the need for FP services.	<ul><li>MPs</li><li>MOFPED</li></ul>	Endorse, maintain, and push for increases in the FP line items in the MOH budget.  Increase the allocation of financial resources by districts and lower level local governments for FP services and commodities.  Promote the creation of FP budget lines at the district level to support the prioritisation and integration of FP into district planning and	<ul> <li>Lobbying and negotiating</li> <li>Policy monitoring</li> <li>Policy dialogue</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>One-on-one meetings with legislators in the respective parliamentary committees</li> </ul>
<b>3.2</b> Engage with development partners to make a case for allocating resources to FP programmes.	• HDPs	budgeting processes.  Demonstrate the value for money derived from financial investments in FP in order to sustain financing by development partners.	<ul> <li>Research and analysis</li> <li>Best practice documentation</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Stories of change (videos, digital, and printed formats using most significant change approach)</li> <li>Annual, quarterly, and bi-annual reports</li> </ul>

3.3 Reinforce evidence-based advocacy, monitoring, and accountability mechanisms to ensure FP is prioritised and commitments are operationalised.	<ul><li>Cabinet</li><li>MPs</li><li>OPM</li></ul>	Promote the case for increased investment in training and support for midwives and nurses at lower-level HCFs to help increase the overall level of human resource development funding for health.  Support measures to increase the retention of FP HCWs by standardising the salary scales for similar cadres of HCWs.	<ul> <li>Research and analysis</li> <li>Policy dialogue</li> <li>Lobbying and negotiating</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Policy briefs</li> <li>Messaging briefs</li> </ul>
<b>3.4</b> Educate the private sector about the benefits of investing in FP as part of the health benefits packages offered to their employees.	• PSFU	Mobilise to ensure that the national health insurance scheme includes coverage for all FP methods in all insurance policies.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Lobbying and negotiating</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Factsheets</li> <li>Messaging briefs</li> <li>Information sessions</li> <li>IEC materials</li> </ul>

ADVOCACY ISSUE 4	STEWARDSHIP, MANAGEMENT, AND ACCOUNTABILITY
FRAMING THE ISSUE	Family planning has to be repositioned for the multi-sectoral approach to service delivery. With this comes the need to ensure coordination, clear leadership responsibility, and authority to address bottlenecks in supervision, monitoring, coordination, and staffing.
ADVOCACY GOAL	By 2025, there is demonstrable improvement in the overall management and governance of Uganda's FP programme.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOH; PSFU; DLGs
	Key Partners:
	OPM; NPA; NPC; HDPs [UNFPA, WHO, UNICEF, USAID, DFID]; IRCU; Cultural Leaders

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
<b>4.1</b> National leaders in all walks of life actively promote FP as a national economic and social development priority and support increased resource allocations for RH.	<ul> <li>Cabinet</li> <li>MPs</li> <li>Political Leaders</li> <li>Civic Leaders</li> <li>IRCU/ Religious Leaders/FBOs</li> <li>Cultural Institutions, Organisations, Platforms and Networks</li> <li>Youth Platforms and Networks</li> </ul>	Engage political, civic, local, cultural, religious, and business leaders, celebrities and social influencers to coordinate and scale up public and community outreach on the benefits of FP.  Strengthen the involvement of civil society in monitoring to improve accountability at policy and programme levels.	<ul> <li>Lobbying and negotiating</li> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Capacity building</li> <li>Social mobilisation</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>In-person briefings</li> <li>Information sessions</li> <li>Factsheets</li> <li>Messaging briefs</li> <li>Media interviews</li> </ul>
4.2 Improve coordination, collaboration, and accountability among the numerous partners and stakeholders involved in FP.	<ul> <li>FP IPs</li> <li>FP DPs</li> <li>MDAs</li> <li>DLGs</li> <li>UFPC</li> </ul>	Strengthen the coordination of interministerial efforts to improve stewardship.  Promote the inclusion of FP indicators in the policies and programmes of related sectors.  Promote measures to strengthen skills for the supervision and management of health staff.  Promote and follow up on measures to strengthen capacity at the MOH to effectively lead, manage, coordinate, monitor, and track performance of the country's FP programme under the FP-CIP.  Promote and follow up on measures to strengthen national efforts to collect, analyse, and use data to track FP progress.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Lobbying and negotiating</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>In-person briefings</li> <li>Information sessions</li> <li>Factsheets</li> <li>Messaging briefs</li> <li>National stakeholder conference</li> </ul>

	ı	I		
4.3 Equip decision makers and duty bearers with knowledge and skills to advocate for policies, laws, and decisions on SRH and FP (e.g. approval of clinical officers to perform surgical contraceptive methods) so they can help to strengthen the FP policy environment through informed and evidencebased dialogue and deliberation.	<ul><li>MPs</li><li>MDAs</li><li>FP IPs</li><li>DLGs</li></ul>	Conduct advocacy training and orientation on FP- and RH-related policies.	Capacity building	<ul> <li>Implementation guide</li> <li>Training manual</li> <li>User guide</li> <li>Policy briefs</li> <li>Learning events</li> </ul>
4.4 District and local councils adopt pro-FP resolutions and actively support increased resource allocations for FP as a priority health, population, and socio-economic development intervention.	<ul><li>DLGs</li><li>FP IPs</li></ul>	Promote and follow up on measures to strengthen the capacity of districts to effectively manage their FP programmes.	<ul><li>Technical support</li><li>Capacity building</li></ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Learning events</li> <li>Roundtable meetings</li> <li>Training manual</li> <li>User guide</li> </ul>
4.5 Top-level national leaders and politicians actively promote family planning, population and development issues, and support increased resource allocations for FP as a priority development strategy.	<ul> <li>H. E. The President</li> <li>Cabinet</li> <li>OPM</li> <li>MPs</li> <li>Political Leaders</li> </ul>	Identify, develop, and support high-profile FP champions and ambassadors at national level.  Develop and widely disseminate a range of advocacy messages and materials targeting national leaders and politicians.  Hold informational seminars for national-level politicians.	<ul> <li>Policy dialogue</li> <li>Lobbying and negotiating</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Messaging briefs</li> <li>In-person briefings</li> <li>Factsheets</li> <li>Information sessions</li> <li>Popular versions of key policy documents</li> <li>Endorsements by public influencers</li> </ul>

4.6 District and Local Councils adopt resolutions and actively support increased resource allocations for FP as a priority health, population and development strategy at district and lower levels.	Counc Lower Counc County	els, dissem of advenue and material assistate support to interprioriti popula develo and displans.  Hold n district officers to plar	ntion, and pment in district pment plans strict health meetings for t technical s and leaders and budget trict RH/FP	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> </ul>	•	Implementation guide Policy briefs In-person briefings Factsheets Information sessions Messaging briefs FAQs Popular versions of key policy documents
4.7 Religious leaders develop and widely communicate policy statements supporting population and development issues as well as FP service delivery and use.	IRCU/Religion Leader     UCS     UCMB     COU     UPMB     UMSC     UMMB     Religion Institut (Cathon Anglich Muslin Orthord Hindu, Aga Kile Evange)	Develor dissem of adversitions lic, an, n, dox, anan,	by, develop, and of high-profile mpions among us leaders.  op and widely hinate a range ocacy messages aterials to of advocacy by us leaders.	<ul> <li>Policy monitoring</li> <li>Lobbying and negotiating</li> <li>Policy dialogue</li> </ul>		Implementation guide Policy briefs Messaging briefs In-person briefings Factsheets Information sessions FAQs Endorsements by public influencers

<b>4.8</b> Cultural leaders develop and widely communicate policy statements supporting	Cultural Institutions and Organisations	Identify, develop, and support high-profile FP champions and ambassadors among cultural leaders.	•	<ul> <li>Lobbying and negotiating</li> </ul>	•	Implementation guide Policy briefs Factsheets
population and development issues as well as FP service delivery and use.		Develop and widely disseminate a range of advocacy messages and materials to support advocacy by cultural leaders.		execution of innovative social/cultural participatory communication approaches	•	Information sessions Messaging briefs Mass media campaign IEC materials
		Identify, develop, and support high-profile FP champions among cultural leaders.	•	Public information dissemination	•	Digital media campaign (targeted online and social networking platforms)

ADVOCACY ISSUE 5	PARTNERSHIPS AND PRIVATE SECTOR ENGAGEMENT
FRAMING THE ISSUE	Partnerships are essential for the optimal functionality of the health system, for improving service coverage, access, quality, and safety, and for financial risk protection. Similarly, exploiting private sector geographical reach, efficiency, work ethic, financial mobilisation expertise, personnel, and physical facilities is crucial to increasing access to health services.
ADVOCACY GOAL	By 2025, partnerships among and between HDPs, line ministries, departments and agencies, and private sector stakeholders and providers are robust and fully functional.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOH [PPPH Coordination Unit, PPPH TWG, HPAC, MDAs, RHD, HPECD, HSSP]; NDA
	Key Partners:
	HDPs [UNFPA, WHO, UNICEF, USAID, DFID]; PSFU; UMA
Department o	f Health Promotion, Education and Strategic Communication

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
<b>5.1</b> Secure commitment from and support the private sector to integrate FP information and services in their business plans and workplace programmes.	<ul> <li>Private health practitioners</li> <li>Private not-forprofit service providers</li> <li>Traditional and complementary medicine providers</li> <li>Not-for-profit providers</li> </ul>	Develop, produce, and disseminate training and communication materials, guidelines, and job aids for integrating FP information and services in private sector programmes.	<ul> <li>Technical support</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Policy briefs</li> <li>Factsheets</li> <li>Information sessions</li> <li>User guides</li> <li>Training manuals</li> <li>Learning events</li> </ul>
5.2 Secure commitment and support to develop, implement, and monitor decisions, policies, strategies, and measures for effective delivery of FP services and integration of FP into the activities, programmes, and core businesses of nongovernmental and private sector partners.	<ul> <li>PHPs</li> <li>PNFP HCPs</li> <li>TCMPs</li> <li>NFP providers</li> </ul>	Ensure the establishment of a clear institutional and legal framework to effectively build and utilise the full potential of PPP in Uganda's national health development.  Ensure the establishment of functional integration and support the sustained operation of a pluralistic health care delivery system by optimising the equitable use of available resources.  Promote comparative advantages of the partners in order to sustain scope, quality, and volume of services to the population.	<ul> <li>Lobbying and negotiating</li> <li>Policy dialogue</li> <li>Policy monitoring</li> <li>Technical support</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Policy briefs</li> <li>Factsheets</li> <li>Information sessions</li> <li>User guides</li> <li>Training manuals</li> <li>Learning events</li> </ul>

<b>5.3</b> Promote and showcase the role of private providers and organisations in building capacity at different levels of the health system.
system.

- PHP
- PNFP HCPs
- TCMPs
- PROMETRA
- TBAs
- NFP HCPs

Demonstrate the benefits of supporting provision of the UNMHCP through private sector providers in terms of increasing the proportion of the population that can access quality services including FP.

Support the efforts – including those by PNFPs, PHPs, PROMETRA, TBAs, and TCMPs - to provide equitable access to quality services by ensuring geographical access and adequate human resources and infrastructure and by addressing the economic, social, cultural, and gender barriers to services.

- Policy dialogue
- Best practices documentation
- Implementation guide
- Information sessions
- Factsheets
- Messaging briefs
- Stories of change (videos, digital, and printed formats using most significant change approach)

ADVOCACY ISSUE 6	ACCESS TO, DELIVERY AND QUALITY OF SERVICES
FRAMING THE ISSUE	
	Barriers to access to family planning include geography and socio-economic status particularly income and education. The current system for delivering family planning services needs to be expanded and new approaches introduced to broaden availability and accessibility and to address the various inequalities through specific policies, programmes, and financing to meet the needs of under-served populations.
ADVOCACY GOAL	By 2025, clients in every region of Uganda have access to the widest choice of contraceptive methods and more equitable access to high-quality FP services.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOH [RHD, HPECD, HRDD, HPD]; HSC; Institutions of Higher Learning; Professional Training Institutions
	Key Partners:
	OPM; NUDIPU; PSFU; NGOs; DLGs

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
6.1 Support integration of FP into other health services by ensuring that relevant protocols are developed, service providers trained, and specific efforts made to ensure that outreach is tailored to address the needs of key populations.	<ul><li>MOH</li><li>DLGs</li><li>Parliament</li><li>HDPs</li></ul>	Promote plans to increase the number and deployment of appropriately qualified and skilled service providers to offer a full range of quality static and outreach FP services that are male-friendly, disability-friendly, and adolescent-friendly.	<ul> <li>Lobbying and negotiating</li> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Information sessions</li> </ul>
<b>6.2</b> Implement measures to increase access of PWDs to FP services.	<ul><li>MOH</li><li>NUDIPU</li></ul>	Monitor the development and dissemination of FP clinical service delivery guidelines to ensure the provision of FP services in accordance with human rights and quality of care standards.  Monitor the provision of services to FP clients with disabilities.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> </ul> • Technical support	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Information sessions</li> <li>IEC materials</li> <li>Targeted roundtable meetings with leaders of PWDs</li> <li>Implementation guide</li> <li>In-person briefings</li> <li>Information sessions</li> </ul>
6.3 Support the scaling up (beyond pilot basis) of innovations in service delivery e.g. community-based distribution of injectable contraception by VHTs, tubal ligation by trained clinical officers, and provision of longacting FP methods by midwives.	• MOH • DLGs	Expand access to FP services by increasing service delivery points, including community-based distribution for rural communities e.g. through mobile clinics and PPP initiatives; provision of injectable contraceptives and other short acting FP methods through drug shops	<ul> <li>Technical support</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Information sessions</li> <li>Training manual</li> <li>User manuals</li> </ul>

<b>6.4</b> Revise staffing norms to provide for adequate numbers of qualified RH/FP providers at all levels of service delivery.	<ul> <li>Parliamentary Social Services Committee</li> <li>MOH</li> <li>MOFPED</li> <li>District Service Commissions</li> </ul>	Engage the HSC and MOFPED to initiate and approve incentive schemes to attract and retain qualified service providers for rural and hard-to-reach districts and locations.	<ul> <li>Lobbying and negotiating</li> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Technical support</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Messaging briefs</li> <li>In-person briefings</li> <li>Information sessions</li> <li>Roundtable</li> </ul>
6.5 Engage district health and HF managers to deploy qualified FP/RH providers at all facilities and service delivery points.	<ul> <li>DLGs</li> <li>District HCF Managers</li> </ul>	Monitor to ensure the deployment of qualified FP/RH providers at all HFs and service delivery points.  Hold districts and HFs accountable for ensuring the availability of suitably qualified and trained FP providers at all HCFs and FP service delivery points.		meetings
<b>6.6</b> Initiate and approve incentive schemes to attract and retain qualified service providers for rural and hard-to-reach districts and locations.	<ul><li>MOH</li><li>MOFPED</li></ul>	Monitor to ensure that a range of options of incentive schemes to attract to and retain qualified service providers in hard-to-reach districts and locations are identified, costed, and presented to the HSC.		
<b>6.7</b> Implement strategies to provide a full range of FP services in all areas served by Catholicrun HFs.	<ul> <li>DLGs</li> <li>UCMB</li> <li>NGOs and FBOs</li> <li>Private HCPs</li> </ul>	Provide technical assistance to districts to identify and cost options for providing a full range of FP services in areas served by Catholicrun facilities.	<ul> <li>Technical support</li> <li>Capacity building</li> <li>Policy dialogue</li> <li>Policy monitoring</li> </ul>	<ul> <li>Implementation guide</li> <li>Training manual</li> <li>User guide</li> <li>Information sessions</li> </ul>

ADVOCACY ISSUE 7	ADOLESCENT AND YOUTH FRIENDLY SERVICES
FRAMING THE ISSUE	Young people and adolescents are a key population for family planning. Addressing their unique needs requires recognising and implementing measures that are responsive to the recommended standards for adolescent-and youth-friendly services.
ADVOCACY GOAL	By 2025, more young people benefit from FP and RH services that meet the standards for adolescent/youth-friendly services.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOES; NCCD; MOH [HPECD, RHD, ADH]; NPC
	Key Partners:  • MGLSD; UNFPA; UNICEF; FP IPs

	<ul> <li>MGLSD; UNFPA</li> </ul>	; UNICEF; FP IPs		
ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
7.1 Promote measures to increase the FP and RH knowledge and empowerment of young people e.g. engaging and supporting peer educators; engaging youth through targeted media, messaging, and outreach.	<ul> <li>Schools</li> <li>Local Communities</li> <li>FP IPs</li> <li>Youth Platforms and Networks</li> <li>Media Gatekeepers</li> </ul>	Mobilise through the school system to create awareness of FP and RH among youth and adolescents.  Support efforts to delay the onset of childbearing by promoting school progression and access to contraception for sexually active adolescents and young women.	<ul> <li>Social mobilisation</li> <li>Community dialogue</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>School activations</li> <li>Mass media campaign</li> <li>IEC materials</li> <li>Digital media campaign (targeted online and social networking platforms)</li> <li>Training manual</li> <li>User guide</li> <li>Youth celebrity endorsements</li> <li>Youth events partnerships / sponsorships such as Buzz Awards, Panda Turn-ups in &amp; out of schools etc.</li> <li>Youth-centric digital apps creation</li> <li>Partnerships with youth mentorship programmes</li> </ul>

7.2 Ensure compliance with the recommended standards for adolescent/ youth-friendly services in terms of provider and HF characteristics and service components.	<ul><li>DLGs</li><li>PSFU</li><li>FP IPs</li></ul>	Monitor the commitment to provide adolescent- and youth-friendly services in clinics through establishment of youth-friendly corners, training of HCWs in youth-friendly services, and extension of FP service delivery times beyond school hours to accommodate more adolescents and youth.	<ul> <li>Technical support</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Policy briefs</li> </ul>
7.3 Secure budget commitments to implement Life Skills and updated sexual and reproductive health curricula in all schools.	<ul><li>MOE</li><li>NCCD</li><li>MOFPED</li><li>Schools</li></ul>	Monitor the implementation of the Life Skills (and SRH) curricula in schools.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Policy briefs</li> <li>Information sessions</li> </ul>
7.4 Secure budget commitments to develop and introduce new information and learning materials for population and development education in all schools.	<ul><li>NCCD</li><li>Schools</li><li>MOFPED</li></ul>	Monitor the implementation of new information and learning materials on population and development education into school curricula at all levels.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Policy briefs</li> <li>Information sessions</li> </ul>

ADVOCACY ISSUE 0	CONTRACERT	VE AND BU COMMODIT	/ CECURITY	
ADVOCACY ISSUE 8		VE AND RH COMMODIT		
FRAMING THE ISSUE	to reproductive them. Interven	of potential and current e health commodities of tions are needed at diffo modity security from the	their choice as, when, erent levels of operatio	and where they need n and service delivery
ADVOCACY GOAL		mmodities and supplies n the places, and at the		ble in the quantities, in to meet demand.
<b>LEAD AGENCIES &amp;</b>	Lead Agencies	:		
KEY PARTNERS	Key Partners:	, Pharmacy Department FPA, USAID, WHO, DFID];		JMS; FP IPs
ADVOCACY	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS
OBJECTIVES				AND PRODUCTS
8.1 Promote initiatives to ensure that the full range of FP commodities and contraceptive methods is available: i.e. inclusion of all WHO pre-qualified commodities in The Essential Medicines List; review of the contraceptive testing policy; implementation of task-sharing policies; facilitating the operationalisation of the alternative distribution system for providing commodities to NGOs.	• MOH • FP DPs	Secure commitments and action to strengthen national systems for quantification, procurement and logistics to reduce national-level stock-outs of FP commodities and supplies.  Hold NMS, DHMTs, HSD managers and health centre managers publicly accountable for contraceptive supplies at service delivery points (e.g. quarterly progress reports published in newspapers, quarterly reports to district councils, adding an appropriate indicator to MOH District League Tables to measure district performance, adding an appropriate indicator to Yellow Star checklists, etc).	<ul> <li>Lobbying and negotiating</li> <li>Research and analysis</li> <li>Policy monitoring</li> <li>Policy dialogue</li> </ul>	<ul> <li>Implementation guide</li> <li>In-person briefings</li> <li>Factsheets</li> <li>Policy briefs</li> <li>Information sessions</li> </ul>

<b>8.2</b> Secure commitments and action from the GOU
and districts to allocate adequate funding and
to strengthen systems
for quantification,
procurement, and
logistics to reduce
and eliminate stock-
outs and wastage of
FP commodities and
supplies at service
delivery points.

- MOFPED
- DLGs
- FP IPs

Hold duty bearers (NMS, DLGs, HCF managers, etc) publicly accountable for contraceptive supplies at service delivery points.<sup>14</sup>

- Lobbying and negotiating
- Research and analysis
- Policy monitoring
- Policy dialogue
- Capacity building
- Implementation guide
- In-person briefings
- Factsheets
- Policy briefs
- Information sessions
- Regional stakeholder conferences
- Training manual
- User manual

ensure that district staff are able to accurately quantify and forecast FP commodities.

Track progress on

the commitment to

Track progress on the commitment to strengthen the supply chain system by ensuring that VHTs and CBDs have commodities through accurate and timely re-stocking and distribution and that supplies are available at the lower levels.

8.3 Ensure
contraceptive security
by maintaining a
robust, reliable, and
adequate supply
of contraceptive
commodities and
supplies to meet
clients' needs and
choices in a timely
manner and to prevent
stock-outs.

## NMS

Promote efforts to strengthen realtime reporting of consumption and stock status at facility level.

Track progress on the commitment to implement comprehensive forecasting, quantification, and procurement of FP

commodities.

Ensure that the contraceptives available in the country are of high quality.

Ensure that contraceptives are delivered through the *last mile* to HCFs throughout the country.

Declassify the contraceptive injection DMPA or Depo Provera® and/or Sayana® Press and emergency contraceptives so as to include drug shops as providers of an expanded FP method mix.

- Lobbying and negotiation
- Policy monitoring
- Policy dialogue
- Implementation guide
- In-person briefings

8.4 Secure
commitments and
action to increase
the promotion and
availability of a full
range of appropriate
FP methods, including
non-hormonal and
natural family planning
methods, in selected
locations, to test
demand for alternative
methods.

- PSFU
- NMS
- UCMB
- JMS

Promote efforts to increase commodity distribution to not-for-profits by seeking common ground with JMS, the second major supplier of EMHS, to persuade it to include FP commodities in procurement to improve FP access for non-Catholic clients in facilities supplied by JMS.

Promote efforts to strengthen private sector involvement in supply planning and commodity tracking.

Secure commitments and action from development partners to support the efforts of the GOU, the districts, and their partners to strengthen the supply chain for FP commodities.

- Policy monitoring
- Policy dialogue
- Capacity building
- Implementation quide
- In-person briefings
- Information sessions
- Training manual
- User manual

ADVOCACY ISSUE 9	FAMILY PLANNING PROVIDER CAPACITY, KNOWLEDGE AND BEHAVIOUR
FRAMING THE ISSUE	The knowledge, attitudes, practices and behaviour of family planning service providers have an impact on the demand for and quality of services. HCW should be supported through supervision, facilitation, and continuous education to equip them with the skills and tools to provide services that address the different needs and situations of service seekers.
ADVOCACY GOAL	By 2025, there are measurable improvements in FP service providers' knowledge, attitudes, and practices when dealing with clients.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOH [HRDD, RHD, HPECD]; DLGs
	Key Partners:
	FP IPs; HDPs [UNFPA, WHO, UNICEF, USAID, DFID]; NUDIPU

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
9.1 Address the FP service providers' own attitudes and professional practices emphasising confidentiality, being non-judgmental, counselling that empowers individuals, and objective information about the side effects of different contraceptive methods.	<ul> <li>Training institutions</li> <li>Professional associations</li> <li>In-service capacity building</li> </ul>	Equip HCWs who provide FP services with the knowledge and skills to counsel clients on full, free, and informed choice without recourse to method-specific bias.  Equip service providers with knowledge and skills of customer care and quality of care.	<ul> <li>Technical support</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Training manuals</li> <li>User manual</li> </ul>
9.2 Support efforts to strengthen FP service delivery through the VHT system.	• DLGs (DHTs)	Monitor the commitment to strengthen FP in the VHT system through measures such as revision of the VHT training manual, scaling up of VHT training, operationalization of the use of DMPA (or Depo Provera®) and/or Sayana® Press by VHTs, and harmonisation of the benefits package for VHTs.  Support the scaling up of the PPP initiative for training service providers in public and private HCFs in the provision of long-acting FP methods.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Roundtable meetings</li> <li>Learning events</li> </ul>

9.3 Improve knowledge and appreciation of FP policies and programmes among HCW at all levels of service delivery and among duty bearers in non-health sectors impacted by FP and RH outcomes.	<ul> <li>Training institutions</li> <li>In service capacity building</li> <li>DLGs [HCWs, DHTs, VHTs]</li> <li>Not-for-profit HCPs</li> <li>Private HCPs</li> <li>MDAs</li> <li>PSFU</li> </ul>	Produce and disseminate customised information products addressing the role of HCWs, DHTs, and non-health sector duty bearers in policy implementation with particular focus on education about the provision of FP services in accordance with human rights and quality of care standards.	<ul> <li>Technical support</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Training manuals</li> <li>User manuals</li> <li>Learning events</li> </ul>
9.4 Include FP in in-service training to improve the knowledge and capacities of FP HCWs.	• DLG (DHTs)	Engage the responsible duty bearers within the MOH, the DLGs, and IPs to develop, implement, and commit funds to support a comprehensive national in-service training programme on FP at all HFs.	<ul> <li>Lobbying and negotiating</li> <li>Policy dialogue</li> <li>Policy monitoring</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>In-person briefings</li> <li>Roundtable meetings</li> </ul>
		Monitor the commitment to improve the management of FP side effects through reassessment of FP counselling guidelines, training of trainers on side effects, and production and dissemination of reporting tools.		

- FP IPs
- HCFs

Monitor the development or updating and dissemination of in-service training guidelines and standards for family planning that include components on establishing and delivering men-friendly, disability-friendly and adolescent-friendly FP services, including provisions for TOTs at regional or district level.

- Policy monitoring
- Policy dialogue
- Capacity building
- Implementation quide
- Information sessions
- Training manuals
- Use manuals

Ensure access for PWDs to FP services in accordance with human rights and quality of care standards, including training of HCWs in providing services to FP clients with disabilities.

ADVOCACY ISSUE 10	SOCIAL NORMS, CULTURE AND RELIGION
FRAMING THE ISSUE	Family planning is undermined by numerous myths, misconceptions, misinformation, and gender dynamics. Changing the negative norms and values and propping up the positive ones is fundamental to improving perceptions towards family planning and therefore encouraging more women and men to embrace it.
ADVOCACY GOAL	By 2025, fewer Ugandans express harmful social norms and negative religious influences towards FP and more men are supportive of contraception and involved in FP.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOICT; MOH [RHD, HPECD]; MOGLSD
	Key Partners:
	UFPC; Media Gatekeepers; IRCU/FBOs; DLGs

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
10.1 Increase demand for and uptake of FP by expanding knowledge of FP and addressing myths and misconceptions.	<ul> <li>DLGs</li> <li>FP IPs</li> <li>HCWs</li> <li>VHTs</li> <li>CDOs</li> <li>FP      Community-     Based     Distributors/     Services</li> </ul>	Invest in and support high-impact demand generation activities designed to address social/cultural norms and religious/spiritual beliefs that negatively affect FP uptake and utilisation.	<ul> <li>Social mobilisation</li> <li>Public information dissemination</li> </ul>	<ul> <li>Implementation guide</li> <li>Community activations</li> <li>Mass media campaign</li> <li>IEC materials</li> <li>Digital media campaign (targeted online and social networking platforms)</li> <li>Endorsements (opinion leaders - religious, cultural, political or social)</li> </ul>
10.2 Support efforts to close the knowledge-use gap through initiatives designed to address myths, misinformation, fear of side effects, and health concerns that impede adoption and continuous use of FP.	<ul> <li>DLGs</li> <li>FP IPs</li> <li>HCWs</li> <li>VHT</li> <li>CDOs</li> <li>FP      Community-     Based     Distributors/     Services</li> </ul>	Mobilise community support to increase demand for FP by helping to foster a supportive environment and to reduce social, cultural, and religious barriers.	<ul> <li>Lobbying and negotiating</li> <li>Policy dialogue</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Policy briefs</li> <li>Factsheets</li> <li>Messaging briefs</li> <li>Regional stakeholder conferences</li> <li>In-person briefings</li> </ul>
10.3 Embrace and routinely communicate policy statements and positions in support of FP and promote it as a fundamental health, population, and socioeconomic development issue.	<ul> <li>Religious         <ul> <li>Institutions</li> <li>and</li></ul></li></ul>	Prepare and equip religious and cultural leaders with the tools, knowledge, and skills to champion FP by promoting positive social norms and religious beliefs.	<ul> <li>Lobbying and negotiating</li> <li>In-person briefings</li> <li>Policy dialogue</li> <li>Events planning</li> <li>Capacity building</li> </ul>	<ul> <li>Implementation guide</li> <li>Information sessions</li> <li>Policy briefs</li> <li>Factsheets</li> <li>Messaging briefs</li> <li>Regional stakeholder conferences</li> </ul>

ADVOCACY ISSUE 11	MALE INVOLVEMENT
FRAMING THE ISSUE	There is a knowledge gap among men on reproductive health. Men to be mobilised as active participants in parenting and in sexual and reproductive health matters.
ADVOCACY GOAL	By 2025, more men have comprehensive knowledge of contraception and regularly contact health care providers to seek FP information and services.
LEAD AGENCIES & KEY PARTNERS	Lead Agencies:  • MOH [HPECD, RHD]; MOGLSD; FP IPs
	Key Partners:  • DLGs

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
11.1 Promote efforts to motivate men to support the use of modern contraception for themselves and their partners.	<ul> <li>HCWs</li> <li>VHTs</li> <li>Cultural Institutions, Organisations, Platforms and Networks</li> </ul>	Encourage men to take part in sexual and reproductive health including FP and maternal and child health, in prevention of STIs including HIV/AIDS, and in prevention of unwanted and high-risk pregnancies with special emphasis on prevention of violence against women and children.	<ul> <li>Social mobilisation</li> <li>Community mobilisation</li> <li>Public information dissemination</li> </ul>	<ul> <li>Implementation guide</li> <li>Community dialogue</li> <li>Mass media campaign</li> <li>IEC materials</li> <li>Digital media campaign (targeted online and social networking platforms)</li> <li>Community activations</li> </ul>
11.2 Promote men's shared responsibility and active involvement in responsible parenthood.	<ul> <li>HCWs</li> <li>VHTs</li> <li>Cultural Platforms and Networks</li> </ul>	Support the roll- out of male action groups throughout the country beyond the selected districts where they were introduced in order to strengthen the strategy for male involvement in sexual and reproductive health.		

ADVOCACY ISSUE 12	ACCESS TO INFORMATION AND KNOWLEDGE MANAGEMENT
FRAMING THE ISSUE	Basic awareness of family planning is generally high Ugandans. However, there are significant knowledge gaps especially among the youth, and sexual health issues are also not adequately addressed in primary health care. Improvements in knowledge management are expected to result in better information sharing and use of feedback to improve service delivery.
ADVOCACY GOAL	By 2025, there is improvement in the scale of information dissemination and utilisation and support for initiatives that address knowledge gaps in FP.
LEAD AGENCIES &	Lead Agencies:  • MOH [RHD, HPECD]; DLGs
KEY PARTNERS	Key Partners:
	UFPC; PSFU; UMA

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
<ul> <li>12.1 Government, development partners and private sector partners prioritise and commit increased budget allocations and resources to support IEC/SBCC programmes that provide accurate</li> <li>MOH</li> <li>MOFPED</li> <li>DLGs</li> <li>NGOs</li> <li>PSFU</li> </ul>	Ensure that family planning issues are fully addressed and that men and adolescents are specifically targeted in national communication strategies.	<ul> <li>Policy monitoring</li> <li>Policy dialogue</li> <li>Lobbying and negotiation</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Information sessions</li> <li>In-person briefings</li> </ul>	
information about family planning at all levels.		Mobilise resources for national-level IEC/SBCC campaigns on family planning.		
		Identify mechanisms and mobilise resources to support IEC/ SBCC programmes through private sector partners and workplaces.		

12.2 Prioritise and commit increased budget allocations and resources to support programmes to provide quality and consistent information about FP at district level.	<ul> <li>DLGs</li> <li>FP IPs</li> <li>HCWs</li> <li>VHTs</li> <li>CORPs</li> <li>CDOs</li> <li>PSFU</li> <li>Cultural Institutions, Organisations, Platforms and Networks</li> <li>Religious Institutions and Organisations</li> <li>FBOs</li> <li>HDPs</li> <li>Media Gatekeepers</li> </ul>	Identify mechanisms and mobilise resources for districts to support IEC/SBCC through CORPs at community level (e.g. dedicated conditional grants such as the PAF- funded Community Development Workers Conditional Grant mechanism).	•	Policy monitoring Policy dialogue Lobbying and negotiation	•	Implementation guide In-person briefings Policy briefs Regional stakeholder conferences Information sessions
12.3 Develop and disseminate, via the MOH and partner websites and digital platforms, specific briefs addressing the role of HCWs in FP policy implementation including knowledge about the provision of FP services in accordance with human rights and quality of	<ul> <li>DLGs</li> <li>FP IPs</li> <li>HCWs</li> <li>VHT</li> <li>CDOs</li> <li>PSFU</li> <li>Cultural Institutions, Organisations, Platforms and Networks</li> <li>Religious Institutions</li> </ul>	Avail curated FP information on the Health Knowledge Management Portal of the MOH.	•	Knowledge management	•	Implementation guide  Updating and maintenance of MOH Health Knowledge Management Portal  Digital mailing lists  Upload knowledge management products for public access by user
care standards.	<ul> <li>FBOs</li> <li>HDPs</li> <li>Media Gatekeepers</li> </ul>	Popularise the legal framework for the promotion of FP through dissemination of tailored information packages.	•	Public information dissemination	•	Popular versions of key policy documents  Mass media campaign  IEC materials  Digital media campaign (targeted online and social networking platforms)

ADVOCACY ISSUE 13	DEMAND SATISFA	CTION AND CREAT	ΓΙΟΝ		
FRAMING THE ISSUE	The efforts that have been invested in generating demand for family planning need to be sustained in order to maintain the momentum. This is critical in order to reduce the rate of discontinuation of contraception use which is so high that 45% of women who start using contraceptives stop within 12 months.				
ADVOCACY GOAL		By 2025, 75% of the FP needs of married women are met and 65% of the demand for FP is satisfied by modern methods.			
LEAD AGENCIES &	Lead Agencies:				
KEY PARTNERS	<ul><li>MOH [HPECD]</li><li>Key Partners:</li><li>DLGs; CHWs</li></ul>				
ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	
13.1 Address barriers to demand, access, and use of FP among married and unmarried couples by strengthening the delivery of high-quality FP services through HFs, community outreach programmes, and other outlets.	<ul> <li>FP champions</li> <li>DLGs</li> <li>Media Gatekeepers</li> <li>VHTs</li> </ul>	Generate support for and participation in on-the-ground community outreach and mobilisation efforts to increase demand for FP.  Scale up the policy for community-based distribution of injectables beyond the pilot phase.	<ul> <li>Social mobilisation</li> <li>Community mobilisation</li> <li>Public information dissemination</li> </ul>	<ul> <li>Implementation guide</li> <li>Community dialogue</li> <li>Community activations</li> <li>IEC materials</li> <li>Media interviews</li> <li>Celebrity endorsements (youth influencers)</li> <li>Youth events (kadankes, sponsorships, youth-centred digital events, mentorship programmes, sports, etc.)</li> </ul>	
13.2 Promote public dialogue – from the highest national to the lowest community levels – to sustain support for FP and recognition of its role in the health, wellbeing, and development of the nation.	<ul> <li>MPs</li> <li>FP Champions</li> <li>DLGs</li> <li>Media Gatekeepers</li> </ul>	Increase knowledge of, and demand for, FP by disseminating accurate information about FP methods and their availability.  Strengthen the national champions programme by supporting its extension to the district and community levels.	<ul> <li>Policy dialogue</li> <li>Lobbying and negotiating</li> </ul>	<ul> <li>Implementation guide</li> <li>Policy briefs</li> <li>Information sessions</li> <li>In-person briefings</li> <li>Media interviews</li> </ul>	

ADVOCACY ISSUE 14	COMMUNICATING FOR SOCIAL AND BEHAVIOUR CHANGE
FRAMING THE ISSUE	Strategic communication is a critical factor as an enabler of sustained social and behaviour change. To be effective, social and behaviour change communication needs to be an integral part of health promotion interventions and backed by evidence to ensure that messaging and campaigns are properly targeted to raise the demand for family planning.
ADVOCACY GOAL	By 2025, the GOU and its partners intensify communication to promote social and behaviour change among FP users and service providers.
LEAD AGENCIES &	Lead Agencies:
KEY PARTNERS	MOH [RHD, HPECD]; MOGLSD; MOLG; MAAIF; MOICT
	Key Partners:
	UFPC; Religious Leaders; Cultural Leaders; Media Gatekeepers

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS
14.1 Invest in and support measures to ensure that SBCC campaigns and efforts are harmonised across interventions, accurately targeted with evidence-based messages, and use market segmentation to increase demand.  14.2 Ensure and support the development and dissemination of tailored, honest, objective, non-judgmental, accurate, clear, and consistent information packages and messages on FP with a multi-sectoral dimension (e.g. FP as a development intervention).	<ul> <li>MOH</li> <li>DLGs</li> <li>FP IPs</li> </ul> <ul> <li>Water and Environment Sector</li> <li>Social Development Sector (gender and youth)</li> <li>PH Practitioners</li> <li>PLWHA</li> <li>PNFP HCFs</li> <li>PWDs</li> <li>TCMP</li> <li>UFPC</li> </ul>	Intensify educational campaigns through the media and other formats to enable couples to realise the benefits of smaller family size for both their own economic well- being and national development.  Engage stakeholders in the non-health sectors – e.g. environment, agriculture, gender, labour and social development, and livelihood – to integrate FP SBCC into their programmes and activities in order to address the holistic and full needs of communities.  Promote efforts to lessen the burden on HCWs by encouraging non-health sector duty bearers and service providers to incorporate FP messages in their programmes.	<ul> <li>Technical support</li> <li>Capacity building</li> <li>Social mobilisation</li> <li>Public information dissemination</li> </ul>	<ul> <li>Implementation guide</li> <li>Factsheets</li> <li>Policy briefs</li> <li>Messaging briefs</li> <li>Mass media campaign</li> <li>IEC materials</li> <li>Digital media campaign (targeted online and social networking platforms)</li> <li>Community activations</li> <li>Regional stakeholder conferences</li> <li>In-person briefings</li> <li>Information sessions</li> <li>Training manual</li> <li>User manual</li> </ul>
14.3 Support and facilitate the development and dissemination of FP information packages and messages targeting all critical FP users i.e. rural and urban youth, adolescents in and out of school, married youth, men, PLHAs, key populations at risk, PWDs, CSWs, etc.	<ul> <li>DLGs</li> <li>FP IPs</li> <li>HCWs</li> <li>VHTs</li> <li>CDOs</li> <li>FP Community-Based Distributors/ Services</li> </ul>	Engage managers of livelihood and human welfare programmes to integrate FP BCC into the activities and programmes of sectors such as education, environment and natural resources, agriculture, water and sanitation, gender, labour and social development, etc.		

# **8.0 COSTED IMPLEMENTATION**

# 8.1 Costing Assumptions

Most of the activities/products for each of the priority areas are cross-cutting and have therefore been addressed and costed as a package. The costed activities/products have come from a variety of sources but include specific data from the MOH and partners implementing programmes. The costing ingredients include standard costs for the government procurement and implementation partners. Each group of the activities that will produce a product such as messaging brief have been detailed and costed separately in the costing procedure; all inputs are also editable in the costing procedure. In addition, each activity's costing inputs for both unit costs and quantities can be changed (e.g. the specific input costs for policy brief, the number of meetings for validation, the cost of dissemination, etc., can easily be edited if change is required).

The costing exercise assumes prices of services and goods remain stable unless otherwise noted. All consumable costs e.g per diem rates, fuel costs, venue hire, public address system, etc., are based on the current costs as of August 2020 and have been adjusted for a base rate of inflation and Bank of Uganda inflation rates projections/PPP, overtime determining the variation of the costs across the strategy. The inflation rate has been adjusted to accommodate the changing conditions. However, the impact of COVID-19 has not been yet analysed into usable inflation indicators. All costs have been calculated in US dollars and Uganda shillings.

# 8.2 Methodology

The methodology adopted micro costing/ingredients approach. This was based on the 14 identified advocacy issues in the advocacy strategy. The activities pathways required to produce a given advocacy issue were identified, quantified, and valuated. For products, the cost of producing a product was established based on the current market rates and prices.

These activities and products were validated by experts in the stakeholder consultative meetings. Due considerations were made to estimate the level of efforts, frequency, duration, man-hour values to determine a total cost of a given activity. The output of this process was a direct average unit cost of activities identified. For human resources for health emoluments the Circular Standing Instruction 6 and 9 of 2018, for government employees was used, average pay for private not for profit was considered for persons in PNFP settings and average public/private market wage rates was considered for persons not in any formal setting but are involved in the FP advocacy activities. This majorly considered allowances. For communication media average cost of the most effective media of communication was considered. For commodities that can be procured locally, NMS, JMS, contracted suppliers' current prices were considered.

# Shared recurrent inputs for the different activities and shared activities for different outputs.

This entailed a series of systematic steps leading to allocation of shared costs to the specific activities using appropriate allocation basis and allocation statistic:

**Note:** Only recurrent shared costs were considered in this cost estimation.

- (i) Identification of the shared recurrent cost drivers, activities and intervention pathways needed to provide or support an advocacy output in a particular target.
- (ii) Analysis of the shared recurrent costs considered, in terms of type, quantification and valuation.

For shared human resources, a time motion sheet was used to estimate the amount time the

person expends in the advocacy. So time was the allocation basis and the proportion of the time became the allocation statistic.

- (iii) Where costs were estimated based on the previous related costing, adjustments were made using the inflation rates provided by Bank of Uganda.
- (iv) Finally, the total cost of the activity is the sum of the direct cost and the apportioned shared costs proportionate to usage.

## Determination of the total cost of the FP advocacy/ Implementation Plan for 5 years.

The total cost of the plan was obtained by summing the total cost of each activity/product for the 5 years based on the total cost of the annual activities in the Implementation Plan. Costs of activities in the subsequent years were adjusted using projected inflation rates from Bank of Uganda.



# 8.3 Costing Summary

The costs of the implementation plan have been estimated using the Ministry and partners' operational rates with a tool developed and linked to an activity framework that is easy to adjust for further revisions. The costs have been estimated for the overall costs of the plan, as well as the costs for each year for the five years.

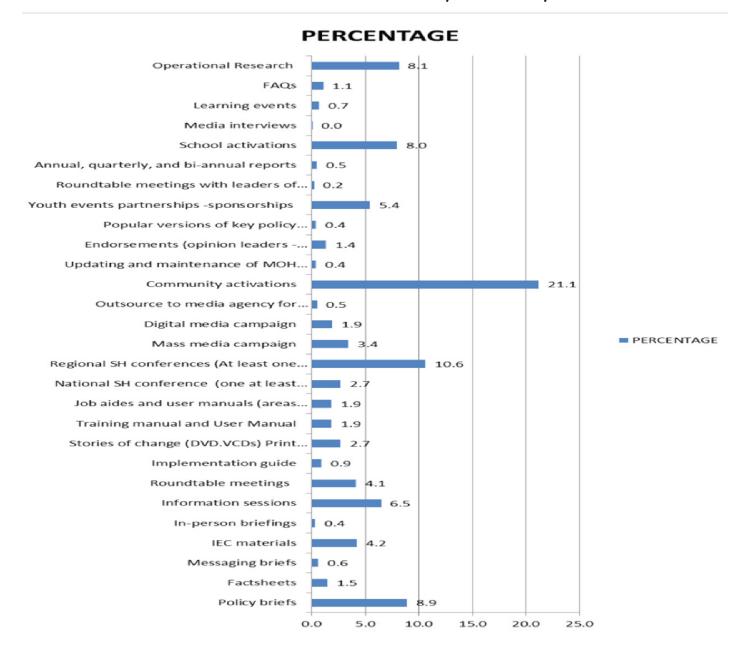
The total costs of the plan from 2020–2025 are \$21 million USD (77 billion UGX). The calculated total costs of the activities/outputs for the five years are as follows: A total of \$4.4 million USD (16.3 billion UGX) for 2020/2021; \$3.6 million USD (13 billion UGX) for 2021/2022; \$4.4 million USD (16 billion UGX) for year 2022/2023; \$3.9 million USD (14.3 billion UGX) for year 2023/2024; \$4.7 million USD (17.3 billion UGX) for year 2024/2025. See the table below.

SUMMARY OF THE CO	ST ESTIMATES FOR 2020/2021-2024/	2025 FP ADVOCACY STRATEGY PER YEAR
	ESTII	MATED COST
FINANCIAL YEAR	COST IN UGX	COST IN USD
2020/2021	16,337,298,500	4,449,155
2021/2022	13,055,103,646	3,555,311
2022/2023	16,095,701,365	4,383,361
2023/2024	14,262,509,135	3,884,126
2024/2025	17,277,037,245	4,705,076
TOTAL	77,027,649,891	20,977,029

Overall, in the five years the following activities/ outputs have relatively higher costs than the rest of the activities/ outputs: Community Activations 16.3 billion UGX. /4.4 million USD that's (21.1%); Regional Shake Holder Conferences 8.2 billion UGX /2.2 million USD that's (10.6%); Policy Briefs 6.7 billion UGX / 1.9 million USD that's (8.9%); School Activations 6.1 billion UGX /1.7 million USD; Operational Researches 6.3 billion UGX /1.7 million USD that's 8.1% and Youth events partnerships and sponsorships 4.2 billion /1.1 million USD.

The activities with the biggest costs all target community and school information dissemination, policy framers as well as support for these activities/ products indicating that the drivers of costs are in community activities. These are priority activities for funding because they directly support communicating issues for action through changes and reinforcement in policies, programmes, and resources. Investing in these activities would contribute to universal access to family planning.

# PERCENTAGE DISTRIBUTION OF COSTS PER ACTIVITY/PRODUCT OVER THE 5 YEAR STRATEGY 2020/2021-2024/2025



# SUMMARY OF THE COSTS PER FINANCIAL YEAR AND PER ACTIVITY/OUTPUT IN UGANDA SHILLINGS

ACTIVITIES AND OUTPUTS TO BE (2020/2021	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	TOTAL COST PER A
Policy briefs	1,336,551,425	1,427,295,401	1,456,841,053	1,647,603,393	995,123,288	6,863,414,561
Factsheets	210,883,500	221,111,350	229,863,015	238,298,355	246,733,695	1,146,889,915
Messaging briefs	89,344,500	93,677,708	97,385,505	100,959,285	104,533,065	485,900,063
IEC materials	597,606,500	626,590,415	651,391,085	675,295,345	699,199,605	3,250,082,950
In-person briefings	50,400,000	52,844,400	54,936,000	56,952,000	58,968,000	274,100,400
Information sessions	916,150,000	960,583,275	998,603,500	1,035,249,500	1,071,895,500	4,982,481,775
Roundtable meetings	585,240,000	613,624,140	637,911,600	661,321,200	684,730,800	3,182,827,740
Implementation guide	190,960,000	-	208,146,400	56,477,400	223,423,200	679,007,000
Stories of change (DVD.VCDs) Print d	381,280,000	399,772,080	415,595,200	430,846,400	446,097,600	2,073,591,280
Training manual and User Manual	343,480,000	152,913,240	374,393,200	164,799,200	401,871,600	1,437,457,240
Job aides and user manuals (areas w	343,480,000	152,913,240	374,393,200	164,799,200	401,871,600	1,437,457,240
National SH conference (one at least	640,000,000	1	697,600,000	1	748,800,000	2,086,400,000
Regional SH conferences (At least on	1,880,000,000	985,590,000	2,049,200,000	1,062,200,000	2,199,600,000	8,176,590,000
Mass media campaign	1,009,360,000	384,547,860	399,768,400	414,438,800	429,109,200	2,637,224,260
Digital media campaign	1,024,000,000	100,656,000	104,640,000	108,480,000	112,320,000	1,450,096,000
Outsource to media agency for devel	72,000,000	75,492,000	78,480,000	81,360,000	84,240,000	391,572,000
Community activations	2,993,874,500	3,139,077,413	3,263,323,205	3,383,078,185	3,502,833,165	16,282,186,468
Updating and maintenance of MOH H	57,600,000	60,393,600	62,784,000	65,088,000	67,392,000	313,257,600
Endorsements (opinion leaders - reli	192,660,000	202,004,010	209,999,400	217,705,800	225,412,200	1,047,781,410
Popular versions of key policy docum	57,570,000	37,232,235	62,751,300	65,054,100	67,356,900	289,964,535
Youth events partnerships /sponsors	771,200,000	808,603,200	840,608,000	871,456,000	902,304,000	4,194,171,200
Roundtable meetings with leaders or	31,860,000	33,405,210	34,727,400	36,001,800	37,276,200	173,270,610
Annual, quarterly, and bi-annual rep	68,000,000	71,298,000	74,120,000	76,840,000	79,560,000	369,818,000
School activations	1,129,680,000	1,184,469,480	1,231,351,200	1,276,538,400	1,321,725,600	6,143,764,680
Mediainterviews	5,400,000	5,661,900	5,886,000	6,102,000	6,318,000	29,367,900
Learning events	97,440,000	102,165,840	106,209,600	110,107,200	114,004,800	529,927,440
FAQs	167,736,000	129,622,910	182,832,240	157,055,310	196,251,120	833,497,580
Operational Research	1,093,542,075	1,033,558,739	1,191,960,862	1,098,402,262	1,848,086,107	6,265,550,044
TOTAL COST PER YEAR	16,337,298,500	13,055,103,646	16,095,701,365	14,262,509,135	17,277,037,245	77,027,649,891

# SUMMARY OF THE COSTS PER FINANCIAL YEAR AND PER ACTIVITY/OUTPUT IN USD

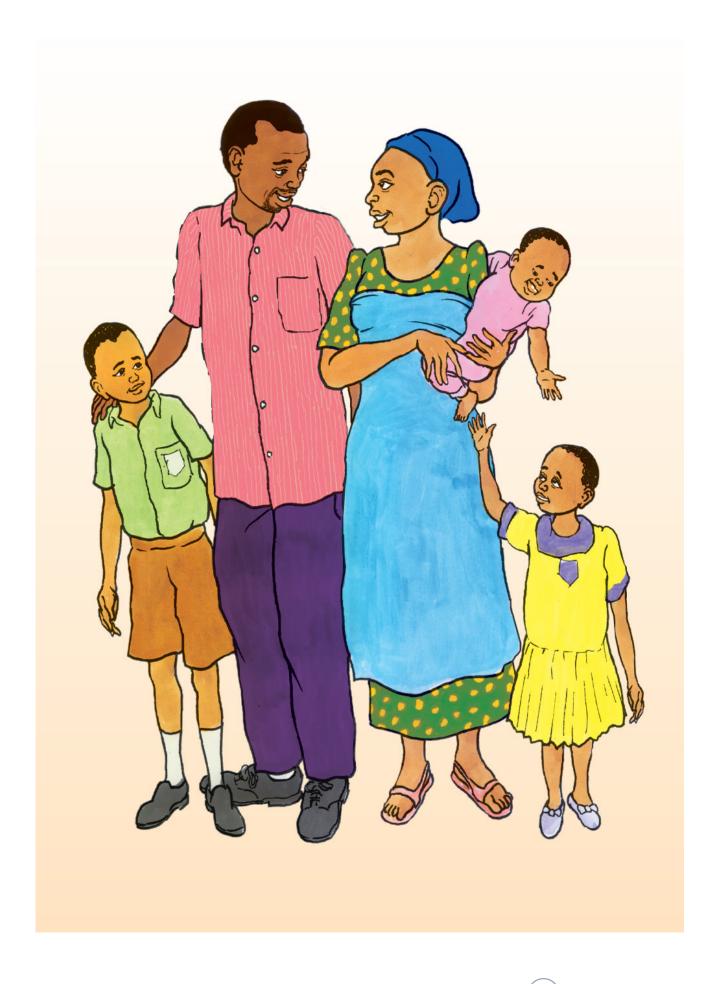
ACTIVITIES AND OUTPUTS TO BE CO	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	TOTAL COST PER AC
Policy briefs	363,985	388,697	396,743	448,694	271,003	1,869,122
Factsheets	57,430	60,216	62,599	964,896	67,193	312,334
Messaging briefs	24,331	25,511	26,521	767'484	28,468	132,326
IEC materials	162,747	170,640	177,394	183,904	190,414	885,099
In-person briefings	13,725	14,391	14,961	15,510	16,059	74,646
Information sessions	249,496	261,597	271,951	281,931	291,911	1,356,885
Roundtable meetings	159,379	167,109	173,723	180,098	186,474	866,783
Implementation guide	52,004	-	289'95	15,381	60,845	184,915
Stories of change (DVD.VCDs) Print	103,834	108,870	113,180	117,333	121,486	564,704
Training manual and User Manual	93,540	41,643	101,959	44,880	109,442	391,464
Job aides and user manuals (areas w	93,540	41,643	101,959	44,880	109,442	391,464
National SH conference (one at leas	174,292	-	189,978	•	203,922	568,192
Regional SH conferences (At least or	511,983	268,407	558,061	289,270	599,020	2,226,740
Mass media campaign	274,880	104,724	108,869	112,865	116,860	718,198
Digital media campaign	278,867	27,412	28,497	29,542	30,588	394,906
Outsource to media agency for deve	19,608	20,559	21,373	22,157	22,941	106,637
Community activations	815,325	854,869	888,705	921,318	953,931	4,434,147
Updating and maintenance of MOH	15,686	16,447	17,098	17,725	18,353	85,310
Endorsements (opinion leaders - rel	52,467	55,012	57,189	29,288	61,387	285,344
Popular versions of key policy docur	15,678	10,139	17,089	17,716	18,343	78,966
Youth events partnerships /sponsor	210,022	220,208	228,924	237,325	245,725	1,142,203
Roundtable meetings with leaders of	8,676	9,097	9,457	9,804	10,151	47,187
Annual, quarterly, and bi-annual rep	18,519	19,417	20,185	20,926	21,667	100,713
School activations	307,647	322,568	335,335	347,641	359,947	1,673,139
Media interviews	1,471	1,542	1,603	1,662	1,721	7,998
Learning events	26,536	27,823	28,924	29,986	31,047	144,316
FAQs	45,680	35,300	49,791	42,771	53,445	226,987
Operational Research	297,806	281,470	324,608	299,129	503,291	1,706,304
TOTAL COST PER YEAR	4,449,155	3,555,311	4,383,361	3,884,126	4,705,076	20,977,029

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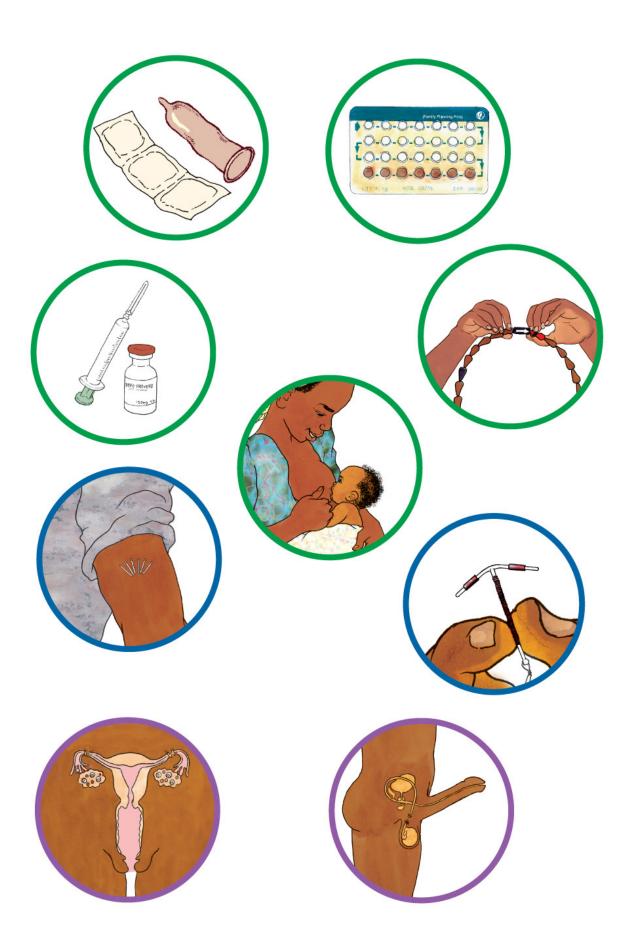
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# **Family Planning Methods**



# **CONTACT:**

The Department of Health Promotion, Education & Strategic communication

## **Ministry of Health**

Plot 6 Lourdel Road, Nakasero P.O. Box 7272 Kampala General telephone: +256 414 340874 / 231563 /9 http://health.go.ug/

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