MAKING FAMILY PLANNING PROGRAMMES ACCESSIBLE TO ALL UNDER UNIVERSAL HEALTH COVERAGE

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Key Messages

- Advocating UHC for family planning shall equally require interventions for addressing gender and power relations regarding fertility decisions among diverse Ugandan cultures.

- UHC advocates can leverage the already high funding available for contraceptives, to address the existing gaps currently presented with other components (service delivery and access; policy and enabling government; contraceptive security; and demand creation) of the country's Costed Implementation Plan (2015 -2010) for family planning.

- For UHC to be realized for family planning, deliberate efforts will be needed around interventions for addressing the socio-cultural norms, which continue to constrain the promotion and uptake of family planning services at all levels, e.g. the technical and political leadership at national, local district and community levels.

- Reducing obstacles and reinforcing enabling factors through education and culturally-sensitive behavior change strategies has the potential to expand universal coverage for contraceptives use. Leaders in the education sector and in cultural institutions should encourage positive behaviors for fertility control.

- Since the government has stepped up funding for contraceptives, this should be followed with educational campaigns to clear any cultural myths and misconceptions about family planning methods. This will improve acceptance and continued use of family planning among eligible populations.

- The right economic and social conditions enabled South Korea to experience a demographic dividend that has since become a model for other developing countries, such as Uganda. Uganda will require deliberate efforts towards bringing high fertility rates down whilst simultaneously making direct investments in the already large youth population in order to attain a population dividend.

List of Acronyms

SDGs	Sustainable Development Goals
CFPIP	Costed Family Planning Implementation Plan
UHC	Universal Health Coverage
UDHS	Uganda Demographic Health Survey
WHO	World Health Organization
UNFPA	United Nations Fund for Population Activities
UNAIDS	Joint United Nations Programme on HIV and AIDS
IPPF	International Professional Practices Framework
PMTCT	Prevention of mother-to-child transmission of human immunodeficiency virus
FP	Family Planning
MOH	Ministry of Health
TFR	Total Fertility Rate
PRB	Population Reference Bureau
USAID	United States Agency for International Development
GDP	Gross Domestic Product
VHT	Village Health Teams

Background

More than 200 million women in developing countries desire to space or limit pregnancies but they lack access to family planning (FP) services. Moreover, of all women of reproductive age who are sexually active in developing countries, 57 per cent (867 million women) need access to contraceptive methods (1). Uganda has for long held a liberal policy on family planning, which states that all sexually active men and women should have access to contraceptives without need for consent from partner or parent. Nonetheless, contraceptive use remains low, and one of the lowest in the world. As the push for universal health coverage (UHC) gains momentum in Uganda, prioritizing FP promotion should be given particular attention. The use of family planning is one of the most cost-effective means to prevent maternal, infant and child deaths globally. It is estimated that through a reduction in the number of unintended pregnancies, one-quarter to one-third of all maternal deaths could be prevented (2). Other FP benefits have been reported to include reducing poverty, increasing gender equity, preventing the spread of HIV, reducing unwanted teenage pregnancies, and lowering infant deaths.

Uganda has made progress with FP, increasing the use of modern contraceptive methods by more than 50 per cent in a decade, from 24 per cent in 2006 to 39 per cent in 2016. However, there is much more to be done for the government to meet its goal of 50 per cent modern contraceptive use by 2020. While the total fertility rate has declined from 7.0 births per woman in 2000 to 5.4 births per woman in 2016 (3), it remains one of the highest in eastern and southern Africa. Many factors influence the uptake of FP, including access to correct information to help challenge socio-cultural norms that affect the acceptability of FP and the availability, accessibility and affordability of services.

Uganda's maternal health is reported to be among the worst in Africa, although there has recently been some noticeable progress. For instance, the maternal mortality rate went down from 435 deaths per 100,000 live births in 2010 to 368 by 2016 (4)(3). In the face of HIV and AIDS, preventing unintended pregnancy among HIV-positive women has been reported to be effective in reducing paediatric HIV infection and vital to meeting HIV-positive women's sexual and reproductive health needs (5). Contraceptive use for HIV-positive women is one of the cornerstones of preventing mother-to-child transmission of HIV (PMTCT), thereby reducing the number of children born with HIV and those orphaned by AIDS. In 2010, a research study by Herbert et al. reported that over 40 per cent of women with HIV in Uganda were not using any form of contraception. Each dollar spent on FP initiatives on average results in six-dollar savings on health, housing, water and other public services (6). Lack of universal access to family planning by adolescent girls has been cited as a major factor contributing to unwanted teenage pregnancy and maternal death in Uganda (7). In low- and middle-income countries, complications of pregnancy and childbirth are the leading causes of death amongst adolescent girls ages 15–19 (8).

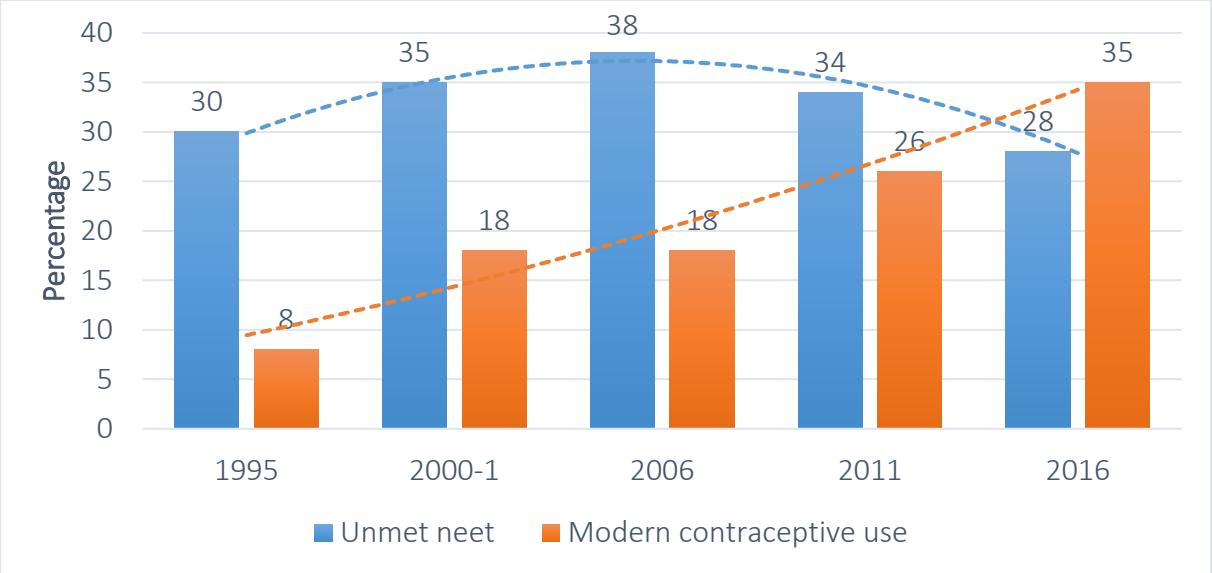
The unmet need for contraception in Uganda has been steadily reducing (from 41 per cent to 28 per cent), according to data from the 2010 World Population Data Sheet and the Uganda Demographic Health Survey (UDHS) of 2016. The 2010 world

population data indicated that only 24 per cent of married women aged 15-49 in Uganda were using modern contraception. This has since increased to 35 per cent, according to the most recent (2016) UDHS. In 2006, Uganda had a total fertility rate (TFR) of 6.5 and was ranked third highest in the world (9). By 2016 the TFR had reduced to 5.4, with a corresponding ranking of tenth country with high TFR globally. The country's population growth rate stands at 3.2 per cent per annum and ranks third highest in the world (10). Women without access to modern contraceptives have children too close together, have more unintended pregnancies, and are at greater risk of dying owing to complications during childbirth or unsafe abortion. Enabling universal access to contraception among Ugandan married couples will be key in preventing maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and unsafe abortions, and stop childbearing when they have reached their desired family size.

Trend in unmet need in Uganda

Today, more than 220 million women in developing countries have an unmet need for family planning. In reality, the number of women experiencing unmet need is likely to be much higher. Contraceptive needs can fluctuate owing to shifts in fertility desires that occur in response to changing life circumstances, such as entering a marital relationship or changes in household finances (11). Accordingly, women may pass in and out of unmet need, rather than experiencing it as a one-time event. The more we understand life's reproductive transitions, the characteristics of women with unmet need, and their reasons for not using family planning, the more we can improve family planning services and better meet the needs of women and men in Uganda.

Chart 1: Trends in unmet need and contraceptive use, 1995 - 2016



***Source*: UDHS 2016**

The proportion of Ugandan women who want to stop childbearing or who want to space their next birth is a crude measure of the extent of the need for family planning. This category of women is all exposed to the risk of pregnancy and some may already be using contraception. This section discusses the extent of the need and potential demand for family planning services. Women who are currently using a family planning

method are said to have a met need for family planning. Pregnant women are considered to have an unmet need for spacing if their pregnancy was mistimed or unwanted. Total demand for family planning services comprises those who fall in the met need and unmet need categories. This unmet need for family planning peaked in 2006 (38 per cent) and has since been on the decline, according to the most recent UDHS of 2016 (28 per cent). It is a promising situation that unmet need for family planning is reducing amidst increasing contraceptive use (3). For instance, the proportion of married women using modern contraceptive methods has increased from 8 per cent in 1995 to 35 per cent in 2016, according to the most recent UDHS. In line with universal coverage, unmet need for family planning and modern contraceptive use must be targeted simultaneously. Unmet need for FP is a more robust indicator of the contraceptive utilisation gaps since it focuses on the prevention of unplanned pregnancies among individuals who do not wish to have children at all and those who wish to postpone pregnancy for two or more years (3).

The 2016 UDHS demonstrates that Uganda is making progress in reducing the unmet need for family planning and in other indicators for contraceptive prevalence. Earlier surveys, such as the 2014 population and reproductive health national survey conducted by the Population Reference Bureau (PRB), showed that about one in three married women of reproductive age reported having an unmet need for family planning at the time of the survey. This translated into approximately 1.6 million women nationally. Moreover, about 60 per cent of these women wanted to space their next birth, and the other 40 per cent did not want to have any more children. The magnitude of unmet need may also be greater than that captured at the time of the survey. A new study revealed that among married women, about 50 per cent – an estimated 2.4 million women – experienced an episode of unmet need at some point during the previous five years. A quarter of those women (about 650,000) experienced two or more episodes (8). The “unmet need” for contraceptive use in Uganda was reported at 38 per cent in 2010, according to the World Data Sheet of the Population Reference Bureau. The 2010 world population data indicates that only 24 per cent of married women aged 15-49 in Uganda are using contraception (9). Of all developing countries with demographic health surveys (DHS) done by 2006, Uganda recorded the highest level of unmet need (12).

Uganda is currently ranked favourably and if the current trend of reducing unmet need can be sustained, this progress will translate positively on other related maternal and child health indicators. The unmet need for family planning contributes to unintended pregnancies and high birth rates, leading to large family sizes among households in Uganda. The situation is much worse for families in rural areas, who constitute 80 per cent of Uganda’s population. These rural families depend on subsistence farming, with land being the main source of livelihood, thus large families place excessive pressure on this resource. Most households do not have sufficient land to sustain their constantly expanding families (12).

The uncontrolled birth rate arising out of the unmet need for contraception puts women’s health at risk, gives rise to high morbidity and strains the health system, making the attainment of UHC a challenge. For every 100,000 live births in Uganda, there are at least 435 maternal deaths. This translates into 6000 maternal deaths annually, or 16 deaths daily. Equally high is the infant mortality rate, which is currently at 137 per 1,000 live births (UBOS, 2016). A study by the U.S. Agency for International

Development (USAID) suggests that satisfying unmet need can directly contribute to reductions in maternal and child mortality – averting an estimated 16,877 maternal and 1.1 million child deaths worldwide by the year 2015 (11). Abortion has been reported as another harmful consequence of uncontrolled births. A study by Ashford in 2003 estimated that 18 million unsafe abortions take place each year in less developed countries, in part due to unintended pregnancies. For more than 30 years, surveys conducted in Uganda asked women about their intentions regarding childbearing and the use of family planning services. A significant number of these women say that they do not want another child, yet many of them do not use any methods of contraception (13).

Therefore, meeting the challenge of decreasing the ever-high birth rate among Ugandan married couples calls for unceasing effort to engage with the government to draw its attention towards making family planning services available to married couples.

Ugandan married women (ages 15-49) are reported to increasingly prefer smaller family sizes and postponing their next pregnancy, although this stated preference has not resulted in an increase in the use of family planning services (4). A study comparing family planning trends in Kenya and Uganda suggested that Uganda's high level of unmet need was due, in part, to slow post-independence economic development and the relative late start of the Ugandan government's efforts to promote family planning (14). Individual, community and institutional factors do equally contribute to the low uptake of family planning services.

Socio-economic and cultural dimensions of family planning in Uganda

The social and cultural value of having children plays a prominent role, as having children is instrumental to the identity and social status of both men and women in most African cultures. "Social norms", defined as "widely shared beliefs and common practices within a particular group" (Jiang & Marcus, forthcoming, p.2), particularly the ideals of masculinity and femininity, often perpetuate inequality between men and women with regard to the desired number of children and the uptake of family planning services. In Uganda's context, these can be exemplified by social norms that grant men control and decision-making authority over women and resources; norms that place a lower value on women and girls than on men and boys; beliefs that a woman's purpose in life is childbearing; and social isolation that women tend to face in diverse cultural settings(15).

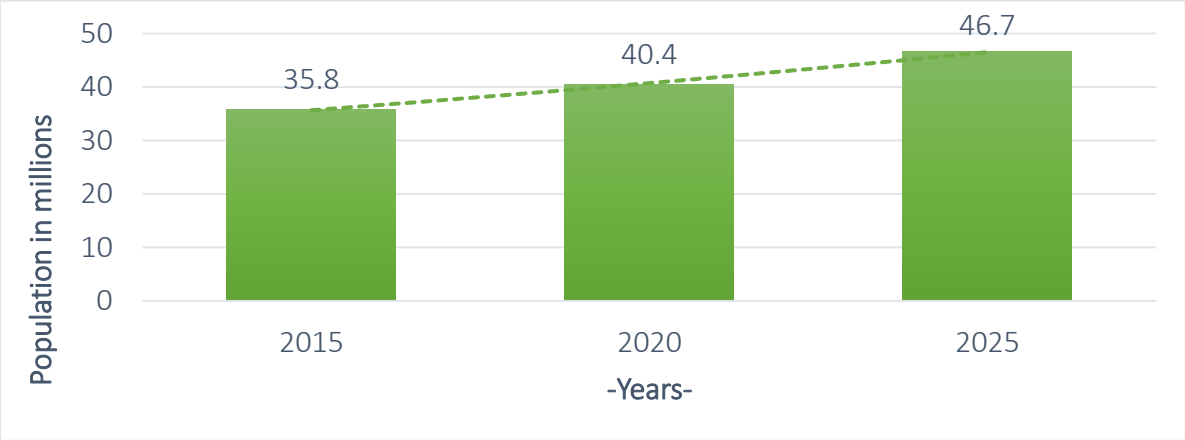
The system of patriarchal gender norms in Uganda (societies controlled by men) influences many aspects of family planning and the use of contraception, including: fertility rates; child marriage; use of safe abortion; family size; and sex preference (4). It is widely argued that research on reproductive health has tended to focus on women without addressing the role masculinity plays in contributing to gender inequities, and in putting men and their partners at risk of unplanned pregnancy (16). Family planning programmes that have selectively accommodated rather than challenged the prevailing gender norms have reinforced the idea that women are expected to fulfil reproduction expectations (17).

For family planning programmes to be effective under UHC, researchers argue that countries must integrate a gender perspective to address men and masculinities that can assure favourable community views about the reproductive rights of both men and women (17)(18).

Trends of Uganda's fertility rates

Based on the current fertility and mortality rates, Uganda's population is projected to increase from 35.8 million to 40.4 million during the period between 2015 and 2020 (PRB, 2016). This gives a growth rate of 3.03 per cent, which is a slight decline from the rate of 3.20 observed between 1991 and 2002. Uganda's high rate of population growth is mainly due to the high fertility levels (over five children per woman) that have been observed for the past four decades, combined with a faster decline in mortality levels, reflected by a decline in infant and childhood mortality rates as revealed by the Uganda Demographic and Health Surveys (UDHS) of 2006 and 2011.

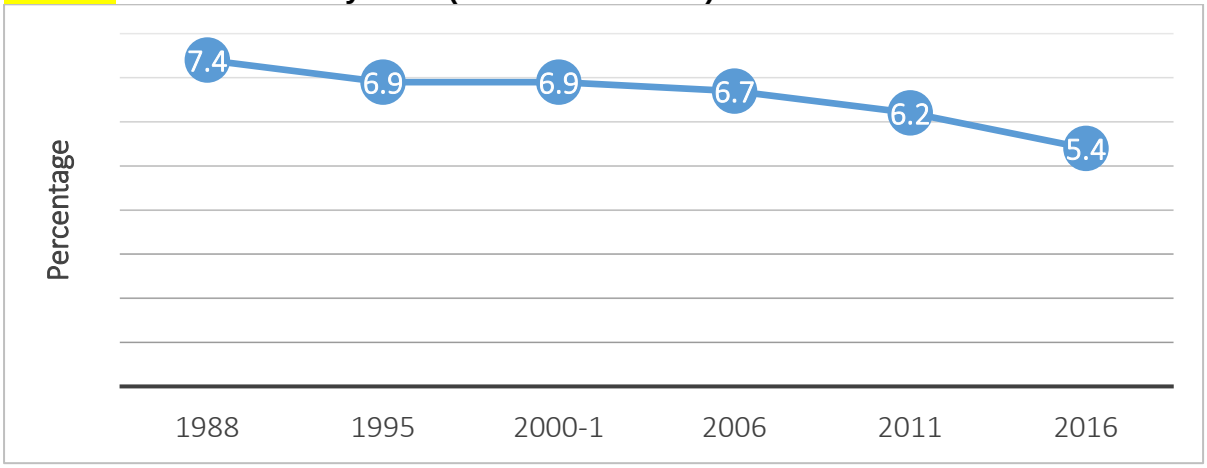
Chart 2: Uganda's projected population



Source: **World population data sheet, 2011**

The country's population growth rate stands at 3.4 per cent per annum and ranks third highest in the world (9).

Chart 3: Trends in fertility rates (UDHS 1998 - 2016)



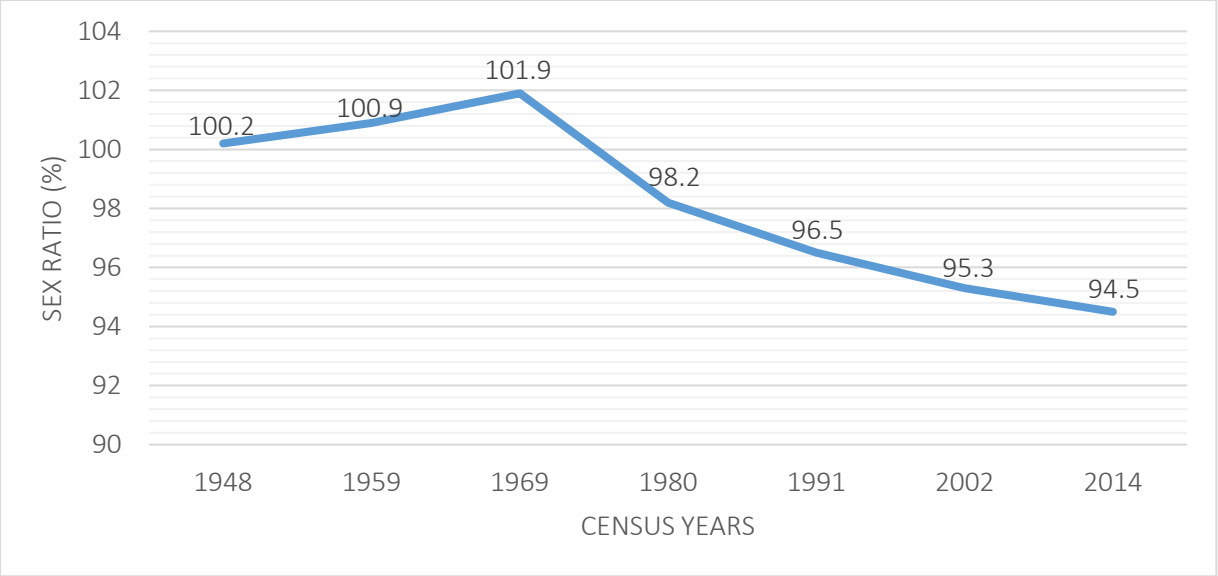
Source: **UDHS, 2016**

Trends in fertility in Uganda since the late 1980s can be examined by observing a time series of estimates produced from the country's demographic health surveys conducted over the last 30 years, from 1988-89 up to 2016. The TFRs for the six UDHS surveys since 1988-89 are presented in Chart 2 above. The data indicates that fertility in Uganda has been slowly declining since the 1980s and the period between 2011 (6.2) and 2016 (5.4) had a more dramatic decline than any other. This decline could be attributed to the recent shift in the political leadership's position on the promotion of family planning to address high fertility rates in Uganda.

Sex preference and family planning use in Uganda

Previous research has shown that family sex preference is associated with family planning use and couples' desire for more children (18). Ultimately, sex preference can be predicted based on a country's population sex ratio. The sex composition of any country's population is useful for understanding both the past and most recent trends of demographic dynamics. The numerical difference between sexes has a major effect on the demographic, social and economic importance of any country's economic growth and development. In 2014, there were 16.9 million males as compared to 17.9 million females (Chart 4) and a sex ratio of 94.5 males per 100 females. The overall sex ratio in Uganda took a rising trend between 1948 and 1969, reached the peak and has since been on a declining trend.

Chart 4: Trends in sex ratios (1948 - 2014)



Source: **Uganda Bureau of Statistics census data 2014**

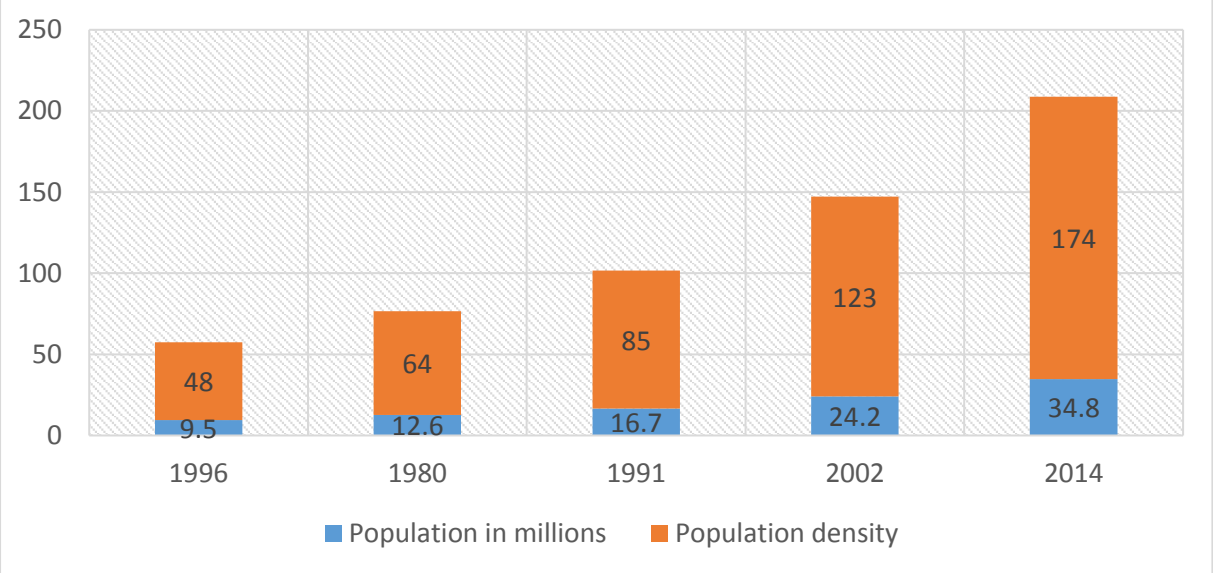
Realising UHC in Uganda's contexts requires addressing the ways in which gender distribution shapes the family planning needs of different communities and their ability to access services. For instance, sex preference, which refers to the attitude that one gender is more important and valuable than the other, impacts the demand for contraceptive services (18). Parents in Ugandan settings have a strong preference for sons over daughters, and they attach important cultural roles to the boy-child in part owing to a belief that only sons can assume certain roles, such as land inheritance and the perpetuation of the family name. These norms create a gap in using family planning especially among parents who have yet to get a boy-child. They also impact

on the uptake of health services for maternal and child health. The attainment of UHC in this context requires ensuring that efforts to support and rebuild the country's health system takes into account the cultural values that the Ugandan population attach to reproduction and the implications such beliefs have for the health system. To realise UHC, researchers ought to gather and disaggregate data by sex as a matter of good practice, regardless of whether sex or gender is perceived to be a factor. Once identified, inequities need to be recognised and addressed lest there is a risk of putting in place policies and programmes which are inefficient and discriminatory.

High fertility exacerbates population density

Population density, which is a measure of the number of persons per square kilometre of land area, has been intensifying over the last decades. Chart 5 shows that Uganda's population density was only 48 persons per square kilometre in 1969, but has since increased to 174, according to the 2014 national housing and population census. Uganda's sustained high fertility rate has had a direct bearing on the population density over the last decades.

Chart 5: Uganda's population density, 1969 - 2014



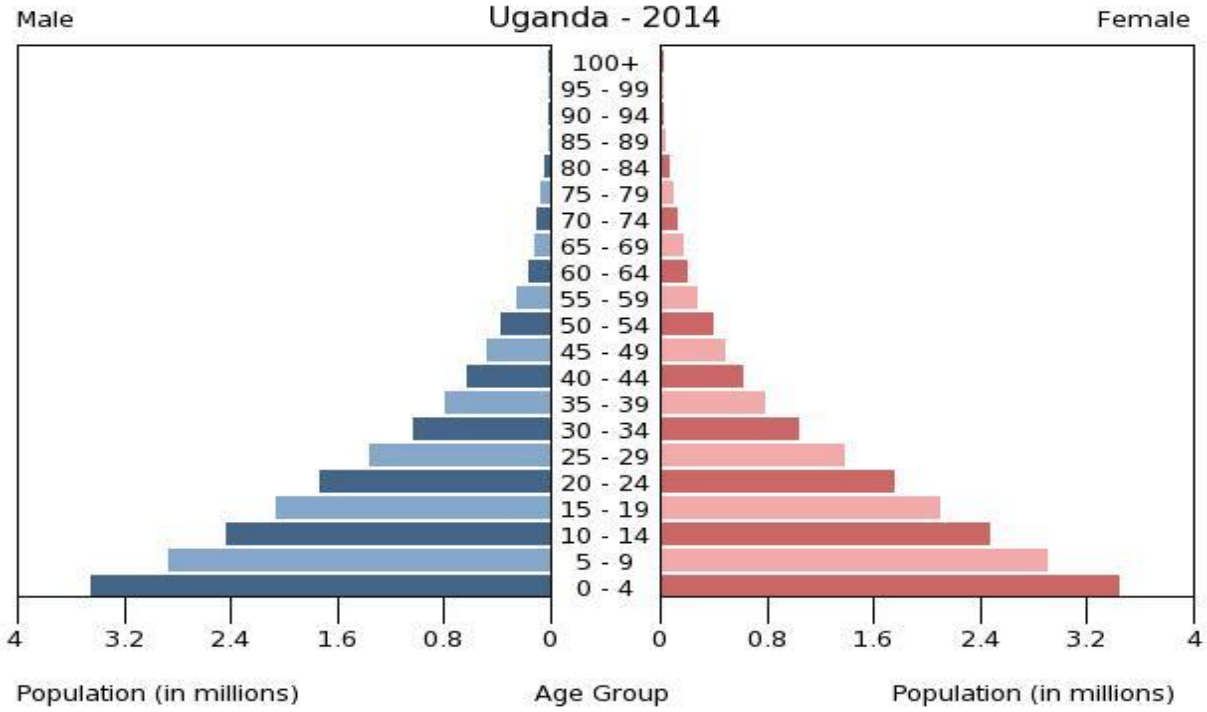
***Source*: World Population Data Sheet 2014**

Population density influences unique forms of health iniquities around population characteristics such as age, socio-economic status or poverty, geographical location, ethnicity, disability and sexuality. Populations from different socio-economic or ethnic groups can have vastly different experiences of the health system, which influences their access to health care, their treatment by health professionals, and their health outcomes. Population density affects the health workforce in terms of doctor-patient ratio, which is alarmingly low at eight doctors per 100,000 patients, according to the 2014 World Population Data Sheet. To respond to population density, UHC advocacy have to address health workforce issues pertaining to adequate production and supply of health workers.

Population age structure and the implications for the attainment of UHC

According to the 2014 national census, Uganda's population increased from 24.2 to 34.9 million during the period between 2002 and 2014, which represents an increase of 10.7 million over a 12-year period. This represented a growth rate of 3.03 per cent (Table 3.1.1), which was a slight decline from the rate of 3.20 registered between 1991 and 2002. Uganda's high rate of population growth is mainly due to the high fertility levels (nearly six children per woman) that have been observed for the past four decades, combined with a faster decline in mortality levels, reflected by a decline in infant and childhood mortality rates, as revealed by the Uganda Demographic and Health Surveys (UDHS) of 2006 and 2011.

Figure 1: Uganda's population structure



***Source*: Uganda Bureau of Statistics, 2011**

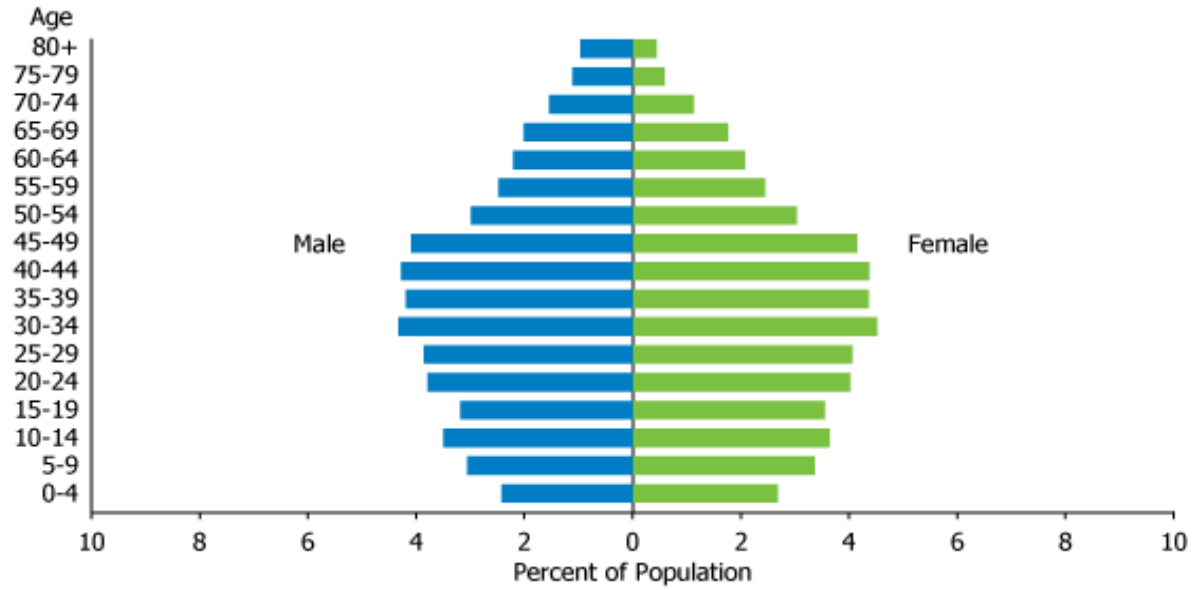
Uganda's population pyramid above helps put into perspective the country's demographic distribution of various age groups and gender. Estimated at 36 million, five in 10 Ugandans are children below 18 years, whereas two out of every 10 Ugandans are children below the age of five. As illustrated above, the population size that falls within economically productive ages (20–65yrs) is far smaller than that of dependent age groups (0–18yrs). A country whose population falls within productive age groups is synonymous with economic growth and development. Some demographers assert that populations that fall within the age group of 40 and above are normally the backbone of any economy's wealth creation. A large population of adolescents transitioning into adulthood stretches the economy, given the limited capacity for employment. Conventionally, youth bulges in developing countries like Uganda are associated with higher unemployment, both of which stem from low contraceptive use for family planning. In the light of UHC, Uganda has an enormous

challenge of providing equitable health to all its population, given the already high dependency syndrome arising from a population whose majority are below the economically productive age group (15–19).

Population dividend

The countries known as the "Asian Tigers" (Hong Kong, Indonesia, Malaysia, Singapore, South Korea, Taiwan and Thailand) are good examples of the economic growth that can be gained when a country deliberately rolls out programmes to reduce high fertility. South Korea, for instance, made a rapid transition from high to low fertility, while at the same time experiencing an annual growth in per capita gross domestic product (GDP) of 6.7 per cent between 1960 and 1990. A 30-year-long period of fertility reduction allowed South Korea to make significant savings, which were re-invested in sustainable reproductive health programmes, education and economic policies to create infrastructure and manufacturing. This resulted in a demographic ***dividend*** (the accelerated economic growth that originates from a decline in a country's mortality and fertility and the subsequent change in the age structure of the population) which placed South Korea on a sustained path of economic growth and development (19).

Figure 2: Lessons from South Korea's 2012 population age structure



Source: **Population Reference Bureau, 2012**

As illustrated by the South Koreas population dividend above, fewer births annually allowed the country's young dependent population to become smaller in relation to the working-age population. Given fewer people to support in the young age-groups, e.g. 0 to 14 years, South Korea realised a window of opportunity for rapid economic growth, which was harnessed through the development and implementation of social and economic policies, including investments at micro and macro levels. Literature indicates that South Korea's rapid demographic transition was a by-product of two well-timed changes: i) deliberate population policies which contributed to slower population growth and helped to create an age structure that facilitated the beginning of a demographic dividend; and ii) the resulting socio-economic change brought about

savings and investment, and the country ensured active women's participation in public service (19). The foresight to develop and implement such policies, plus the right economic and social conditions, enabled South Korea to experience a demographic dividend that has since become a model for other developing countries, such as Uganda. Uganda will require deliberate efforts for addressing high fertility rates, and skilling the population and creating economic conditions for growth in employment as a springboard to realise a population dividend.

Dimensions of family planning under UHC

A discussion of UHC within FP programmes requires the examination of three dimensions of FP services: i) which FP services are covered; ii) who is covered with FP services; and iii) what FP service costs are met.

Which FP services are covered?

FP information is universal – 98 per cent of all women and 100 per cent of all men know of at least one modern method of contraception (12). However, universality of information has not translated into universality of service availability and utilisation.

- Method mix among married and unmarried women is predominated by short-term methods, with injectables at 51.9 per cent for married and 38.7 per cent for unmarried women. Long-acting reversible contraceptives (LARCs) which are known to have higher effectiveness and continuity rate are low in usage – implants at 20.8 per cent for married women and 8.7 per cent for unmarried; and intrauterine devices (IUDs) at 2.6 per cent for married and negligible (1.2 per cent) for unmarried women. Variations in method mix mirror the differences in contraceptive availability. For example, nearly all public facilities had short-term methods (90 per cent injectables and 97 per cent male condoms) in stock compared to LARCs (67 per cent implants and 57 per cent with IUDs), suggesting wider coverage with less reliable short-term methods. The public-private sector divide is just as pronounced, with more public than private facilities tending to have FP methods in stock. These variations potentially exclude many, given that nearly half of FP users obtain methods from private sources, which are more likely to be out-of-stock; yet those who use public sources are unlikely to find the more reliable LARCs.
- Quality of care varies. Methods chosen by self or jointly is 92 per cent, suggesting that choice, a key indicator of quality, is universal. Nevertheless, only 61.7 per cent of FP clients were counselled on side effects and 60.8 per cent were told of other methods.

Who would be covered?

- Much remains to be done, especially with the youth and the poor. The adolescent fertility rate in Uganda is high, estimated at 139 births per 1,000 women aged 15–19; and 25 per cent of girls are parents or pregnant before the age of 18. Adolescents have higher rates of discontinuation of contraceptive methods than older women. Although the reasons for this are not fully understood, it is possible that they include providers' negative views about premarital sex or misconceptions about the use and suitability of long-acting methods for young women. The

consequences of teenage pregnancies vary with the location and context, but there are some common challenges. Up to 65 per cent of women with obstetric fistula develop this as adolescents, and unsafe abortion and its complications are most common among teenagers and girls under the age of 24 years.

- One in five sexually active or married women age 15-24 uses a modern method of contraception, compared to 34 per cent of all married women of reproductive age. Further, unmarried adolescent users of family planning are less likely to access family planning services from public facilities.
- Rural-urban and wealth disparities underline FP use in Uganda. About 20 per cent of the poorest women, compared to 45 per cent of the richest and 33 per cent of rural compared to 41 per cent of urban women are using a modern method of contraception.
- Sixty-five per cent of the population live more than five kilometres from a government health facility, and few trained health personnel are available in rural areas. Access to modern contraceptive methods is limited and the distribution chain is weak. The government sector provides contraceptives for nearly half of the users of modern contraceptive methods (47 per cent), mainly through the highest level of Ugandan clinics (health centre III or IV). Only 2 per cent receive services from such outreach efforts as Village Health Teams (VHTs), indicating an over-reliance on static facility-based services.
- Reproductive choice constitutes a key gender issue beyond maternal health. It enables women and girls to make decisions on health, education and employment. High overall fertility rates in general and high adolescent birth rates in particular are associated with gender inequalities. In Uganda, partner-opposition against contraceptive use has been highlighted as one of the major barriers to family planning use.

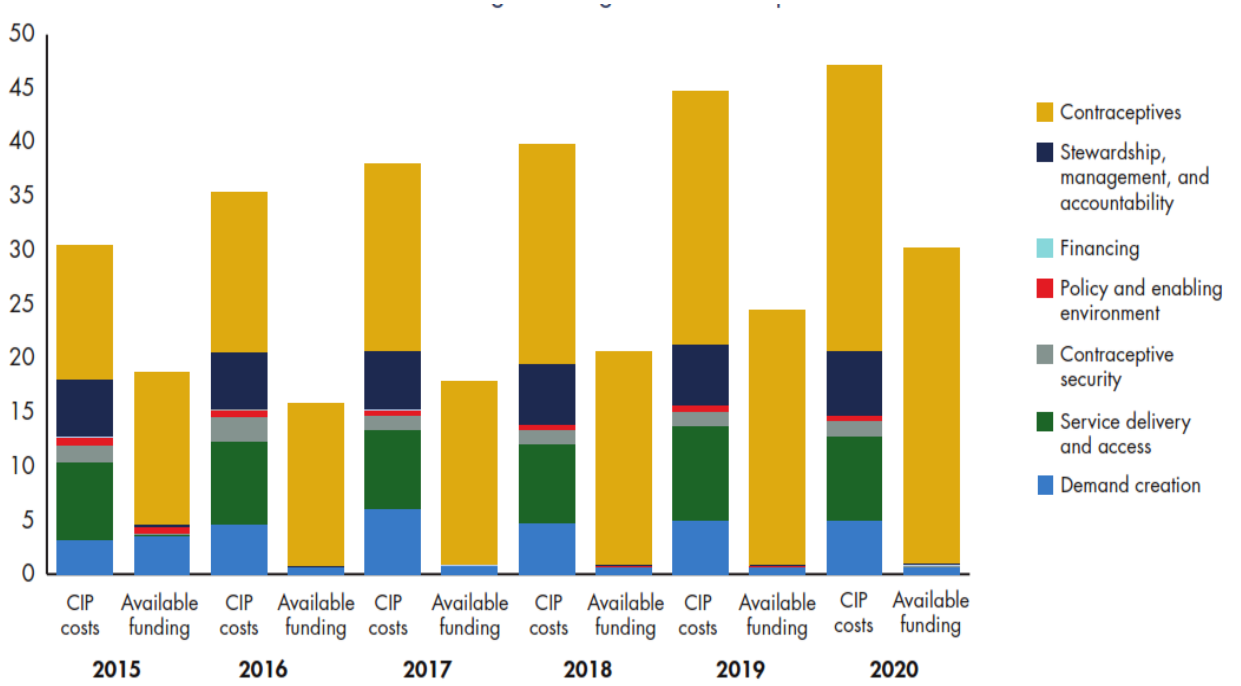
What FP costs are covered?

The Uganda Family Planning Costed Implementation Plan (FP-CIP) details programmatic activities and related costs for increasing modern method contraceptive prevalence rate (MCPR) from 27.3 percent to 50 per cent by 2020. The CIP estimates that between 2015 and 2020, the largest funding gap for FP – US$ 21.8 million – would be experienced in 2019. Service delivery and access, which comprises scaling up mobile clinics, retraining all VHTs, and creating youth corners at health facilities, has the largest gap in funding among all the thematic areas – only 3 per cent of projected activity costs are funded in the first year, and funding levels drop to about 1 per cent for the following years. Of the five CIP priority areas, task-sharing is the most underfunded, at 0.2 per cent funding. Contraceptive commodities are well-funded at 100 per cent or higher for all CIP years. The implication of these funding gaps is that whereas contraceptives are likely not to suffer shortages, Ugandan FP services are unlikely to achieve a holistic, rights-based approach that will include all sections of society without efforts at demand generation, task-sharing and improvements in service access and quality (7).

A five-year plan (2015–2020) dubbed “Family Planning Costed Implementation Plan” (CIP) was developed in November 2014 by the Ministry of Health (MoH) with the

objective of reducing the unmet need for family planning to 10 per cent and of increasing the modern contraceptive prevalence rate among married women to 50 per cent by 2020. CIP includes strategies to improve the following: demand creation; service delivery and access; contraceptive security that ensures safety standards and minimises side effects; policy and an enabling environment; financing; and stewardship, management, and accountability. The cost of the total plan is estimated at US$ 236 million between 2015 and 2020. The overriding goal of this plan is to increase the number of women in Uganda using modern contraception from approximately 1.7 million in 2014 to 3.7 million by 2020 (7).

Chart 6: Projected cost of the plan against projected available funding



***Source*: MoH – Costed Implementation Plan 2015 - 2020**

In 2012, the Ugandan president, who has for long spoken critically of family planning, made a U-turn at a London Family Planning Summit by pledging increased government funding. The funding for contraceptives has since remained high and is projected to increase for years ahead. As described in the FP-CIP, the Ugandan government and development partners have made significant contributions to funding contraceptive procurement in recent years, and there is robust coordination for commodity financing. As seen in Chart 6 above, the gap analysis found that contraceptives are more than 100 per cent funded in the first two years and remain at 95 per cent or above for the 2017–2020 period (7). Funding for contraceptives differs depending on the type, with implant contraceptives budgeted to receive the most funding (US$ 49.6 million between 2015 and 2020), in part due to the global push to scale up access to LARCs. Injectable contraceptives receive the second highest funding in the FP-CIP (US$ 40.7 million), as they are the most popular method preferred in Uganda. This is promising as far as the attainment of UHC is concerned.

Recommendations

- The attainment of UHC for family planning in Uganda has to first and foremost address gender-related power inequities, given how it exacerbates high fertility in many Ugandan cultures. Making family planning universally accessible will not be enough. Cultural norms which undermine women's role in choosing and using contraceptive methods must be targeted with education campaigns to raise awareness.
- Strategies to promote contraceptive methods targeting youth will be needed to impact behavioral change at an early age and empower the youth to better plan their future family sizes.
- There should be enhanced government efforts to bring down fertility rates while simultaneously investing in the current younger people's education and job creation for the country to realize a population dividend in the near future.
- Mainstream implementation of the FP policy, interventions and the delivery of services in multi-sectoral domains to facilitate a holistic contribution to social and economic transformation.
- Since the government has stepped up funding for FP contraceptives, this should be followed with educational campaigns to promote and nurture change in social and individual behaviours to address myths, misconceptions and side effects, and to improve the acceptance and continued use of family planning among eligible populations.

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