A CASE STUDY OF REPRODUCTIVE HEALTH SUPPLIES IN UGANDA

POPULATION ACTION INTERNATIONAL

BY ELIZABETH LEAHY AND ESTHER AKITOBI

JUNE 2009
Population Action International uses research and advocacy to improve access to family planning and reproductive health care across the world so women and families can prosper and live in balance with the earth. By ensuring couples are able to determine the size of their families, poverty and the depletion of natural resources are reduced, improving the lives of millions across the world.
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LIST OF ACRONYMS

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<tr>
<td>CPTs</td>
<td>Contraceptive Procurement Tables</td>
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<tr>
<td>CRTU</td>
<td>Contraceptive and Reproductive Health Technologies, Research and Utilization</td>
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<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>DANIDA</td>
<td>Danish International Development Assistance</td>
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<tr>
<td>DFID</td>
<td>Department for International Development, UK</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DISH</td>
<td>Delivery of Improved Services for Health</td>
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<td>DSW</td>
<td>German Foundation for World Population</td>
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<td>DTC</td>
<td>Drugs and Therapeutic Committee</td>
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<td>EARHN</td>
<td>Eastern Africa Reproductive Health Network</td>
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<td>EDLU</td>
<td>Essential Drugs List of Uganda</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FPAU</td>
<td>Family Planning Association of Uganda</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FY</td>
<td>Fiscal year</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunizations</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis, and Malaria</td>
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<td>GOU</td>
<td>Government of Uganda</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HPAU</td>
<td>Health Policy Analysis Unit</td>
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<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IDP</td>
<td>Internally displaced person</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>IUD</td>
<td>Intrauterine device</td>
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<td>JAF</td>
<td>Joint Assistance Framework</td>
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<td>JMS</td>
<td>Joint Medical Stores</td>
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<td>JSI</td>
<td>John Snow, Inc.</td>
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<td>KIW</td>
<td>German Development Bank</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MMR</td>
<td>Maternal mortality ratio</td>
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Young people wait outside the Naguru Teenage Centre, which provides reproductive health supplies and other services. (Jennifer Johnson/PAI)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<tr>
<td>MSU</td>
<td>Marie Stopes Uganda</td>
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<tr>
<td>NDA</td>
<td>National Drug Authority</td>
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<tr>
<td>NMS</td>
<td>National Medical Stores</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>PAF</td>
<td>Poverty Action Fund</td>
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<td>PAI</td>
<td>Population Action International</td>
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<td>PEAP</td>
<td>Poverty Eradication Action Plan</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PPD</td>
<td>Partners in Population and Development</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>RAISE</td>
<td>Reproductive Health Access, Information and Services in Emergencies</td>
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<td>RH</td>
<td>Reproductive health</td>
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<tr>
<td>RHCS</td>
<td>Reproductive health commodity security</td>
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<td>RHD</td>
<td>Reproductive Health Division (Ministry of Health)</td>
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<tr>
<td>RHU</td>
<td>Reproductive Health Uganda</td>
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<tr>
<td>RMA</td>
<td>Resource Mobilization and Awareness</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SWAp</td>
<td>Sector-Wide Approach</td>
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<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<td>UAC</td>
<td>Uganda AIDS Commission</td>
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<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
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<tr>
<td>UHMG</td>
<td>Uganda Health Marketing Group</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNMHCP</td>
<td>Uganda National Minimum Health Care Package</td>
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<td>UPMO</td>
<td>Uganda Private Midwives Association</td>
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<td>URHAN</td>
<td>Uganda Reproductive Health Advocacy Network</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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A nurse demonstrates the medical supplies, including contraceptives, in stock at a rural clinic near Mityana. (Elizabeth Leahy/PAI)
BACKGROUND AND INTRODUCTION

This case study was produced by Project Resource Mobilization and Awareness (“Project RMA”), whose three organizational partners are Population Action International (PAI), the German Foundation for World Population (DSW) and the International Planned Parenthood Federation (IPPF). The Project is funded for the period from October 2006 to April 2010.

Project RMA partners operate at the global, regional and national levels, working in synchronicity with each other and with the project’s overarching goal, which is “to increase tangible financial and political commitment to sustainable reproductive health supplies through international coordination and support of national advocacy strategy development and implementation in developing countries.” Project RMA has three central objectives:

- Promote a supportive political environment for reproductive health (RH) supplies by enabling civil society organizations (CSO) and networks to engage in advocacy at the international and regional levels in a comprehensive and coordinated manner.
- Create a supportive political and financial environment for improving access to RH supplies at the regional level.
- Strengthen national level advocacy on RH commodities supplies in six partner countries in the global south.

The Project adopts the definition of reproductive health supplies established by the Reproductive Health Supplies Coalition, which is: “…any material or consumable needed to provide reproductive health services. This includes, but is not necessarily limited to contraceptives for family planning, drugs to treat sexually transmitted infections, and equipment such as that used for safe delivery.” Use of the term “reproductive health supplies” is intentionally broad in order to encompass the wide array of supplies necessary for quality reproductive health care, including and beyond family planning. However, the research provided in these six case studies focuses on contraceptives and condoms because of the historical priority placed on these supplies, as well as the challenges in monitoring and tracking the full array of other products and medications. Contraceptives and condoms are the hallmark of many family planning and reproductive health programs and are the primary emphasis of Project RMA’s advocacy efforts at the national, regional and global levels, but the full range of reproductive health supplies extends well beyond the specific commodities discussed in this report.

Uganda is one of six countries selected for inclusion for Project RMA-supported in-depth case studies, together with Bangladesh, Ghana, Mexico, Nicaragua and Tanzania. Countries were selected based on the potential derived from project partners’ work to coordinate country, regional and global level advocacy efforts. This paper, together with five additional case studies from other countries and information from other sources, provides an evidence base for national level advocacy. Each case study is written with generalist advocates in mind. These can include, but are not limited to, civic leaders, parliamentarians, faith-based leaders, and community leaders.

This report provides overview of how RH supplies, specifically contraceptives and condoms, are programmed, managed and funded in Uganda. It presents a distillation of information on policies, systems, budgets and key actors to help raise the awareness of experienced advocates—who may lack technical knowledge about contraceptives—so that they strategically choose advocacy actions and targets. This information should also facilitate collaboration and coordination with advocacy.
efforts at the global and regional levels. Information and issues from one country may be useful to other countries facing similar challenges.

Project RMA has identified four indicators by which to assess tangible results at the country level in contraceptive security. These are:

- the existence of a contraceptive supply coordination mechanism;
- the inclusion of contraceptives on the national essential drug list;
- a functioning government budget line item for contraceptive supplies; and
- the integration of contraceptive supplies into a financing mechanism.

This document provides information to help advocates understand aspects of reproductive health supplies in the specific case of Uganda. Every family planning program faces different conditions in ensuring contraceptive availability. For example, programs facing reductions in donor funding may be aware of supply constraints, but may not have convened stakeholders in a forum through which they can address these constraints. In other cases, family planning activities may become a lower priority as national officials cope with addressing the HIV/AIDS pandemic. Here, fostering understanding among leaders of the crucial role that RH supplies play in HIV programs is paramount.

A third scenario might be a government that is decentralizing or undergoing health sector reform; officials must anticipate and plan for how to ensure uninterrupted supplies and services as management is moved from the central to local levels. In addition to these structural issues, family planning may be controversial in certain settings. This is particularly true for some identified sub-populations such as adolescents and unmarried couples. Therefore, advocacy related to contracep-
tives may be more difficult than that for other public health issues such as maternal health. Linking family planning acceptance, continuation and contraceptive security to other maternal and child health outcomes or development and poverty-alleviation goals is an important tactic. Raising awareness and facilitating policy change at the country level requires carefully planned and informed strategies.

This report should be considered as helping to form a bridge between technical experts and advocates, informing the former about RH supplies and, for the latter, highlighting some key supplies issues that are ripe for advocacy. This and the other Project RMA case studies demonstrate to advocates seeking policy change how RH supplies issues can be used to raise awareness of policy needs that can positively affect reproductive health more broadly.

Uganda’s president, Yoweri Museveni, maintains a strong pronatalist stance, positing that a large population leads to power and economic growth.
The family planning movement in Uganda was launched in 1957 when the Family Planning Association of Uganda (FPAU) was established by a group of volunteers. At this time, FPAU was the only provider of family planning services in the country. In 1986, the government began including family planning in the primary health care package of the Ministry of Health (MOH). In 1995, the National Population Policy for Sustainable Development was introduced, reversing a previous requirement that married women receive permission from their husbands in order to use family planning services. While the Ministry of Health is supportive of reproductive health, and members of parliament have emerged as forceful advocates, such support is weak or nonexistent at the highest levels. Uganda’s president, Yoweri Museveni, maintains a strong pronatalist stance, positing that a large population leads to power and economic growth. Recently, a chairperson of the National Resistance Movement, President Museveni’s ruling party, in a district in northern Uganda spoke out in opposition to family planning, stating that family planning advocates “will not be tolerated,” and urged his constituents to have many children. Meanwhile, the newly appointed state minister for planning has speculated that Uganda’s rate of high population growth can

### TABLE 1. DEMOGRAPHIC INDICATORS FOR UGANDA

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<tr>
<th>Indicator</th>
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<tr>
<td>Population size (millions), 2005</td>
<td>28.7 UN Population Division</td>
</tr>
<tr>
<td>Population size (millions), 2025 (projected, medium-fertility variant)</td>
<td>53.4 UN Population Division</td>
</tr>
<tr>
<td>Population size (millions), 2050 (projected, medium-fertility variant)</td>
<td>91.3 UN Population Division</td>
</tr>
<tr>
<td>Population under age 15 (%), 2005</td>
<td>49.3 UN Population Division</td>
</tr>
<tr>
<td>Annual population growth rate (%), 2000-2005</td>
<td>3.2 UN Population Division</td>
</tr>
<tr>
<td>Life expectancy at birth (years), 2000-2005</td>
<td>48.1 UN Population Division</td>
</tr>
<tr>
<td>Total fertility rate, 2006</td>
<td>6.7 DHS</td>
</tr>
<tr>
<td>Contraceptive use among married women, modern methods, aged 15-49 (%)</td>
<td>17.9 DHS</td>
</tr>
<tr>
<td>Unmet need for family planning among married women, aged 15-49 (%)</td>
<td>40.6 DHS</td>
</tr>
<tr>
<td>Maternal deaths per 100,000 live births, 2005</td>
<td>550 WHO</td>
</tr>
<tr>
<td>Infant mortality rate per 1,000 live births, 2006</td>
<td>76 DHS</td>
</tr>
<tr>
<td>Population living below national poverty line (%), 1990-2004</td>
<td>37.7 UNDP (Human Development Report 2007/08)</td>
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</table>
be attributed to limited access to electricity, and suggested that infrastructure improvements would “lower the high population growth rate even without birth control measures.”

The 2006 Uganda Demographic and Health Survey (DHS) reports that from 1995 to 2006, the total fertility rate (TFR), the average number of children a woman will have in her lifetime, decreased only slightly from 6.9 to 6.7 children per woman. Of the eastern and southern African countries that have completed a DHS within the past ten years, Uganda has the highest TFR. Modern contraceptive use by married women remains very low, but has increased significantly from 8 percent to 18 percent over a ten-year period. This increase is due in part to the rising use of injectables, which currently account for 10 percent of modern contraceptive use. The second most common contraceptive method is the pill (three percent). Despite the upward trend in contraceptive use and nearly universal knowledge of modern contraceptive methods, unmet need for family planning is startlingly high at 41 percent among married women, the third-highest rate in the world. Table 1 highlights relevant demographic indicators.

The apparent discrepancy between knowledge and use of contraception may be attributed partially to cultural issues. Ideal family size among women decreased slightly from 5.3 to 4.8 children per woman between 1995 and 2000/01, but has risen again to 5.0 children in 2006; men currently prefer to have a family averaging 5.7 children. Twenty-five percent of women with an unmet need for family planning would like to space births compared to 16 percent who want to limit births. Uganda has a high maternal mortality ratio (MMR) of 550 deaths per 100,000 live births. The lifetime risk of maternal death is 1 in 25.
The Uganda case study was conducted using a two stage research process.

Stage One: Through an initial period of document review, Project RMA staff analyzed policy documents relevant to reproductive health programs and the associated supplies (detailed in section four). A review of each document identified the programmatic emphasis, goals and objectives of the activities described, and indicators of success.

Stage Two: In December 2007, April 2008 and March 2009, Project RMA staff interviewed key stakeholders including representatives of the Ministry of Health and other governmental agencies; donor agencies; and non-governmental organizations (NGOs) active in RH supplies (see Appendix One for a complete list of interviewees).
Despite disinterest and occasional opposition at high levels, Uganda has reasonable reproductive health policies that are currently being enhanced by the introduction of new strategies for contraceptive security and other issues. However, policy implementation is extremely weak. A perceived duality of concurrent support and resistance to family planning may explain the inconsistency between policy formation and implementation. In 1995, the Population Secretariat produced the earliest document in support of family planning, the National Population Policy for Sustainable Development, but some recent reports from the Secretariat emphasize the benefits of a large population.

Uganda’s policy framework is complicated by the rhetoric of President Museveni, who makes frequent statements espousing the benefits he perceives from a rapidly growing population. In a 2008 statement, he said “Uganda has got much more natural resources than [developed countries]. How can we fail to cope with a population of 30 million or the subsequent increases?”

Although First Lady Janet Museveni has affiliated herself with the cause of maternal health and has discussed the importance of birth spacing, strong support for family planning and a broader definition of reproductive health is lacking, not only among the presidential couple but also from other leaders. “What is missing is a serious and wide-ranging commitment from government,” one stakeholder summarized. Although there is no deliberate obstruction in family planning programs, except in the case of some individual providers and managers with contrary religious beliefs, the lack of political support has created an environment of malaise and fatigue among managers and policy-makers. The draft Roadmap for maternal health, prepared by the MOH, notes that “many contradictory arguments emerge from political and religious leaders about the role of family planning.”

Poverty Eradication Action Plan 2004/05 – 2007/08 (PEAP)

The PEAP, produced by the Ministry of Finance, Planning and Economic Development, was first published in 1997. It was revised in 2000 to meet the criteria of a Poverty Reduction Strategy Paper, a document that is required by the World Bank and International Monetary Fund in order to qualify for debt relief. The plan addresses gender inequality and a commitment to the Millennium Development Goals (MDGs). Family planning and reproductive health are linked to poverty in the discussion of the effects of the high fertility rate on individual families’ economic situation, and the effects of population growth on the country’s economic growth. A health services review reveals that reproductive health services have not improved, the contraceptive prevalence rate is too low, and there are stockouts of reproductive health drugs and supplies (although stockouts are not quantified). The PEAP suggests activities that will promote family planning in an effort to alleviate problems caused by the high fertility rate, such as providing family planning to three million couples annually.

Indicators for monitoring the PEAP include: lowering the maternal mortality ratio (target of 354 deaths per 100,000 births by 2007/08), raising the percentage of facilities without stockouts of various drugs, including the injectable contraceptive Depo Provera (target of 60 percent by 2007/08), and raising the percentage of demand...
Although there is no deliberate obstruction in family planning programs, except in the case of some individual providers and managers with contrary religious beliefs, the lack of political support has created an environment of malaise and fatigue among managers and policy-makers. 

The PEAP will be replaced by the five-year National Development Plan. A draft of the Plan could not be reviewed for this case study, but a list of proposed development objectives prepared by the Ministry of Finance, Planning and Economic Development included access to quality of health, family planning, and population growth and employment. 

National Health Policy, 1999
The focus of the National Health Policy, produced by the Ministry of Health, is on the implementation of the Uganda National Minimum Health Care Package (UNMHCP), which places great importance on sexual and reproductive health and rights. Sub-topics are antenatal and obstetric care, family planning, adolescent reproductive health, and violence against women, but there is no mention of ensuring access to RH supplies. However, RH commodities are part of the National Minimum Health Care Package.

Health Sector Strategic Plan 2005/06 – 2009/10 (HSSP II)
Developed by the Ministry of Health as a guide for short-term health sector operations, the HSSP II identifies the reduction of the MMR and TFR as priorities based on the UNMHCP. In addressing sexual and reproductive health, the strategy notes that family planning and emergency obstetric care needs are still largely unmet, and includes an increase in the contraceptive prevalence rate for all methods from 23 percent to 40 percent as one of the targets. As part of the strategy to combat HIV, a target is to improve access and availability of condoms to 100 percent.

Some indicators for monitoring the HSSP II are: the percentage of facilities without stockouts of various drugs, including Depo Provera, with a target of 80 percent by 2009/10; and the percentage of health units providing emergency contraceptives, with a target of 60 percent by 2009/10.

National Population Policy for Sustainable Development, 2008
The Population Secretariat in the Ministry of Finance and Economic Planning published this first revision to Uganda’s original 1995 population policy. The revision was designed to incorporate the commitments of the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs), 2002 national census, and other developments. 

The policy has 11 objectives related to: integration of population into development planning; monitoring of population trends; analysis of population trends; human capital development; improved nutrition, income and environmental protection; health seeking behavior; reduction of
unmet need for family planning; protection of vulnerable groups; urbanization; resource mobilization; and monitoring and evaluation. One of the strategies for the objective related to reduction of unmet need for family planning is to “promote reproductive health commodity security.” However, the objectives and strategies are not quantified with specific targets for contraceptive prevalence, stockout rate, or other indicators.

A Strategy to Improve Reproductive Health in Uganda, 2005 – 2010

This strategy was published by the Reproductive Health Division of the MOH in 2004 to align with the period covered by the HSSP II. The overarching goal of the strategy is to reduce Uganda’s maternal mortality ratio to 408 deaths per 100,000 live births by 2010 “through improved access to RH services, notably family planning and emergency obstetric care.” This goal is to be accomplished with improvements in the service provision of three areas: deliveries, family planning and antenatal care. In the area of family planning, the strategy aims to raise the contraceptive prevalence rate (all methods) to 50 percent by 2010, with an unspecified “reduction in contraceptive stockouts” as one of the projected outputs. The MOH is identified as the lead national-level agency for the strategy, with districts responsible for program implementation.

Uganda Reproductive Health Commodities Security Strategic Plan 2009 – 2014 (draft)

The development of Uganda’s first contraceptive security strategy was led by the MOH with financial support from the United Nations Population Fund (UNFPA). The draft version of the strategy contains eight strategic objectives related to policies, coordination, political and financial commitment, financing, commodity security, demand and utilization of services, logistics, and monitoring and evaluation. It specifies the assumptions and risks underlying its expected results, such as the assumption of continued and growing financial resources and the risk of political rigidity towards changing policies. Among the specific expected results of the strategy is a reduction in the projected contraceptive financing gap, currently estimated at 30 percent, to five percent by 2014 and development of a five-year RH supplies procurement plan.

The strategy estimates a total resource base of $52.7 million for implementation over five years, slightly less than half of which would be allocated to commodities based on levels of unmet need. Although the strategy does not assign resource allocations among government and donors, it does expect that the government contribution would increase from current levels. The Ministry is seeking technical assistance to develop a broader list of costed commodities, a monitoring and evaluation framework and an implementation and workplan for the strategy.


The objective of this strategy, produced by the Reproductive Health Division of the Ministry of Health, is to reduce the high levels of unmet need for family planning. The strategy highlights relevant supportive policies (PEAP, National Population Policy, and HSSP II), but notes that not much has been achieved in regards to their family planning and reproductive health goals. The advocacy recommendations include: public leadership and support, access to information, availability of commodities and supplies, access to services through integration, capacity for service delivery, and education for young people in school.


The second major advocacy strategy, produced by the Population Secretariat with funding from UNFPA, aims “to guide implementation of advocacy interventions targeting decision makers” and “provides a framework for identifying key issues in reproductive health, gender, population and development requiring actions on the part of policy makers.” The strategy identifies four focal areas: high unmet need for family planning, high infant and maternal mortality, resource shortfalls and inadequate adolescent sexual reproductive health services. Although one of the strategy’s goals is to ensure access to an “adequate variety of
family planning services,” it does not discuss reproductive health commodity security specifically, nor are its goals quantified. The target audiences of the strategy range from the Ministry of Health to local community leaders, but do not include external development partners.

**Adolescent Health Policy, 2004**
Uganda’s Adolescent Health Policy was approved in 2004 after five years in draft form and ongoing advocacy efforts by interested NGOs. Although the policy was not reviewed for this case study, stakeholders report that it highlights the need to increase access to contraceptives among young people as a critical issue, along with adolescent pregnancies, abortion and harmful traditional practices.

**National HIV & AIDS Strategic Plan 2007/8 – 2011/12**
The Uganda AIDS Commission produced this national plan to address the HIV/AIDS epidemic. Prevention of transmission is one of the three thematic areas of the plan, with a goal to reduce the incidence rate of HIV by 40 percent by 2012. The promotion of the ABC+ approach (“Abstinence, Being faithful, and Condom use with risky sexual encounters, plus other strategies to reduce sexual risk”) covers the use of condoms. The integration of family planning services and HIV/AIDS service delivery is a strategy to combat the high rate of mother-to-child HIV transmission. The annex includes four indicators that track condom use and availability, but the issue of ensuring condom supply security as a prevention strategy is not addressed in the body of the plan.

**Essential Drugs List of Uganda (EDLU), 2001**
Three methods of hormonal contraceptives are included on the EDLU: implants, injectables and oral contraceptives. However, they are not included on the national credit line of vital products.

The Roadmap was developed by the MOH and the World Health Organization (WHO) and also supported by UNFPA. One stakeholder reported that its first drafts included no discussion of family planning, but the current draft has three central objectives: improve antenatal and obstetric services, promote health seeking behavior, and ensure family planning information and services are available. It is considered a tool for mobilizing resources by including resource requirements and broadening responsibility beyond the MOH and donors. One of the key activities for the strategy’s interventions will be to “support logistics management for the right family planning commodities and supplies in the right times and right places.” Its targets include increasing the contraceptive prevalence rate (CPR) (all methods) to 35 percent in 2010 and 50 percent in 2015; and to decrease unmet need for family planning to 20 percent in 2010 and five percent in 2015.

**Condom Distribution Plan**
The MOH has a Condom Coordination Unit with a distribution plan designed to improve the supply chain for condoms between districts and facilities. Like contraceptives, condoms are integrated into the essential drugs credit line and distributed by the National Medical Stores (NMS).
While the public sector health system allows for coordination and thorough examination of health policies and programs at the central level, decentralization has given more decision-making power but also created more challenges for Uganda’s districts. Standards and processes that are developed at the national level in the Ministry of Health are sometimes unknown or ineffective by the time services are rendered at the district level. There needs to be greater accountability on the part of both central-level and district leaders to make sure national policies translate to district outcomes.

**CENTRAL LEVEL**

**Population Secretariat**
Founded in 1988 and housed in the Ministry of Finance, Planning and Economic Development, the Population Secretariat is a semi-autonomous government body tasked with coordinating the implementation of the country’s population policies across sectors at the central and district levels. The agency advises the government on demographic trends and advocates for the inclusion of population issues in policies, programs, strategies and resource allocation. The Secretariat also produces an annual report titled *The State of Uganda Population*, with support from UNFPA.

**Ministry of Health (MOH)**
The objective of the MOH is to establish policies and standards for health care delivery at all levels of the health care system. Its core functions include policy formation, resource mobilization, and monitoring and evaluation of health sector performance. The MOH coordinates stakeholders, research activities, professional training and employment processes to ensure the smooth operation and integrity of health care services.

**Health Policy Analysis Unit (HPAU)**
The Health Policy Analysis Unit of the MOH is the highest decision-making body on health care policy. This unit researches, analyzes, and formulates the policies of the various health sectors in keeping with the goals and standards of national policies. The HPAU evaluates proposed policies and advises sector leaders on policy changes.

**Reproductive Health Division (RHD)**
Housed in the Department of Community Health under the Directorate of Clinical and Community Services, this division is responsible for advancing the reproductive health interventions outlined in the Uganda National Minimum Health Care Package. RHD services include sex education, family planning, antenatal and obstetric care, and other efforts to ensure safe pregnancy and delivery. The RH Division chairs the RH Commodity Security coordination committee and a Maternal and Child Health technical working group tied to the HSSP.

**National Drug Authority (NDA)**
The National Drug Authority is the regulatory body for all medicines. It ensures the quality, safety, and efficacy of the drugs that are made available to the public. Commodities must be registered with the NDA prior to distribution in Uganda. The NDA inspects all health commodities before they are sent to various warehouses to be prepared for distribution. The inspection process includes the testing of imported condoms (except from the U.S. Agency for International Development) by a modern condom-testing unit to prevent expired condoms from being shipped to National Medical Stores.

**National Medical Stores (NMS) and Joint Medical Stores (JMS)**
The National Medical Stores is an autonomous body of the MOH whose purpose is to provide the country with affordable, good quality pharmaceutical products. NMS is responsible for the procurement, storage, administration, and distribution of drugs, medical supplies and equipment. It is charged with maintaining the level of drug and service quality mandated in the
National Drug Policy. The NMS manages the distribution of all contraceptives, including those procured independently by donors, to lower levels of the health system.

JMS is a parallel, equivalent agency to NMS which provides drug distribution services to faith-based and NGO health providers. Due to its link to the Catholic Church, it does not procure or distribute contraceptives and condoms.

Uganda AIDS Commission (UAC)
Established in 1992, the Uganda AIDS Commission coordinates responses to the HIV/AIDS epidemic. The UAC is responsible for formulating policy and mobilizing resources for the AIDS control program. The UAC does not implement programs; rather, it leads AIDS research and advocacy efforts and is instrumental in promoting the use of condoms and other forms of contraception that can prevent the transmission of HIV.

District Health Services
Uganda’s health services, as well as other authority and responsibilities, were decentralized to the district level through the Local Government Act of 1997. Each district develops a District Health Sector Strategic Plan that feeds into the district development plan. Districts are responsible for implementing health services, including family planning and reproductive health, using funds transferred to them by central level, which may or may not arrive on time or in full.¹⁶

There are 81 districts, each with two to eight health sub-districts. Each health sub-district has approximately ten health facilities under its jurisdiction. These sub-district health facilities are instrumental in increasing access to health services at the lowest levels. A district population officer has been established in all districts to incorporate population issues into district plans, working with economists and statisticians.

At the community level, members of village health teams, who make home visits, can provide pills, condoms and, in practice, injectables. The provision of injectables by village health team workers was tested in pilot projects implemented by the MOH, Family Health International and other partners, though this method is not yet reflected in official policy. Clients are referred to Level III health centers at the sub-district level for implants and IUDs (injectables are also available), and to Level IV centers at county level for permanent methods, which are provided by doctors.
FINANCING OF REPRODUCTIVE HEALTH SUPPLIES

It is difficult to determine spending on reproductive health broadly in Uganda due to the decentralized nature of the budget. Figures on spending for contraceptives and condoms are somewhat more clear, but disbursement lags significantly behind allocations for health in general and reproductive health supplies specifically in the public sector. Contraceptives are still largely funded through off-budget vertical support from donors.

HEALTH SECTOR FINANCING

Government of Uganda (GOU)
Financing of the health sector in the budget of the government of Uganda is drawn from a mix of sector support and the Poverty Action Fund (PAF). The PAF is a general budget support fund that pools resources to support the implementation of the Poverty Eradication Action Plan. These funds are targeted to both central and district levels, with districts developing their own health sector plans in line with the HSSP II. Government-supported contraceptives and condoms are funded through a PAF budget line item and are provided free of charge to districts. In addition, some donors maintain dedicated vertical funding off-budget; this modality provides a majority of the funding for RH supplies.

The GOU has cited increasing program funding from donors and the need to increase funding in other sectors as reasons for lowered government health support.\(^7\) Government support for health remains minimal; “between 50 and 70 percent of the MOH budget for drugs and services is provided by donor organizations.”\(^8\) For the health sector as a whole, supplies of medicines are less than half of required amounts.\(^9\)

Currently, there are no indications that government health spending will increase. In fact, data on health expenditures show a recent decrease in GOU support. In fiscal year (FY) 2004/05, the GOU devoted 9.7 percent of the national budget to health. This percentage decreased to 9.0 in FY 2005/06 and further still to 8.3 percent in FY 2007/08.\(^10\) According to a MOH official, the government contribution to health rose to 9.8 percent of the total budget in 2008/09. Despite the recent upward movement, this trend suggests a need for continued strong donor support. From 2005 to 2007, Uganda was among the top ten country recipients of donor support for contraceptives and condoms.\(^21\)

Uganda’s Medium Term Expenditure Framework sets strict budget ceilings that limit the funding that can be allocated to any sector. The budget ceilings were implemented in part to encourage greater country ownership and to create a balanced budget. But as a result, funds that are channeled through the health sector and the Poverty Action Fund compete with funds supplied through global initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI).\(^22\) The result is that the presence of external disease-specific funding can be detrimental and reduce the amount of internally generated funds for other health issues.

Joint Assistance Framework
A new Joint Assistance Framework (JAF) guiding donor contributions to the priority development areas of Uganda’s government began in the 2008/09 fiscal year. With a focus on performance and results, the government and its development partners agreed to include CPR as an indicator to measure the success of the framework. However, the agreed target for CPR among married women is a relatively unambitious 30 percent, including traditional methods, a level that currently stands at 24 percent as measured by the DHS. Progress towards the CPR target will be measured annually by the Uganda Bureau of Statistics (UBOS) with technical and financial support from UNFPA.\(^23\)
Government support for health remains minimal; “between 50 and 70 percent of the MOH budget for drugs and services is provided by donor organizations.”

**Sector-Wide Approach (SWAp)**
In 2000, the SWAp was introduced in Uganda as a way to improve coordination between the government and development partners. The donors who signed the Memorandum of Understanding (MOU) that enacted the SWAp are: the bilateral governments of Austria, Belgium, Denmark, France, Germany, Ireland, Italy, Japan, the Netherlands, Norway, Sweden, the United Kingdom and the United States; the African Development Bank, the European Union, the United Nations, the World Bank, and the World Health Organization. All donor funding is overseen by the Ministry of Finance and Economic Development, which then allocates money to each sector. The government and SWAp donors meet regularly to coordinate health sector policies through the Health Policy Advisory Committee and annual Joint Review Mission, while donors also meet in the Health Development Partners Group.

The successful funding of the SWAp is critical to the realization of the Health Sector Strategic Plan. In its early years, the Uganda SWAp had been widely cited as an example of a successful financing modality. In the Memorandum of Understanding for implementation of the HSSP II, the government has stated that its preferred funding mechanism is direct budget support.

Upon the signing of the MOU, the GOU took seriously its commitment to increase health spending and donors strove to provide budget support as opposed to program support. These efforts led to success in reaching targets set out in the first Health Sector Strategic Plan. However, a drawback of the SWAp is that donor funds that previously were earmarked for contraceptives and other reproductive health supplies are now pooled in one fund to support the general budget, and the amount of funding that is allocated to contraceptives is not guaranteed.

**Direct Donor Funding to Vertical Programs**
As in other countries, many donors in Uganda have shifted to sector and general budget support, but others continue to provide direct funding to vertical programs. This funding modality remains the mainstay for the U.S. Agency for International Development (USAID), which is unlikely to shift to country-driven mechanisms given concerns about accountability and transparency of government spending, as well as for UNFPA. Direct contraceptive funding from UNFPA and USAID represents approximately two-thirds of the total public sector budget for contraceptives. The government of Uganda is reportedly negotiating a financing arrangement from the African Development Bank that would in part support reproductive health.

**Global Initiatives**
The emergence of global health partnerships and initiatives such as GFATM, GAVI and the President’s Emergency Program for AIDS Relief (PEPFAR) is another factor in the shift from budget support to disease-specific program funding. These global funds place emphasis on health interventions that advance progress on the MDGs,
and donors are drawn to their targeted programs. The vast majority of donor support for HIV/AIDS in Uganda is provided by PEPFAR.27

Uganda has not maintained consistent funding from the GFATM due to the Fund’s concerns about mismanagement.28 After corruption issues prevented a Round 8 bid, the committee managing GFATM applications was disbanded and is currently being reformed.29

Contraceptive Financing and Coordination
Tracking funding for reproductive health is difficult given the decentralization of service delivery and budgeting as well as the shift toward health service integration. According to an official in the Ministry of Health, five percent of the health sector budget is targeted to reproductive health; another source reports a much higher ratio of 19 percent.30 The funds are sourced roughly equally from donors and government contributions from the Poverty Action Fund.31

Approximately 14 percent of the contraceptive need in Uganda is covered by government financing, including funds drawn from sector and budget support.32 The budget line item for contraceptives is supported by the PAF. In 2007/08, 0.7 percent of the government budget for medicines was spent on contraceptives.33 Since FY 2005/06, the Ugandan government has allocated approximately 1.5 billion Ugandan shillings (US$700,000) annually for reproductive health commodities.34 However, spending of the contraceptive line item has been low, with as few as two to six percent of the allocated funds disbursed. According to one government official, the 2008/09 contraceptive allocation was reprogrammed to immunization after GAVI withdrew funding from Uganda due to corruption concerns. The MOH prioritizes procurement of condoms, injectables, oral contraceptives and emergency contraception.

Total contraceptive funding from USAID is approximately $3 million annually, excluding condoms funded by PEPFAR, which account for another $2 million. USAID procurement, which has been dedicated to condoms, implants, injectables, IUDs and oral contraceptives, occurs through a central mechanism managed in Washington. UNFPA provides condoms, implants, injectables, IUDs and oral contraceptives.35 Table 2 highlights the value of contraceptive shipments to Uganda from 2004 to 2008.

The Ministry of Health has identified a 30 percent gap between contraceptive need and avail-
able funding. In light of the uncertain status of contraceptive financing and unstable government spending on health, the existence of a Reproductive Health Commodity Security (RHCS) coordination committee plays an important role guiding the future of RH supplies financing and coordination. The RHCS coordination committee is chaired by the Reproductive Health Division of the MOH and members include National Medical Stores, the Population Secretariat, the UK Department for International Development (DFID), the USAID | DELIVER Project, UNFPA, USAID, social marketing entities, and other important NGOs. This group maintains a stance of zero tolerance for contraceptive stockouts. The committee recently commissioned a situation analysis that identified six priority areas and fed into the development of the draft Contraceptive Security Strategy.

Another coordination body is the Family Planning Revitalization Working Group, started in approximately 2004 by the Ministry of Health and USAID. It is chaired by the MOH and intended to expand the mix of available RH supplies. The Working Group has been meeting irregularly, with most recent meetings in June 2008 and March 2009.

At lower levels, each district has a Drug and Therapeutics Committee (DTC) that is designed to coordinate procurement and distribution of all pharmaceuticals. Each district also has a population officer and a RH focal person.

**Linkages with HIV and AIDS Funding**

Family planning and reproductive health are rarely tied to HIV/AIDS other than through condoms, a dual protection method. Stakeholders report that the government counts external HIV/AIDS contributions against the health sector budget, leaving only a small amount of pooled and internally generated funding to support the wide range of other health programs. HIV and family planning have been kept parallel and separate, with political commitment from the government and donors often focused on HIV/AIDS.

Due to the mismanagement of HIV/AIDS funding, it is unclear whether efforts to improve contraceptive security will benefit from integrative HIV/AIDS/FP services. The government of Uganda deferred submitting a proposal with a large component of integrating family planning with HIV/AIDS activities for round 8 of funding from the GFATM.

### TABLE 2. CONTRACEPTIVE FUNDING BY SOURCE, VALUE OF SHIPMENTS, 2004-2008 ($US)³⁶

<table>
<thead>
<tr>
<th>Source</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
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<tr>
<td>USAID</td>
<td>$4,957,063</td>
<td>$4,490,535</td>
<td>$3,487,513</td>
<td>$3,214,432</td>
<td>$3,678,226</td>
</tr>
<tr>
<td>UNFPA</td>
<td>255,449</td>
<td>1,169,748</td>
<td>493,107</td>
<td>799,914</td>
<td>1,766,549</td>
</tr>
<tr>
<td>IPPF</td>
<td>8,134</td>
<td>15,326</td>
<td>10,370</td>
<td>11,483</td>
<td>9,383</td>
</tr>
<tr>
<td>KIV</td>
<td>164,088</td>
<td>164,278</td>
<td>192,017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>112,292</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,220,647</strong></td>
<td><strong>$5,675,605</strong></td>
<td><strong>$4,155,078</strong></td>
<td><strong>$4,190,108</strong></td>
<td><strong>$5,758,467</strong></td>
</tr>
</tbody>
</table>
At the 2007 meeting of the Eastern Africa Reproductive Health Network, RH advocates identified the uneven distribution system below district level and weak demand and utilization of RH supplies as main challenges in Uganda. Stockouts of RH supplies are widely described as common. Although there is an integrated distribution system, the government relies on external technical assistance for forecasting and the logistics data used for long-term planning are poorly maintained by facilities and unreliable. Logistics and procurement problems are more detrimental to the availability of RH supplies in Uganda than any limitations on funding.

Technical capacity of bureaucrats varies, with some describing the knowledge base on reproductive health in the MOH as outdated. At the facility level, institutional capacity needs great improvement, and MOH supervision is limited. As in many countries, there are too few health workers; in Uganda, many stakeholders report a low level of motivation among staff and a lack of passion to push for change. When orders don’t arrive on time, district officials may lack the time to track order status and follow up with the NMS. Given the scale of these logistical problems, it can be easy to overlook that contraceptives are essential medicines.

Stock quantities at central level are generally considered adequate, but there is a breakdown in the distribution system between central and facility level. Reproductive health supplies are listed at the end of the credit line order forms filled out by facilities. Because they are provided on a “third party” basis, there is no cost to districts to order them but also no financial benefit to National Medical Stores for supplying them. According to one stakeholder, such “third party” drugs are loaded last onto delivery trucks. A government official reported that poor management of stock recently forced NMS to destroy expired commodities worth 800 million shillings ($375,000), of which roughly one-quarter were contraceptives. Still, NMS at central level is not immune from shortages of supplies. In late February 2009, NMS was stocked out of one brand of implants and had an inventory of less than two weeks supply of Microgynon, an oral contraceptive, with the next shipment not expected until two months later. The stock levels of four other methods (condoms, a second brand of implants, IUDs and a second brand of oral contraceptives) were lower than the recommended six months’ supply.

Uganda’s health system is supplemented by faith-based facilities, which help fill the gap in the provision of services. This does not always apply in the case of RH supplies, however. If NMS is unable to provide commodities, districts can turn to the alternative Joint Medical Stores that supplies Catholic facilities. However, JMS does not provide contraceptives. In addition, some district drug orders are managed by individuals who will not push facility orders for contraceptives further up the supply chain due to their religious beliefs.

Forecasting
Annual forecasting for contraceptives occurs at the central level, led by the RHCS coordination committee, which meets quarterly to review stock levels and financial commitments. Contraceptive procurement tables (CPTs) for the forthcoming three years are prepared by the MOH with technical assistance from the USAID | DELIVER Project. The annual CPTs are used by MOH and donors to set funding commitments, which in turn determines annual contraceptive procurement.

Procurement
The MOH and its major donors of RH supplies, USAID and UNFPA, each handle their own procurement of contraceptives. UNFPA also offers a pooled procurement service in which government and international agencies can have access to the Fund’s volume discounted pricing in exchange for an administrative fee. USAID and UNFPA
together procure almost two-thirds of Uganda’s contraceptives.\textsuperscript{43} Unfortunately, donor coordination related to the delivery of commodities is still weak. While the MOH knows the quantity of contraceptives and condoms that need to be procured, the MOH is not always sure how much donors plan to commit towards the fulfillment of the requirements set out in the CPTs, and the timing of shipments is ad hoc.\textsuperscript{44}

Various challenges inhibit smooth procurement on the part of the National Medical Stores. Government funds are released quarterly, with none available for contraceptives and certain other non-emergency drugs in the first quarter until the annual budget is approved. The MOH typically makes a single large annual procurement in order to take advantage of volume pricing discounts.\textsuperscript{45} However, these delays in the release of funds reverberate throughout the system, as NMS is unable to process order requests from facilities until funds are available. Other major problems include “limited human and infrastructural capacity available at NMS as well as inadequate delegation of authority and poor allocation of funds to...NMS by government.”\textsuperscript{46} Together, these challenges create a situation in which “the MOH is extremely dependent on third-party procurement and when this procurement fails or is delayed, the result is major product stockouts.”\textsuperscript{47}

The transference of logistics information between NMS, districts and lower levels is spotty. Health facilities use integrated Health Management Information System (HMIS) forms to monitor consumption data. However, quantities of physical and recorded stock are often mismatched, and monthly consumption data reported from facilities to higher levels is often inaccurate.\textsuperscript{48}

\textbf{Storage and Distribution}

Formerly separate from essential drugs, contraceptives procured for the MOH are now a part of the essential drug distribution system. Contraceptives for the public sector are managed in a pull system, with sub-district level health facilities responsible for ordering contraceptives. There is a monthly stock review at the national level.

A 2006 survey found that the distribution of contraceptives to MOH facilities surpassed that of NGO facilities with 80 percent of MOH facilities having contraceptives in stock on the day of visit compared to 60 percent of NGO facilities. Condoms were in stock in two-thirds of both MOH and NGO facilities.\textsuperscript{49} This is promising given recent widespread limited condom availability due in part to condoms getting stuck at district levels. Annual tracking of the availability of essential drugs includes Depo-Provera (injectable contraceptive) as a tracer drug; its availability has varied widely in recent years, with 16 percent of facilities reporting a monthly stockout in 2006/07.\textsuperscript{50}

Many stakeholders report that stockouts of RH supplies are frequent, but primarily affect facilities. Although there are sufficient quantities at central level, one government official identified weaknesses in NMS that prevent supplies from effectively reaching service delivery points. These weaknesses include poor management, lack of long-term forecasting, and various transport issues, including too few vehicles and inadequate maintenance. While funding challenges remain, health systems strengthening is more critical, according to many observers.
The government relies heavily on its two major donors and their partners for financial and technical assistance. Many NGOs carry out work related to reproductive health and supplies and have moderate capacity, but their efforts are hampered by an unenthusiastic response from government officials, whose attention may be diverted by other health issues or who feel fatigue about reproductive health issues. The most promising champions for reproductive health supplies currently may be parliamentarians, whose support is mingled with a certain degree of budgetary authority. Still, stakeholders agree that new champions are desperately needed.

MULTILATERAL AGENCIES

United Nations Population Fund (UNFPA)
UNFPA has collaborated with the government of Uganda since 1987 and has been instrumental in the operation of maternal and child health and family planning programs. UNFPA funds training for reproductive health and family planning services, and is one of two donors of contraceptives (other than condoms) in Uganda. UNFPA provides a range of technical support services, funds a RHCS coordination position in the MOH, and has facilitated the development of advocacy policies related to FP/RH and the new contraceptive security strategy.

World Bank
From 2001 to 2006, the World Bank procured condoms for the MOH, through its Multi-Country HIV/AIDS Program for Africa. The Bank provided up to 80 million condoms for the public sector, which is the bulk of the average yearly requirement of 120 million condoms. During a four-year collaboration period with USAID DELIVER, the World Bank provided 160 million condoms to the MOH.51

World Health Organization (WHO)
The World Health Organization has served as a policy advisor, especially in the formation of the Essential Drugs List. The agency also drafted the new Roadmap to reduce maternal mortality. In the past, the WHO provided condoms through the Multisectoral AIDS Program.52

BILATERAL AGENCIES

Danish International Development Agency (DANIDA)
The Danish International Development Agency (DANIDA) has been active in Uganda since 1986 and directs the vast majority of its sector and budget support through the National Health Policy, with a small amount provided to hospitals. It has historically funded a large share of the National Medical Stores budget for drugs, and has also provided training and capacity-building to NMS. Its only vertical program support to the health sector is targeted to HIV/AIDS.

Department for International Development (DFID)
The Department for International Development (DFID) is the United Kingdom’s international aid agency. Its main funding purpose in Uganda is to support the implementation of the Poverty Eradication Action Plan (PEAP). Thus, it provides budget support for the government of Uganda to use at its discretion. DFID has also funded PSI condoms.

German Development Bank (KfW)
KfW is a German development bank that has historically provided funding to Marie Stopes International for LifeGuard condoms, although this is ending, as well as general budget support to the Ugandan government. Programs funded include Healthy Life vouchers which allow Ugandans from poor communities to receive STI treatment services.

U.S. Agency for International Development (USAID)
USAID has been a longtime supporter of family
The private sector provides the majority of contraceptives, accounting for 65 percent of the market.

planning activities in Uganda. It is the largest donor of contraceptives and manages the activities of multiple cooperating agencies (see below). Currently, it funds the AFFORD social marketing program, which markets contraceptives, condoms and MoonBeads, a traditional family planning product, and in 2009 is beginning a new five-year project on family planning service delivery. In the past, USAID funded the activities of PSI in addition to several projects including the Delivery of Improved Services for Health (DISH) and the Community Reproductive Health Project. According to a DELIVER report, USAID contributions for the purchase of contraceptives may decrease as UNFPA funding increases.

CIVIL SOCIETY/NGOs

The private sector provides the majority of contraceptives, accounting for 65 percent of the market. The bulk of this share is from the private medical sector. The remaining 35 percent market share of RH supplies is covered by the public sector. Civil society has an important role to play in improving availability and access to RH supplies among government and other sources.

Reproductive Health Uganda (RHU)
Formerly named the Family Planning Association of Uganda (FPAU), RHU is the International Planned Parenthood Federation (IPPF) member association in Uganda. Its mission is to ensure universal access to sexual and reproductive health. Established in 1957, RHU was the pioneer in providing family planning services in Uganda.

FPAU was officially recognized by the government and registered as a non-governmental organization in 1963, and became a member of IPPF the following year. The organization changed its name to Reproductive Health Uganda in 2007 to reflect a focus on providing comprehensive reproductive health care.

For the past fifty years, RHU has worked to empower women, reduce unsafe abortion, meet needs for family planning, increase access to youth sexual and reproductive health services and increase advocacy for reproductive health. Complementing government family planning services, RHU helps to expand access underserved populations. Services are delivered in 23 clinics, each operated by registered midwives. In addition to the staff at the clinics, RHU has a network of 260 community-based distribution agents. The agents are trained to provide services to continuing and new family planning acceptors. Through Project RMA, RHU is actively involved in RH supplies advocacy in Uganda, including engagement with the media, awareness-raising at district level and participation in the development of new policies and strategies.

Marie Stopes International (MSI)/Marie Stopes Uganda (MSU)
Marie Stopes Uganda and the Uganda country office of Marie Stopes International operate separate activities in Uganda as two different organizations under the Marie Stopes umbrella. Marie Stopes International focuses on social marketing of Life-Guard condoms for HIV/AIDS prevention, while
MSU maintains 16 clinics offering RH supplies in addition to mobile clinics and outreach teams that cover 85 percent of the country’s districts. MSU implements the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative to provide access to sexual and reproductive health services in emergency settings, including camps for internally displaced persons (IDPs) in Uganda. MSI’s Life Guard condoms comprise a majority of the condom market but their longtime funder, KfW, has withdrawn its support to focus on other sectors, and as of March 2009, the condoms were likely to be stocked out within four months. Two of MSU’s other donors, DFID and the European Commission, are also phasing out their contributions.

In late 2008, Ugandan First Lady Janet Museveni stated in a public speech that a U.S. government official had informed her that MSU was providing illegal abortion services in various countries, including Uganda. At approximately the same time, the U.S. government issued a directive banning the provision of any contraceptives funded by USAID from being directed to national affiliates of MSI, which seriously disrupted MSI’s services in six African countries, including Uganda. Because all contraceptives in the country are distributed through the National Medical Stores, fears of accidentally directing a USAID-funded shipment of supplies to MSI essentially froze the distribution of any supplies to the agency for months. In March 2009, two months after the Mexico City Policy/Global Gag Rule was overturned, USAID officially rescinded the ban targeting MSI.

**Population Services International (PSI)**

In 1998, Population Services International began work in Uganda, and PSI/Uganda was established in 2003. PSI/Uganda works with the MOH and community-based organizations to disseminate health services to rural populations, with some activities funded by DFID. PSI/Uganda supports social marketing and has marketed the Trust condom brand since 2006. Through funding from UNFPA, PSI is supporting the MOH in the development of a female condom programming strategy for Uganda.

**Uganda Private Midwives Organization (UPMO)**

Formerly the Uganda Private Midwives Association, the UPMO is a network of approximately 2000 midwives. In their private practices, midwives provide reproductive health, HIV/AIDS/PMTCT (prevention of mother to child transmission) and primary health care services. The midwives work to supplement the services offered by the Ministry of Health, operating according to the MOH Midwifery Standards. UPMO’s many outreach activities are funded by its partners, including USAID, UNFPA and EngenderHealth.

**Uganda Reproductive Health Advocacy Network (URHAN)**

URHAN was formed in 2006 as a loose network of organizations working on reproductive health and was originally funded by the Futures Group.
Its work has focused on youth-friendly services, including advocating for the publication of the Adolescent Health Policy, and now for its effective implementation. URHAN currently relies on the volunteered time and contributions of its members and is not externally funded.

Parliamentarians
Of the 102 female members of Uganda’s parliament, 40 are active in a network supporting maternal health. The network, whose members are often described as among the most vocal champions of reproductive health in the country, has worked with other organizations such as RHU to promote family planning at the district level. The network is also currently advocating for a budget line item for reproductive health within the health sector budget. Another related lobby group of parliamentarians is the Forum on Food Security, Population and Development, whose members receive training from the Population Secretariat.

USAID Cooperating Agencies

Center for Communications Programs
The Center for Communications Programs at the Johns Hopkins University Bloomberg School of Public Health leads AFFORD, a social marketing program funded by USAID. Its goal is to provide affordable health products and services in a wide range of areas, including HIV/AIDS and malaria. In 2008, AFFORD launched the Uganda Health Marketing Group (UHMG) to market a wide range of reproductive health supplies, including oral contraceptives, injectables, condoms, STI treatments and a traditional family planning method.

EngenderHealth
EngenderHealth has been working in Uganda for over 20 years. It served as the lead implementing agency on the ACQUIRE Project, which ended in late 2008. In Uganda, ACQUIRE focused on family planning revitalization at the national and district levels, obstetric fistula and strengthening the integration of family planning and HIV/AIDS prevention programs. Currently, EngenderHealth is implementing a five-year project on fistula in 10 countries, including Uganda, and continuing the family planning revitalization efforts in four districts.

Family Health International (FHI)
FHI implements the Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) project in five focus countries, including Uganda. The project’s work to improve access to existing contraceptives, especially long-term methods, has included advocacy with the MOH to allow community health workers to dispense injectables. FHI also provides training and capacity-building for FP/HIV integration.

Futures Group
The Futures Group is one of the five organizations working with CCP to implement the AFFORD project. Through the POLICY Project, in previous years the Futures Group implemented advocacy activities to strengthen the policy environment for reproductive health, raised awareness of the connections between population and other development issues and collaborated with the Population Secretariat and district officials.

John Snow, Inc. (JSI)
Since 2001, JSI has implemented the USAID DELIVER Project, which provides technical assistance to Uganda in the area of logistics systems, working to improve the delivery of health services for family planning, HIV/AIDS, tuberculosis and essential drugs. The DELIVER Project also provides technical assistance in the development of CPTs and contraceptive forecasting information.

Management Sciences for Health (MSH)
MSH is the lead implementing partner on USAID’s new major family planning, reproductive health and child health service delivery
project in Uganda, unnamed as of March 2009. The project will work for five years to bridge programming at the central and district level, with 15 focus districts.

Pathfinder International
Pathfinder has been working in Uganda since the 1950s, when it was instrumental in forming the country’s family planning program. Its work currently includes the Community-Based Family Planning Project, funded by an anonymous donor to train health workers, raise awareness among community leaders about family planning and equip health centers with RH supplies and improved water sources in eight districts in the northern region. USAID has funded Pathfinder projects to provide services to orphans and other children affected by HIV/AIDS, and other projects have been supported by UNFPA. In general, Pathfinder focuses on the conflict-affected regions of the north, where access to RH supplies is also especially limited, and has a number of programs targeting youth on issues such as unsafe abortion and capacity-building.
In addition to some specific issues identified in the above sections, the following advocacy entry points were gleaned from discussions with stakeholders in Uganda, and are based on recommendations for future advocacy around RH supplies that were solicited in interviews. However, these entry points should not be considered to prescribe or in any way direct the strategies and plans for advocacy devised by civil society organizations and others in Uganda.

Project RMA has identified four indicators by which to assess national readiness in contraceptive security. These are:

- the existence of a contraceptive supply coordination mechanism;
- the inclusion of contraceptives on the national essential drug list;
- a government budget line item for contraceptive supplies; and
- the integration of contraceptive supplies into a financing mechanism.

Uganda is an interesting case because of the contrast between policies supporting family planning and reproductive health and high level disinterest and sometimes, disapproval, of these issues. Advocates for RH supplies must be able to shape public opinion by successfully touting the benefits of family planning and the cultural acceptability of smaller family sizes. Although unmet need for family planning is extremely high, it is rarely vocalized, and only when demand is clearly articulated by communities will RH supplies be prioritized by MOH officials as important health commodities.

Stakeholders generally agree that financial resources are not the main constraint on improving access to RH supplies in Uganda. “With all the money we’ve had over the past years, we should have achieved results, but motivation throughout the health system is lacking, except for HIV,” one stakeholder reports. If no one holds the government accountable now, the chances for achieving a high-quality reproductive health program in the future diminish.

Even though unmet need for family planning in Uganda is among the highest rates in the world, few clients are pressuring the government for access to contraceptives. “If you’re not used to a service, you don’t ask for it,” one official explained. Another said that “people need to know it is their right to receive the services; it is not a favor.” Grassroots advocacy is uncommon in Uganda, and according to a recent situation analysis, “civil society is not empowered enough for RH commodity security advocacy.”

Opinions differ on whether to focus efforts on awareness-raising, gender and cultural issues and generating demand for RH services, or on strengthening the weak systems that impede delivery of such services. Commenting on Uganda’s high rate of unmet need, one stakeholder said “Advocacy without services is getting us nowhere. As we rally communities, we must empower them around working systems.” However, others express concern with the way that family planning is “packaged.” In Uganda, children are revered for various cultural reasons, and promoting smaller family size as a stand-alone message counters certain important social norms and can therefore be ineffective. Instead, linking access to RH supplies as part of a broader framework with other issues, such as health and human rights, may have greater resonance.
There is a Reproductive Health Commodity Security (RHCS) coordinating committee operating in Uganda with representation from government agencies, donors and NGOs. However, the RHCS working group is still developing a policy on contraceptive security. The draft strategy includes ambitious results and a quantification of resource needs, but does not delineate funding responsibilities among the government and its development partners. In order to promote government accountability for financing contraceptives and other reproductive health supplies, the RHCS coordination committee should lead the development of a financial sustainability plan for contraceptives.

Stockouts occur regularly, but the stock level of supplies at central level is widely described as adequate, and the process clearly breaks down at lower levels. Given decentralization in Uganda, district leaders may be best-positioned to press National Medical Stores on delivery issues. A recent contraceptive security assessment recommends that the RHCS coordination committee initiate regular meetings with district Drugs and Therapeutic Committees to formalize RH supplies coordination between central and lower levels. Currently, there is no formal mechanism for coordination of only RH supplies at district level. The contraceptive security assessment recommends that DTCs begin holding designated meetings for coordination of RH supplies, chaired by district health officers with ongoing implementation by district RH focal persons.

Three hormonal methods of contraceptives are included on the Essential Drugs List of Uganda: oral contraceptives, injectables and implants. To help ensure that procurement of contraceptives will meet increasing demand, the list should be expanded to include the full range of commodities on the World Health Organization’s inter-agency list of essential medicines for reproductive health.

In accordance with the National Health Policy, which states that the “government shall continue to allocate and spend an increasing proportion of its annual health budget (both domestic and external resources) for the provision of the [minimum health care] package,” there is an MOH budget line for contraceptives. As family planning is an important component of the

Opinions differ on whether to focus efforts on awareness-raising, gender and cultural issues and generating demand for RH services, or on strengthening the broken systems that impede delivery of such services.
Uganda National Minimum Health Care Package (UNMHC), there should be a continued effort to ensure adequate funding of the budget line for contraceptives. The current trend of government funding for the health sector shows that there has been a decline in health spending, and money allocated to the PAF budget line item for contraceptives remains mostly unspent or redirected. This pattern obviously is at odds with the National Health Policy, so steps should be taken to reverse the decreasing funding, at least until the Abuja Declaration commitment of allocating 15 percent of the budget to the health sector is met. Parliamentarians active in the maternal health network have already served as effective advocates, pressuring the government to be completely transparent about its contributions to FP/RH by threatening not to pass the health budget.

The issue of decentralization affects funding for RH supplies in addition to coordination. “One of the main challenges to ensuring commodity security and promoting a demand for family planning...is the problem of translating the national RH agenda into concrete action at district level.”\(^57\)

Given that supplies challenges are occurring below the central level, the decentralization of Uganda’s health system reinforces the need for targeted advocacy among districts and communities. Noting that no districts are currently using their own budgets for contraceptives, one government official stated that “advocacy at the national level doesn’t help women get the contraceptives they need.”

### 4 The integration of contraceptive supplies into a financing mechanism

Reproductive health, including access to supplies, is a priority area in Uganda’s Poverty Eradication Action Plan, which even sets a concrete target for the reduction of supply stockouts. Theoretically, RH supplies should be an integral component of the PAF supporting the PEAP and other health sector financing, but spending remains low. The government’s stagnant relative funding for the health sector may be a signal that it perceives donor funds to be protected and guaranteed: The government is well aware that “donors are not going to let commodities run out and are ready to step in when necessary.”\(^58\) However, the shift towards country ownership is already underway among many donors and the government is likely to face increasing responsibilities for financing Uganda’s development. Advocacy efforts could focus on strengthening government commitment to use its own resources for RH supplies, for example by ensuring the PAF contraceptive budget line item is fully disbursed.

Uganda is currently planning the development of a National Health Insurance Scheme. It will be critical to ensure that RH supplies are fully included in the list of covered services. In Ghana, for example, the recent roll-out of an insurance scheme that neglected contraceptives was a tremendous missed opportunity to expand access to services and supplies.
APPENDIX 1: INTERVIEWS AND CONTACTS

During three trips to Kampala in December 2007, April 2008 and March 2009, members of the Project RMA research team (Susan Anderson, Jessica Bernstein, Jennifer Johnson, Elizabeth Leahy, Kate Tibone and Carolyn Vogel, all of PAI) met with the following individuals. We are very grateful for the time and information each of them shared with us.

Dr. Angela Akol, Project Director, Family Health International
Hannington Burunde, Head, Information and Communication Department, Population Secretariat, Ministry of Finance, Planning and Economic Development
Dr. Henry Kakande, EngenderHealth
James Kotzsch, Country Director, DSW Uganda
Dr. Betty Kyaddondo, East African Reproductive Health Network
Mona Herbert, Advocacy and Communication Officer, DSW Uganda
Catherine Mbabazi, Nation Programme Officer, Monitoring and Evaluation Department, Population Secretariat, Ministry of Finance, Planning and Economic Development
Dr. Anthony Mbonye, Assistant Commissioner, Reproductive Health Division, Ministry of Health
Thomas Mega, Country Director, Marie Stopes Uganda
Hassan Mohtashami, Deputy Representative, UNFPA
Elly Mugumya, Executive Director, Reproductive Health Uganda
Paschal Mujasi, Deputy Chief of Party/General Logistics Advisor, JSI, USAID/DELIVER Project
Jotham Musinguzi, Partners in Population and Development, East African Regional Office
Moses Muwonge, National RH Commodity Security Coordinator, Ministry of Health
Grace Nagendi, FP-HIV Integration Coordinator, EngenderHealth
Hon. Nansubuga Sarah Nyombi, Member of Parliament (Ntenjeru North)

Peter Ogwang Ogwal, Programme Officer, DANIDA
Dr. Olive Sentumbwe-Mugisa, National Professional Officer, Family Health and Population, World Health Organization
Anne Sizomu, Training Manager, DSW Uganda
Hon. Sylvia Ssinabulya, Member of Parliament (Mityana District)
Dr. Krista Stewart, Social Science Analyst, USAID
Dr. Michael Strong, PEPFAR Coordinator, U.S. Embassy
Sereen Thadeus, Senior Technical Advisor, USAID/Uganda
Bernard Tusiiime, Senior Projects Coordinator, DSW Uganda
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