FAMILY PLANNING BUDGET ANALYSIS REVIEW REPORT UGANDA

FINANCIAL YEAR 2015/16

DSW (Deutsche Stiftung Weltbevoelkerung)

DSW is an international development and advocacy organisation. It focuses on achieving universal access to sexual and reproductive health and rights (SRHR), which is fundamental to improving health and fighting poverty. In addition, we monitor and influence political decision-making in areas relating to SRHR. DSW is partner of the United Nations Population Fund (UNFPA) and has consultative status with the United Nations Economic and Social Council (ECOSOC). With headquarters in Hannover, Germany, DSW maintains four country offices in Ethiopia, Kenya, Tanzania, and Uganda, as well as liaison offices in Berlin, Germany, and Brussels, Belgium.

CITATION

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ACRONYMS

SRH- Sexual Reproductive health

FP- Family Planning

DSW- Deutsche Stiftung Weltbevoelkerung

FY- Financial Year

ODA- Official Development Assistance

USD- United States Dollar

CSO- Civil Society Organisation

CIP- Costed Implementation Plan

USAID- United states Agency for International Development

UK- United Kingdom

DFID- Department for International Development

BCC- Behavioral Change Communication

PMTCT - Prevention of Mother -to -Child Transmission

ANC - Antenatal Care

NMS- National Medical Stores

LG- Local Government

SRHR- Sexual Reproductive Health and Rights.

EL- Euro Leverage

APR- A promise Renewed

NDP- National Development Plan

DHS- District Health Service

MCH- Maternal and Child Health

DHO- District Health Officer

MTEF- Medium Term Expenditure Framework.

UNMHCP- Uganda National Minimum Health Care Package

HSSIP- Health Sector Strategic Investment Plan

CMH- Commission of Macro Economics and Health

NGO- Non Governmental Organization

KCCA- Kampala City Council Authority

PHC- Primary Health Care

PNFP- Private Not for Profit

UHI- Uganda Heart Institute

UCI- Uganda Cancer Institute

UBTs- Uganda Blood Transfusion

ARV- Anti Retroviral

HC- Health Center

ACT- Antemisinin-based Combination Therapy

MoH- Ministry of Health

HCT- HIV/Counseling and Testing

SGBV- Sexual Gender Based Violence

STD- Sexually Transmitted disease.

GAVI- Global alliance for Vaccines and Immunisation

RHU- Reproductive Health Uganda

PC- Performance Contract

HDDP- Health District Development Plan

GoU- Government of Uganda.

EU- European Union

HIV- Human immune deficiency Virus

AIDs- Acquired Immune Deficiency Syndrome

FGD- Focus Group Discussion

VHT- Village Health Team

IUD- Intra Uterine Device

Acknowledgments

The budget review report on Reproductive health and Family Planning has been developed by DSW. The report was informed by National and district budgets, health sector budgets and work plans and other existing family planning /RH literature. It was also informed by Focus Group discussions by community members and interviews with district officials and national level government technocrats**.**

We appreciate the participation of the District Health Teams in the two districts on Kamuli and Mityana, the DHOs in the two districts: Dr Fred Lwasampijja from MItyana and Dr. Dinah from Kamuli. We further want to thank the health facility in charges who also played a big role in providing health facility budgets and works**.**

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1. Executive summary

The government of Uganda's efforts to scale up use of family planning methods is motivated by the knowledge that family planning helps women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing. More broadly, family planning improves maternal and child health, facilitates educational advances, empowers women, reduces poverty, and is a foundational element to our economic development

The government of Uganda has developed a number of policies and programs intended to address SRH/FP. One of the barriers today that affects FP programming is to ensure adequate finances to effect implementation of FP/health policies, alongside the effective use of available resources. Policy gaps identified along with the absence of cross sectoral planning and coordination hinder opportunities to consolidate health programming efforts such as FP.

DSW each financial year analyses government policies and budgets in relation to reproductive health and family planning. The analysis explored how the Uganda Government prioritizes Family Planning and supports the implementation of the policies to reach its chosen goals of having a quality population. It further explored whether the Government and development partners make the necessary investments to family planning at national and in two selected districts – Mityana and Kamuli. The analysis covered three financial years 2013/14, 2014/15 and 2015/16 with a particular focus on the 2015/16.

The analysis was done using quantitative trends and patterns were complimented with a qualitative understanding of the underlying budget allocations. This allowed us to get quantitative findings with input from district officials and community members through focus group discussions. In this way the quantitative budget analysis was integrated with qualitative work that focused on identifying reproductive health/family planning spending at national and district level.

DSW reviewed and analyzed the health sector budgets and work plans both at the national and district level and was able to derive some figures on reproductive health/family planning. The demographic transformation if prioritized contributes to structural changes in the country.

The enabling environment for family planning in Uganda exists. Polices have been put in place to ensure that family planning and sexual reproductive health is implemented policies include the Sustainable development goals, the national development plan phase II, vision 2040, the National population policy, the national health policy, the health sector strategic plan, the costed implementation plan for family planning , the adolescent reproductive health policy**.** In 2013 government launched the Reproductive, Maernal, Newborn and child health (RMNCH) sharpened plan which was geared to act on the slow progress of MDG 4[1] and 5[2]. This has been emphasized in SDG 3[3].

The total national approved budget FY 2015/16 is Shs 23,972 billion and external financing is equivalent to Shs. 5,649 billion in grants and loans. An increase of 8,267bn was realized. FY 2015/16 Budget focus is mainly on the National Security and Defense, Private Sector Enterprise Development and health comes fifth with 1,270.8 billion FY 2015/16. Other sectors include: Security Sector with 1,632.89, 479.96 billion for the agriculture sector, and 30.8 billion for Tourism 3,328.79 billion for the transport sector and 547.3 billion was approved for the Water and Sanitation sector.

The total health sector approved budget FY 2015/16 stand at 1,270.8billion which is 5.3% of the national budget. There has been a reduction is the % share from 8% FY 2014/15 to 5.3% FY 2015/16. This is still below the Abuja declaration of 15%.

Official development assistance (ODA) to Uganda by 2013 consists of disbursements of loans made on concessional terms (net of repayments of principal) and grants by official agencies of the members of the Development Assistance Committee (DAC), by multilateral institutions, and by non-DAC countries to promote economic development. The United States in 2013 increased its general assistance to Uganda by 59.209324 million USD, the United Kingdom increased by 6.0777 million USD. United States still stands as the biggest funder of family planning in Uganda followed by United Kingdom.

[1] Reducing two thirds of under five mortality rate

[2] Reducing three quarters of maternal mortality ratio and achieving universal access to reproductive Health by 2015.

[3] Ensure Health lives and promote well-being for all at all ages.

The reproductive health budget increased by 82% at the national. The increase was attributed to a number of components under maternal, new born and child health. These include: maternal deliveries, immunization, ANC, abortion care, PMTCT, construction of maternity wards which hold big budgets. This was the same case at district level. Family planning is 9% of the reproductive health budget at the national level, which is mainly brought by the reproductive health budget line under NMS. Family planning is 1% in Mityana district and 2.45% in Kamuli district of the reproductive health budget. Financing for family planning is not clearly reflected in both the district and national budget.

The health facilities in the two district of Kamuli and Mityana do provide family planning**.** They receive commodities according to the health facility standards. The general hospital and health center IV in kamuli provide all FP services including youth friendly services, health center threes provide all apart from the long term methods because they do not have operating theaters. Health center IIIs in Kamuli district provide youth friendly services. Health center IIs provide pills and condoms.

In Mityana district, the general hospital provides 35% of FP services. Private facilities in Mityana have also contributed to bringing FPO services closer to the people. Reproductive Health Uganda in Mityana provides all FP services apart from cycle bids but also reaches a huge number of people compared to general hospital.

These health facilities are at least equipped with 2 nursing professionals and mid wife. However there is more need to recruit more skilled staff in these health facilities to provide FP services.

Recommendations

a. The allocation formula for LG grants should be revised to address reproductive health and family planning funding.
b. Health workers need continuous capacity to provide family planning services
c. Need for comprehensive dissemination and sensitization on family planning to the community
d. Civil Society organizations need to enhance advocacy at national level towards ensuring that the central government priorities family planning funding in its releases to local governments.

e. Districts should be engaged on a continuous basis to ensure that they prioritize family planning within their work plans and budgets.

1.1 Introduction

DSW Uganda is; a partner development and advocacy organization with a focus of achieving universal access to sexual and reproductive health and rights (SRHR).Its goals contribute to increased access to SRHR services, information and supplies in Uganda, to integration and prioritizing of SRHR within national health programme and to empower and improve young people's health and socio-economic well being.

Under the EL project, DSW focuses on improving effectiveness of interventions at each level by ensuring that stake holders are working from the best collective knowledge to affect the policy and funding decision making processes. In order to achieve the above, DSW ensures that target groups place FP on the national agenda and work to increase FP allocations from respective budgets. Budget tracking is one of the methods used to get information on FP financing to inform advocacy engagements at all level

The EL project is implemented at the National level and in two districts of Kamuli and Mityana. In each district, DSW operates in 4 sub-counties. Some of the activities implemented include: Civic education- dialogues with community and decision makers at district level are held to provide opportunity for engagement. Documentation of lessons –impact stories, engage with CSOs regarding funding for family planning and technical assistance, engagement with FP champions ,Policy and budget reviews, engagement with relevant ministries: Ministry of health, Education and gender of family planning and adolescent reproductive health.

2. Policy Analysis on family planning

Uganda has made more policy moves and plans to increase contraceptive use. Government realized that lowering fertility and child mortality rates will help to harness the demographic dividend for economic growth as outlined in Vision 2040.

The country signed into law the long-awaited National Population Council bill in June 2014. The law will create a new government body—the National Population

Council—to oversee the country's population, reproductive health and family planning policies.

At Uganda's first National Family Planning Conference, held in July 2014, President Museveni announced his endorsement of family planning as a key strategy for accelerating social and economic transformation. These are big wins, with national—and international—repercussions.

The country has then made a big ticket win by developing the Family Planning Cost Implementation Plan 2015-2020 (CIP) with the ministry of Health, United Nations Population Fund and the United States Agency for International Development (USAID) and UK Department for International Development (DFID).

2.1 Commitment at the London summit 2012/ FP2020

The President of Uganda, His Exellence Yoweri Kaguta Museveni reinforced the strengthening of NMS. A budget line for reproductive/FP supplies under NMS was developed and it is worth 6.9 million dollars. *However government funding for SRH/FP resources to support the demand side, including BCC intervention is still very low.* Distribution of commodities to the public and private health delivery units requires strengthening.

2.2 The National advocacy strategy 2013-2022: the strategy intends to contribute to the realization of the National Population Policy 2008 and National Policy Action Plan 2011-15. The strategy addresses inadequate prioritization and budget allocation to RH and child health, inadequate uptake for RH commodities and services by women , men and communities, limited access to reproductive services by young people and inadequate behavior change and information education and communication interventions.

2.3 The Family Planning costed Implementation plan 2015- 2020

The FP CIP provides national guidance towards attainment of increased knowledge of and access to family planning interventions. In summary, the FP CIP aligns it's self to several national frameworks, including the Committing to Child Survival: A Promise Renewed, 2013, and Uganda's Vision 2040. The plan emphasizes key strategic priorities that will enhance the achievement of our

Objectives:

- Increasing efforts to reach all young people
- Developing a national social and behavior change communication strategy with harmonized programme efforts
- Implementing task sharing amongst health care workers to increase access to rural and underserved populations. so as to scale up service delivery
- Mainstreaming family planning in a multi sectoral manner to improve policy, interventions, equity, and implementation
- Ensuring FP commodity security across the public and private service delivery point[4]

2.4 Promise renewed: In 2012, Uganda joined other nations and committed to a renewed promise to end preventable deaths among mothers, newborns and children, under the "A Promise Renewed" (APR) initiative. Ministry of Health with support from World Vision is in plan of rolling it out in all the districts of Uganda.

2.5 Vision 2040: Uganda's population is largely young and this reality informs the country planners that investments in this young population can be one of the major ways to ensure future economic, social and political stability. Uganda's Vision 2040 strongly reflects this reality and will focus on harnessing the demographic dividend as the strategy of benefiting from the country's abundant young population.

2.6 The National Development Plan II (NDP)

The NDPII under health and family planning addresses the unmet need of family planning on prioritizes reduction of barriers to demand, access and use of family planning

2.7 Health sector strategic plan III

The Division of Reproductive Health at the MoH is responsible for the development of policies as well as providing overall coordination and guidance of Sexual reproductive Health (SRH) activities. It is also in charge of provision of technical support to the District Health services (DHS). The division works through the MCH

[4] Family Planning costed implementation Plan 2014/15 to 2019/20

cluster to engage various stakeholders in the planning, monitoring and evaluation as well as approving SRH policies, strategies and standards. The responsibility of implementing SRH policies and interventions lies with the District Health Officers (DHO) together with CSOs and health care providers at delivery points within the districts

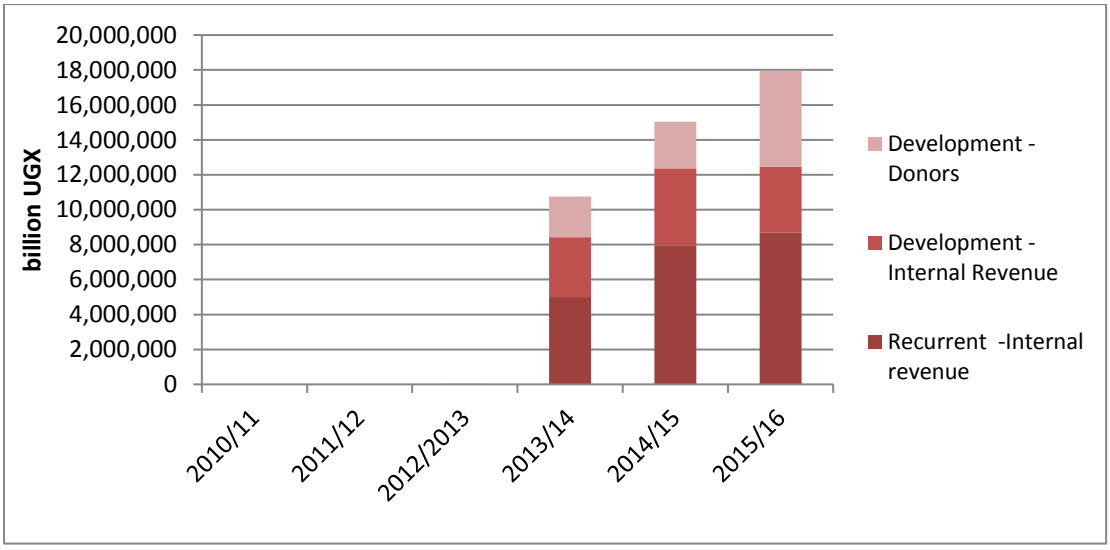
2.8 The national adolescent health policy

The National Adolescent Health Policy is an integral part of the National Development process and reinforces the commitment of the Government to integrate young people in the development process.[5]However it's important to note that a review of this policy clarifies the need to address issues of comprehensive coverage related to the RH/FP needs of young people in Uganda. This is based on the fact that Uganda is strongly characterized by a youthful population.

3. Budget Findings

3.1 Uganda's national budget FY2015/16

Figure 1: trend of the National Budget



Source: Approved budget estimates FY 2015/16, 2014/15

The National budget is an important tool used by government to transform society and thus achieve socio-economic development. **Total resource inflow** for FY

[5] Health sector strategic Plan 2011

2015/16 amounts to Ushs 23,972 billion, an increase of Ushs 8,267bn billion from FY 2014/15. Domestic resources rose from 9,799 billion in FY 2014/15 to Ushs 11,333 billion in FY 2015/16. Budget support to the country has slightly increased this financial year however some sectors like health experienced reductions in amounts disbursed.

Sectoral share FY 2015/16

Table 1: Sectoral share allocations

Sectors	2014/15	%share	2015/16	%share
Security	1,159.29	7.70	1,517.66	6.3
Works & Transport	2,389.37	15.87	3,328.79	13.9
Agriculture	473.73	3.15	484.68	2.0
Education	2,026.63	13.46	2,012	8.4
Health	1,281.14	8.51	1,270.80	5.3
Water & Environment	420.45	2.79	520.88	2.2
Justice/Law & Order	807.6	5.36	906.62	3.8
Accountability	1,188.47	7.89	1,106.83	4.6
Energy	1,829.39	12.15	2,782.72	11.7
Tourism, Trade and Industry	63.88	0.42	79.31	0.3
Lands, Housing and Urban Development	96.62	0.64	125.93	0.5
Social Development	71.3	0.47	79.97	0.3
ICT	17.01	0.11	20.87	0.09
Public Sector Mgt	1,191.03	7.91	776.12	3.2
Public Admin	554.84	3.69	716.35	3
Legislature	331.92	2.20	301.68	1.3

Source: Draft budget estimates for central government FY 2015/16

The above figure demonstrates the proportion of the national budget to various sectors. Despite the high increase in the national budget, some sectors budgets declined in FY 2015/16. sectoral share indicate the level of government priorities in achieving the National Development Plan (NDP) objectives. Sectoral allocations FY 2015/2016 increased by UGX 2,128.50bn in the MTEF allocation. The highest increase of resource allocation is under the works and Transport Sector (939.51 billion). Reductions were experienced in the major sectors like health with (-10.34

billion) of which 35% of the health sector is funded by donors. The biggest cause of budget cuts is reduction in donor financing.

3.2 Health sector financing

Government's focus in the health sector is to increase the attainment of a good standard of health for all the people in Uganda. The goal of the health sector is to reduce mobility and mortality as a contribution to poverty reduction as well as economic and social development of the people of Uganda[6]. To that end, the key health sector activities relate to strengthen health systems and ensuring universal access to the National Minimum Health Care Package (UNMHCP). Over the next medium term, the sector aims to address the key challenge of morbidity and mortality from the major causes of ill health and premature death.

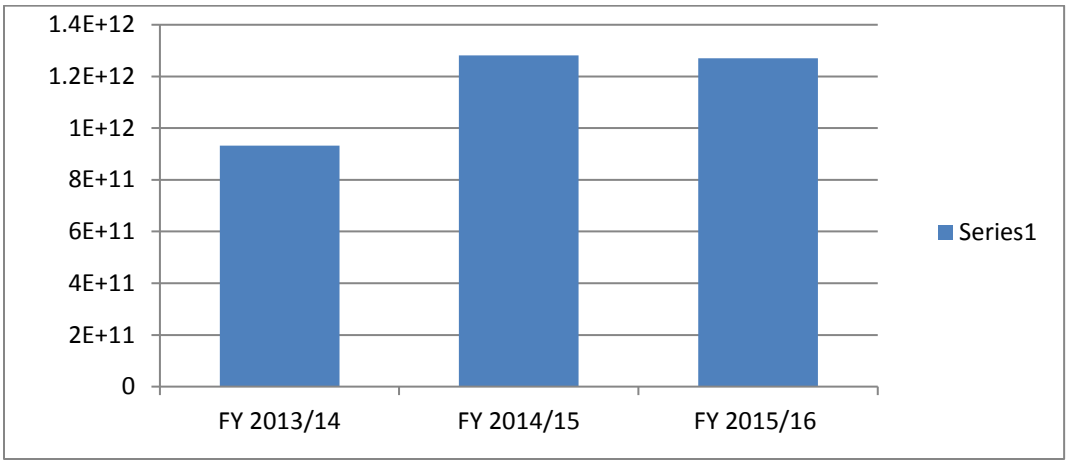
The sector is now implementing the Health Sector Strategic and Investment Plan (HSSIP) III and the National Health Policy II will guide the implementation of the planned activities for FY 2015/16. The key areas of focus enshrined in the HSSIP and NDP are: human resource, infrastructure, medicines and service delivery.

The health sector shall thus prioritize addressing a number of issues that continue to undermine the sector's performance. These include: low deliveries in health facilities, high rate of children dyeing below the age of 5 years, and the inadequate availability of essential medicines and health supplies in health facilities. In addition to the above factors causing poor indicators in reproductive health, high birth rates and high illiteracy rates among women need to be addressed.

Health sector financing by financial year

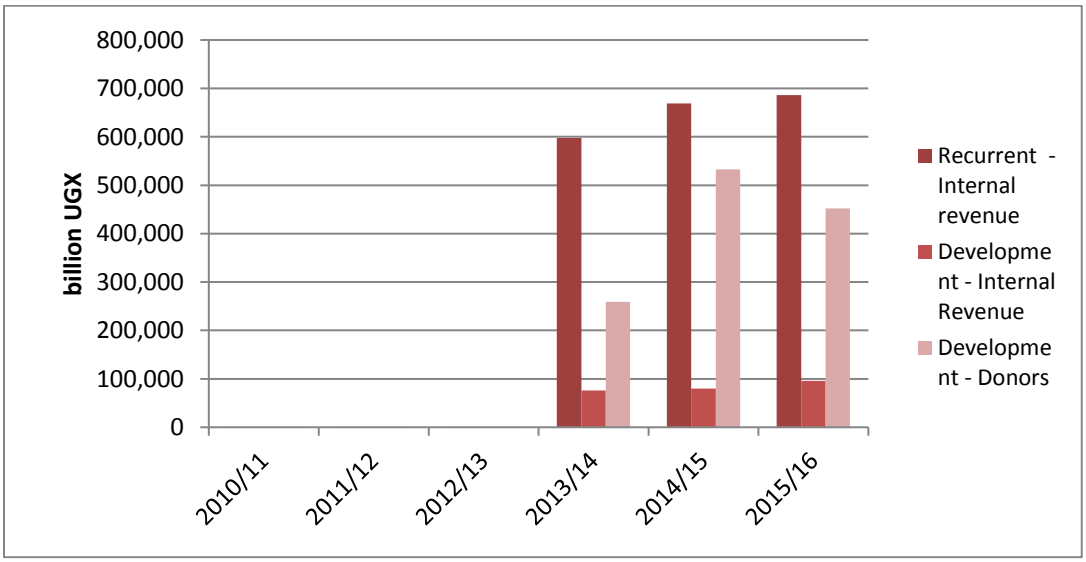
[6] Health sector MPS FY 2015/16

Figure 2: Health sector financing by FY



Source: Approved budget estimates FY 2015/16

Figure 3: Health sector financing by source



Source: draft central government budget estimates FY 2015/16

The health sector budget in FY 2013/14 was very low with 932,252,000,000 billion. In FY 2014/15 increased to 1,281,140,000,000 billion, taking 8% as a percentage share of the national budget. **FY 2015/16 the sector received** 1,270.80 billion, with 5.3% share. A reduction of 10.34billion was recognized. This is largely attributed to a significant reduction in donor financing from Ushs 532.5 billion in FY 2014/15 to Ushs 451.94 billion in FY 2015/16. This amounts to a reduction of Ushs 80.56

billion. Donor support is expected to fall continuously as reflected in the approved budget estimates. FY 2016/17 external support is projected at UGX 1, 22.15billion.

The health sector budget translates into a government contribution of US $ 12 ***(34,985UGX p. a/person)*** per capita on health. This is below the recommended per capita government expenditure on health of US $ 34 per capita as per WHO Commission of Macro Economics and Health (CMH) but also below the HSSIP target of per capita government expenditure on health target of US $ 17 by 2015.

The composition of donor support to the sector shows a decline in FY 2015/16, excluding off- budget support. Conversely, government local contribution to the sector has risen by 33,630,000,000 billion to compensate for the shortfall left by donors. In addition the largest government contribution is made towards consumptive items and less of investment items. This justifies government need to increase investment in the sector using own resources

3.3 Health sector budget by institution

Table 2: Health financing by institution

Vote	institutions	2013/14	2014/15	2015/16	Yr-Yr Change (FY 2013/14 and FY 2014/15	Yr-Yr Change (FY 2014/15 and FY 2015/16
14	Ministry of Health	462.391	577.13	514.357	114.739	-62.773
107	Uganda AIDS Commission.	5.448	6.95	6.85	1.502	-0.1
114	Uganda Cancer Institute	6.482	10.4	15.637	3.918	5.237
115	Uganda Heart Institute	5.111	9.08	11.085	3.969	2.005
116	National Medical Stores	219.375	218.614	218.614	-0.765	0.004
134	Health Service Commission	3.583	4.07	4.07	0.487	0
151	Uganda Blood	4.057	6.36	8.646	2.303	2.286

	Transfusion Services					
161	Mulago Hospital Complex	37.985	38.13	39.506	0.145	1.376
162	Butabika Hospital	9.108	9.11	9.108	0.002	-0.002
163-175	Regional Referral Hospitals	70.35	68.92	69.508	-1.43	0.588
501-850	District NGO Hospitals	17.195	17.19	17.189	-0.005	-0.001
501-850	District Primary Health Care grants	274.61	296.53	289.234	21.92	-7.296
501-850	District Hospitals	5.943	9.14	14.143	3.197	5.003
501-850	District sanitation and hygiene Grant	2.208	4.51	4.678	2.302	0.168
122	KCCA Health Grant	3.638	5	5	1.362	0
	Total	1,127.484	1,281.130	1,220.97		

Source: Health MPS FY 2015/16

The analysis shows a reduction in the Ministry of health budget. This was caused by a reduction in donor financing. National Medical Stores (NMS), Regional Referral Hospitals, district hospitals, cancer institute and heart institute received more funding. District Primary Health Care (PHC) and district NGOs experienced a reduction. Despite the need for human resources for health to improve service delivery, Health Service Commission (**HSC)** received the same funding. This implies that government does not have huge plans of recruiting health workers this financial year. Local Government allocation was reduced by UGX 2.127 bn. Local Governments are at the frontline of serve delivery. Having their budgets cut implies that the services at local level will greatly suffer. The district PHC and District NGO grant were reduced. The recurrent budget for local governments increased by 4.7bn to run the health service delivery. This is however still small to run the 137 LGs with 56 General Hospitals, 61 PNFP Hospitals and 4,205 Lower Level Health Units.

NMS allocations

Table 3: NMS allocations

Vote 116 NMS Major Expenditure Allocations		
Level	**Allocation 2015/16 'Bn'**	**% Share**
Health Centre II	**11.163**	**5**
Health Centre III	**18.36**	**8**
Health Centre IV	**7.992**	**4**
General Hospital	**13.106**	**6**
Regional Hospital	**13.024**	**6**
National Referral Hospital	**12.365**	**6**
Specialized Supplies to UHI, UCI, UBTS	**18.103**	**8**
Supply of ACTs, ARVs to accredited facilities	**100**	**46**
Supply of emergency and donated medicines	**2.5**	**1**
Supply of Reproductive Health Items	**8**	**4**
Supply of Immunisation Items	**9**	**4**
Supply of Laboratory Commodities	**5**	**2**
Total	**218.613**	**100**

Source: health MPS FY 2015/16

Despite of the ever increasing population, NMS has continued to receive the same funding like for last financial year, 218.614bn. The reproductive health supplies budget line has for the last three financial received UGX 8,000,000,000bn, which is 4% of the MNS budget, despite of the ever reported stock outs on FP commodities and mama kits. However FY 2015/16, NMS has increased the budget to the supply of mama kits from 13,000,000 FY 2014/15 to 18,900,000 FY 2015/16. It is envisaged that this change will improve of the maternal conditions for mothers. Most interventions under the UNMHCP depend on access to essential medicines and health supplies. It has been reported that 43% of health facilities report drug stock outs. Reproductive/FP commodities tend to be the highly reported.

Provision of the kit system- which involves packaging predetermined quantities of selected medicines and "pushing " them, was re-established as a mechanism for preventing medicines stock-outs at HCIIs and HCIIIs. This was partly due to the failure to build procurement and drag management capacity at health facilities. In addition this has also increased waste of medicines that are sent but not required at various health facilities while creating shortages of non basic, but essential medicines that are required at the facilities. There are some non-needs medicines given to some centers without due consideration of population served.

Reliance on NMS as a sole procurement and supply agency is very crucial to ensuring availability of medicines in the entire public health system. In case of stock-outs at NMS, districts and health facilities have no other alternative to avail medicines.

4. Financing for family planning in Uganda

The increased political commitment to FP/RH was evident at the 2012 London FP Summit when the president of Uganda committed the government to allocating US$5 million annually. This commenced in 2013/14 when the president developed a budget line under vote 116(NMS) for reproductive health commodities and increased family planning commodities to 6.9USD. The World Bank also supports FP commodities which are distributed through NMS and Uganda Health Marketing Group.

Government intends to lower unmet need further to 10 percent by 2020 and increase modern contraceptive prevalence rate amongst married men and women to 50 percent. Government first priority is to increase age-appropriate information, access and utilization of contraception among young people, 10-24 years.

The State health Minister, Chris Bar yomunsi said that Government plans to spend Shs 622 billion ($235 million) between 2015 and 2020 to ensure that family planning supplies and services are availed to everyone who needs them., the state minister for health, says his ministry's midterm review revealed that only 36 per cent of HCs IV are functional and have the ability to carry out emergency obstetric care, an area that needs to be improved to lower infant and maternal mortality.

FY 2014/15 the ministry increased its staffing levels and mentoring of health workers to offer reproductive health services. Village health teams are being mobilized to provide family planning in rural areas, including injectable contraceptives[7].

An alternative commodity distribution channel is in place to ensure contraceptives and other reproductive health commodities are at public and private service delivery points by 50% annually[8].

Impact of the family Planning costed implementation Plan

The total cost of the plan is 622 billion Uganda shillings (UGX) or $235 million USD between 2015 and 2020. The Uganda health budget of 2015/16 is 1,270.80 billion UGX; the 2015 CIP budget is 80.4 billion UGX. Implementation of the CIP will lead to an increased number of women in Uganda using modern contraception from 1.7 million in 2014 to 3.7 million current users by 2020.

	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Unintended pregnancies averted	503,981	571,828	640,983	711,443	783,211	856,285	**4,067,731**
Abortions averted	71,805	81,471	91,324	101,363	111,588	121,999	**579,550**
Maternal deaths averted	868	938	999	1,051	1,092	1,124	**6,072**
Child deaths averted	14,707	16,686	18,704	20,761	22,855	24,987	**118,700**
Unsafe abortions averted	68,760	78,017	87,452	97,065	106,857	116,826	**554,977**

[7] DSW's FDG on FP in Mityana and Kamuli

[8] Uganda alternative distribution strategy for contraceptives and selected RH commodities in public and private sector.

Maternal and infant health care costs saved (millions, USD)	15.7	17.8	20.0	22.1	24.4	26.7	**$126.7 million USD**

Source: FP costed Implementation Plan FY2015- 2020

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

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

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

4.1 National Budget Percentage Share of Health, Reproductive and FP budgets (From Nominal Value)

Table 4: percentage share of health, RH, FP

Item	FY2013/14	FY2014/15	FY2015/16
Health percentage of national budget	**9**	**9**	**7**
RH percentage of health budget	**1**	**2**	**8**
FP percentage of RH budget	**45**	**40**	**9**

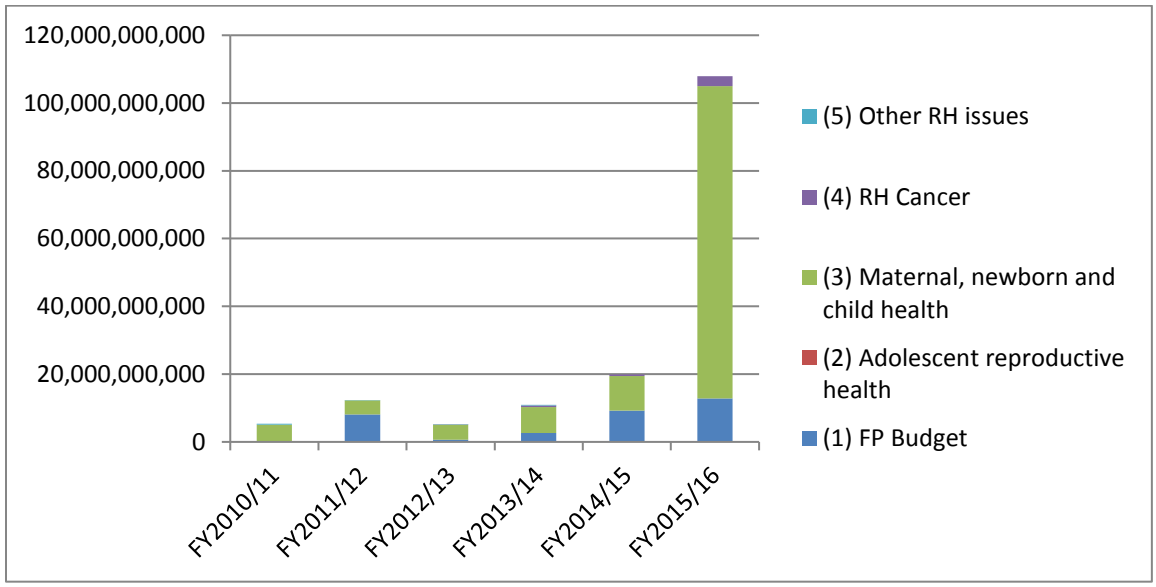
Source: DSW computation

From the analysis, the health budget reduced from 9% FY 2014/15 to 7% FY 2015/16. Reductions were seen in MoH, butabika hospital, district NGO hospitals/primary health care and district primary health care. The health sector budget percentage share has declined to 7% in FY 2015/16. The reproductive health budget increased to 8% FY 2015/16 from 2% FY 2014/15. This was due to increased funding in activities contributing to maternal, child and new born. These include maternal deliveries mainly in the regional referral hospitals which are combined with admissions, major surgical operations, bed occupancy rate and patient days, the construction of the maternal and neoternal hospitals.

Family Planning of the RH budget in 2013/14 was 45% and in 2014/15 decreased to 40%. FY 2015/16 the FP budget of RH reduced to 9%. This was due to the 82% increase in total RH budget and a 17% increase in the FP budget. This implies that an increase in the RH budget doesn't mean an equal increase in the FP budget. The 82% increase was due to the increase in maternal, child and new born activities. These include: including: maternal deliveries, immunization, ANC, abortion care, PMTCT, construction of maternity wards which hold big budgets. Family planning also does not have a specific budget line it can only be assured under NMS under the reproductive health budget line. It is highlighted in the regional referral hospitals under prevention and rehabilitation which constitutes of FP, ANC, PMTCT, HCT, postnatal visits and SGBV attendances. Thus this does not clear and specific funding for FP

4.2 National Budget for Reproductive Health and Family Planning

Figure 4: RH and FP national budget.



Source: DSW computation

FY 2015/16 the reproductive health budget had a remarkable increase compared to the previous years. The total reproductive health budget increased by 82 %(UGX 88028801 bn). Maternal, new born and child health took the biggest part of the RH budget. It increased from UGX 11,472,044,000 bn to UGX 95,294,425,000 bn. The increase is due to the composition of activities contributing to it as explained above. Also to note that there was an increase in the family planning budget by 17% from 8,000,000,000 bn to 9,658,000,000 bn. Reproductive health cancer also increased from 435,931,000 bn FY 2014/15 to UGX 2,984,352,000 bn FY 2015/16. This has been due to the prevailing cancer situation in Uganda. FY 2015/16 the government plans to complete a radiotherapy bunker and a cancer institute bill was also proven by cabinet. Despite government's efforts towards adolescent health, no specific funds have been reflected in the budgets to cater for the health of the ever growing population of young people.

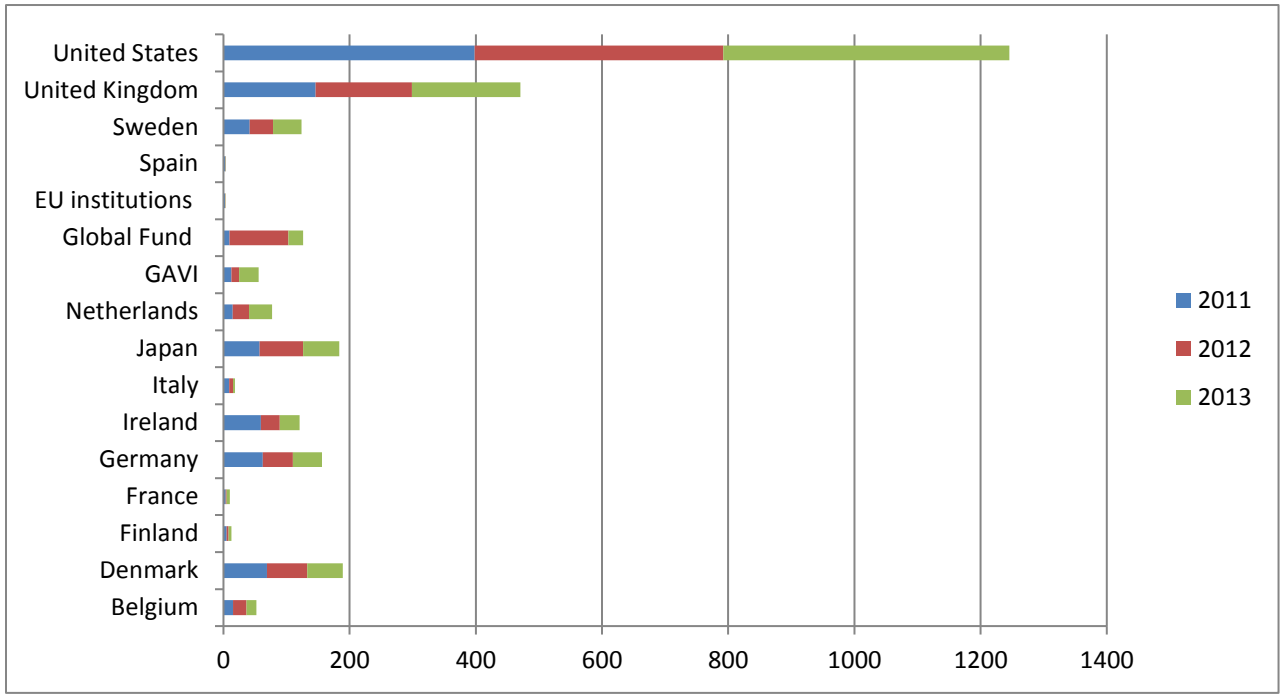
Health care services are still inadequate in terms of adolescent health. Health centers and hospitals have a lot to be desired. They have inadequate health supplies such as drugs for STDs and contraceptives. Stock outs have been common phenomena in many health centers where adolescents go for treatment. This also applies to basic equipment and clinical expendable supplies for RH. Clients do not see the reason to travel distances to come to the units that have scarcity of such basic items.

Accessibility of services in terms of affordability is one disincentive for uptake of services. In health facilities where young people pay a fee for instance for family planning services, adolescent cannot access services due to financial constraints. This was reflected in the Focus Group Discussions conducted by DSW in Mityana and Kamuli.

5 General health assistance in Uganda

Official development assistance and the Millennium Development Goals have largely concentrated on low-income countries and direct donor aid.

Figure 5: health assistance in Uganda



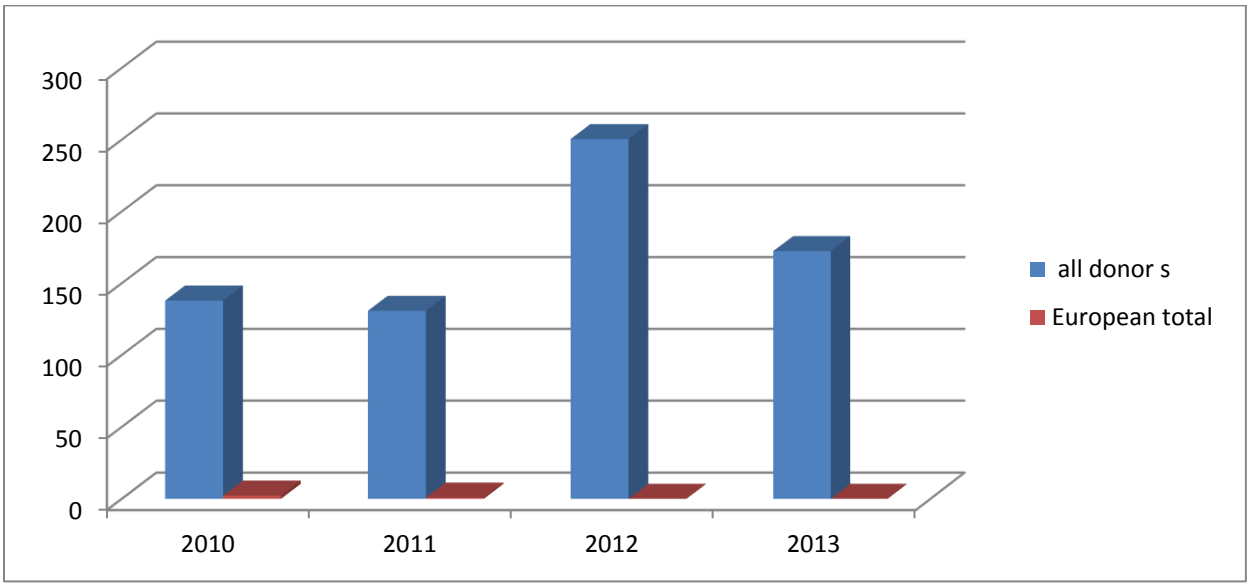
Source*: *www.oecd.org

Development assistance varies depending on which country. The United States between 2012 and 2013 made a tremendous increase towards the health sector by 59.209324 million USD. The United Kingdom increased by 6.0777 million USD in 2012 and 19.949369 million USD in 2013. GAVI also increased by 81.703499 million USD in 2013, Netherlands increased by 10.358626 million USD. Finland, France, Ireland Sweden and Spain slightly increased their support in 2013. Germany, Belgium, Denmark, Italy, Japan, EU institutions and global fund reduced their

support towards the health sector in 2013. The global fund had the biggest reduction of 70.309422 million USD. Despite the aid given, the reduced development support to the sector has been one the major reasons of not attaining the Millennium development goals.[9]

5.1 All donors Vs EU health assistance in Uganda

Figure 6: All donors Vs EU health assistance



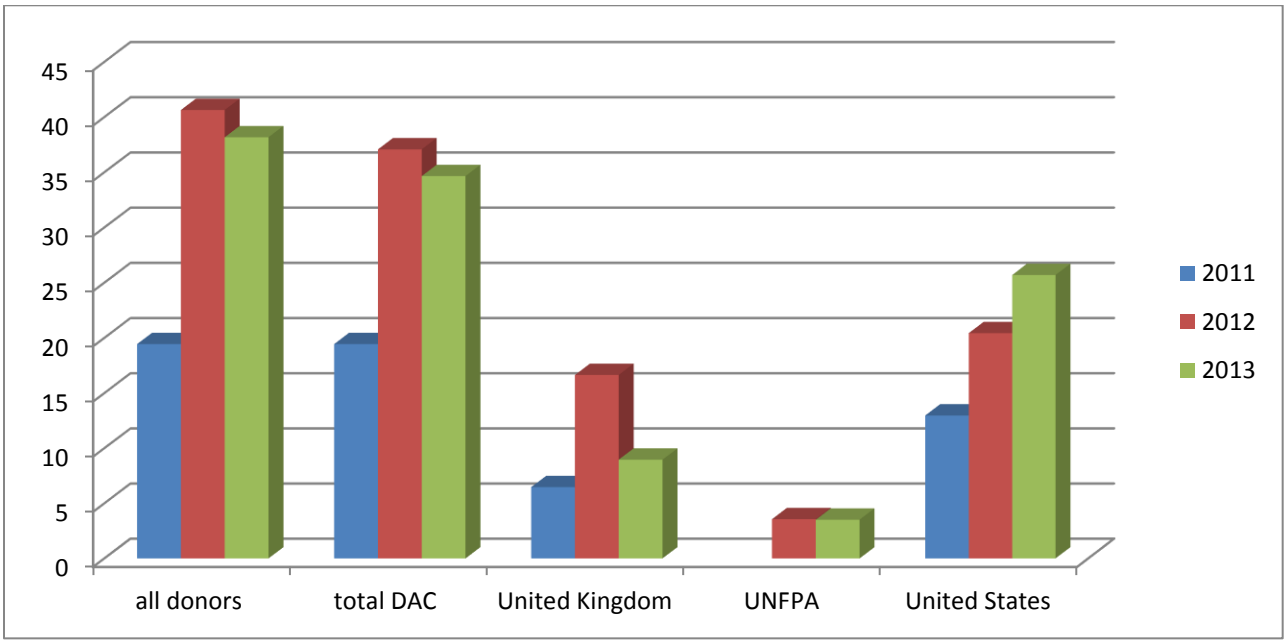
Source: ***www.oecd.org***

The suspension of budget support to Uganda in 2012/13 served to accelerate a long term decline in Government's foreign aid receipts. The graph reflects the trend of donor financing. In 2013 there was a decline. Studies show that donor assistance will continue to fall up to 2040. Thus government needs to plan for that earlier to avoid inefficiency in the sector

[9] Report from world bank

5.2 Family Planning assistance in Uganda

Figure 7: FP assistance in Uganda



Source: ***www.oecd.org***

General external FP financing shows a decline as of 2013. The total support from DAC also declined as of 2013. Despite United Kingdom being one of the biggest funders of the health sector, in 2013 reduced FP funding by 7.681736 million USD. The United states have consistently from 2011 to 2013 increased FP funding to Uganda. Between 2011 and 2012 it increased funding by 7.460349 million USD and between 2012 and 2013 increased by 5.262854 million USD. Development assistance

under the sector-wide approach (SWAp) [49%], off-budget aid (aid provided outside a government's public financial management systems and not reflected in the national budget) [2%] and private out-of-pocket expenditures [35%]. [10]

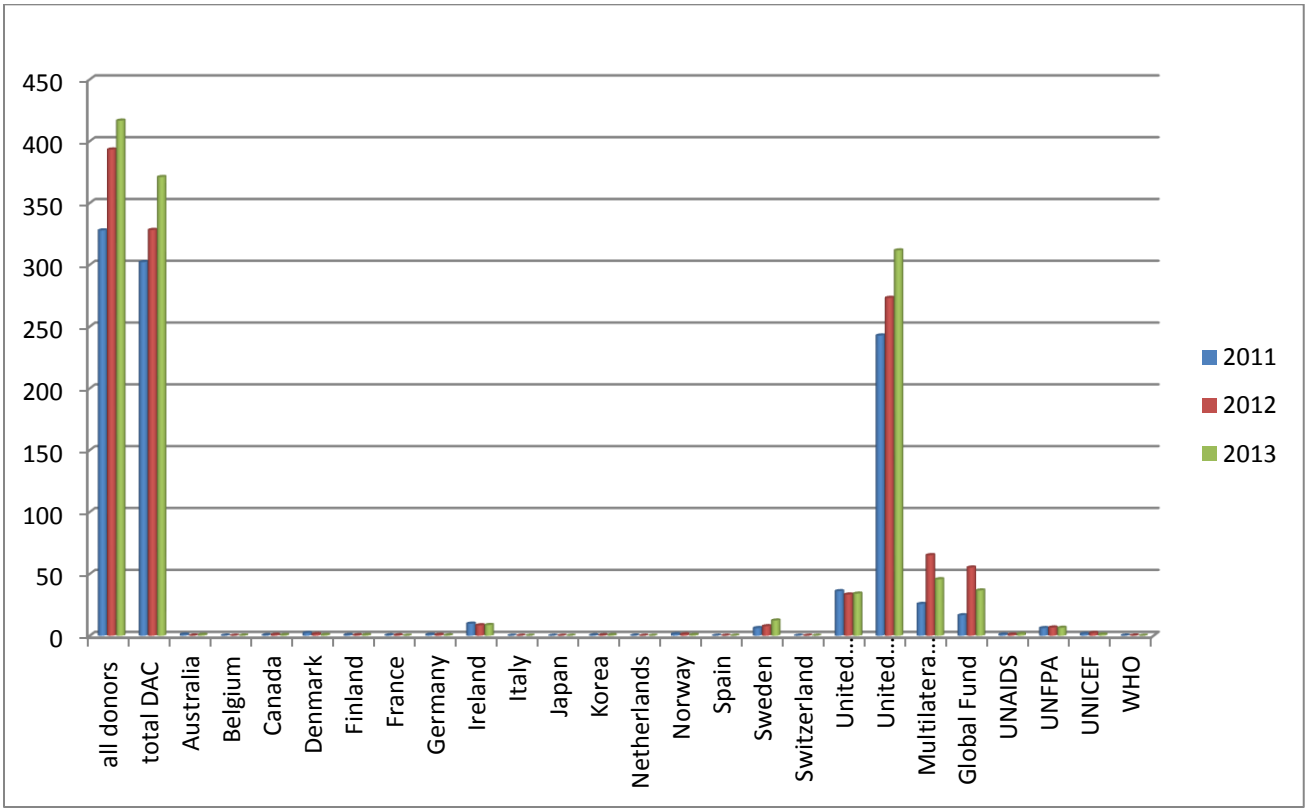
5.3 Population assistance in Uganda

Uganda's age structure is driven by the demographic transition from high mortality and fertility to a relatively slow reduction in fertility and mortality but the rate of reduction is still not acceptable compared to other countries

The health status of a country's population is directly related to its development. Uganda's population has experienced a fair improvement in health indicators. However, child malnutrition, high prevalence of malaria and HIV/AIDS, and high rates of maternal morbidity and mortality remain a challenge, to the country's development. Proper nutrition for boys and girls in Uganda needs to be prioritized if the government is to realize sensible human capital development that will drive the nation into reaping a demographic dividend and achieve socio-economic transformation. Therefore if the country is to harness the demographic divided, the high population that is ready to provide labour force need to be healthy and should bear a minimum disease burden

[10] Uganda Health Accounts 2010/11 and 2011/12.

Figure 8: population assistance in Uganda



***Source*: www.oecd.org**

The United States (US$15 million) stands as the largest donor of population assistance to Uganda in 2011, 2012 and 2013 with 242.742373 million USD, 273.176063 Million USD, and 311.59485 million USD respectively. Followed by United Kingdom with 35.983765 Million USD, 33.313581 Million USD, 34.036916 million USD.(2011, 2012 and 2013 respectively). Followed by Sweden with 12.328354 million USD in 2013.

6 District assessment (Kamuli and Mityana district)

6.1 District profiles

Mityana District is found in central region of Uganda about 60kms West of Kampala. It borders the districts of Butambula & Mpigi to the south, Kiboga to the North, Mubende to the West, Nakaseke and Wakiso districts to the East. The district has 3 HSDs (constituencies);Mityana South, Mityana North and Busujju. The total area of

Mityana district is about 1953.36km2. Mityana District has two counties (Busujju & Mityana) which are subdivided into eleven sub counties and one Town Council. The district has a total of 93 parishes and 640 villages.

It has a population 331,266, Women in child bearing age in the district: 66,916 No. of pregnancies in the district: 16,563, No. of births in the district: 16,066, No. of children under one year in the district: 14,244, children under 5 years in the district: 66,916, People under 15yrs of age: 152,382.

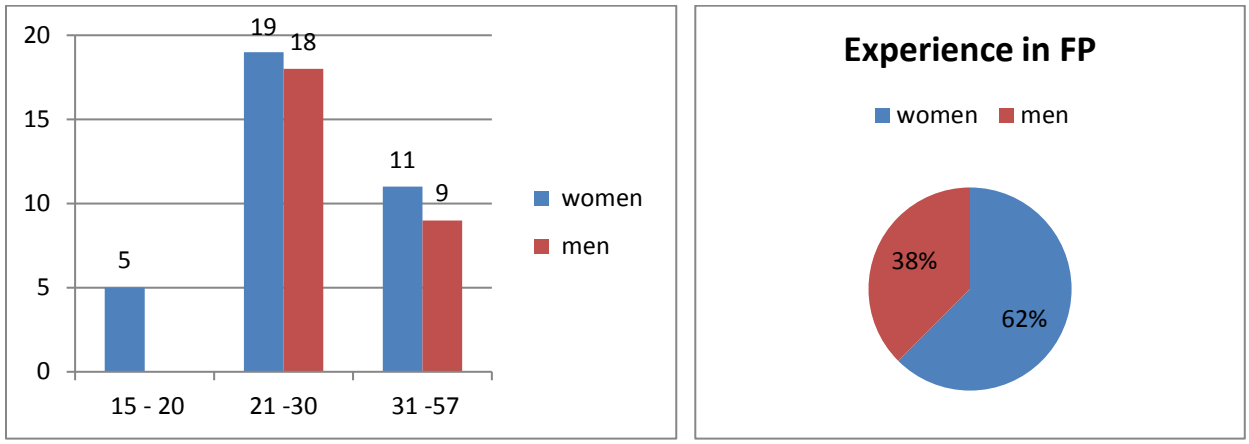
Kamuli District is part of the former Busoga District (Luwero region). It is located in south-eastern Uganda, The district borders River Nile and Kayunga district in the west, Jinja district in the South, Iganga district in the Southeast, Kaliro. Kamuli District is composed of three counties namely: Budiope, Bugabula and Buzaaya. The District is also composed of 17 lower local councils (Sub-counties) and one Town council, One hundred and five (105) and 1,284 villages. It has a population of 490,255 people, 236,150 males and 254,105 females.

6.2 Focus Group discussions

This year 2015 DSW conducted focus group discussions to further look at any changes in the community attitudes to family planning and barriers of access and use of contraception in kamuli and Mityana district. The discussion focused on the unmet need for family planning. The Focus Group Discussions (FGDs) were conducted with women, men, and youth in the selected districts. In Kamuli they took place in Namasagali Sub-county, and Kamuli town council. In Mityana they took place in Kabuwambo sub-county and Mityana town council.

The discussion centered on changes on availability and accessibility of family planning services. It assessed whether community members' thoughts and feelings about family planning was still the same but also to see if there are changes due to interventions done. The FDGs furthermore explored whether the challenges that women and men faced in community regarding family planning are still the same or there are notable changes.

Figure 9: Attendance by age/FP experience



Source: DSW FDGs Kamuli 2015

Figure 10: reflects that more women in the various age rages turned up for the focus group discussions. Between 15-20 years were 5 women, between 21 to 30 years were 19 women and 18 men and between 31 to 57 years were 11 women and 9 men. From figure 2: 62 % of women have used and are still using family planning, 38% of men are using family planning.

6.3 Attitudes to Family Planning in Kamuli district

Politicians, VHTs, married women and girls at school going age greatly support family planning. A notable increase in young people accessing family planning services was highlighted. This is due to the change in attitudes of health workers towards them and women have been sensitized on FP. Men (famers, motor cyclist), parents and born again Christians are still some of the key people or institutions that do not support family planning.

A community member noted that side effects that come along with the different methods of FP are still a barrier for women and men to access FP. She further said that men stop there women from FP due to the continuous bleeding. However it was also noted parents still have a poor attitude and myths about family planning. This has stopped them from informing their children about family planning.

One of the male participants in Kamuli narrated that, he and the wife agreed to have two children and the only way to achieve it was to use family planning. They visited the hospital together and inquire about FP. After having their second child, they woman took up a permanent family planning

method. He said that he has been able to plan for his family and they are living a happy. His neighbor of seven kids came and asked him how he has managed to have a small family and he informed him about FP and its benefits however he encouraged them to visit the health facility for more information. The neighbor took her wife to hospital and took up a permanent method. This helped the family not to add on the number of kids and are now working towards ensuring that all the seven access basic need.

During the women focus group discussions, majority of them were using family planning. Majority said they were not having side effects thou some sill experience heavy and continuous bleeding but they are seeking medical attention.

6.4 Method Mix: Regarding methods of family planning- change

The commonly used family planning methods in Kamuli include:

1) IUD
2) Pills
3) Injectables
4) In plants
5) Condoms
6) Vasectomy
7) Tubuligation

Community members noted that FP methods are provided according to the level of health facility. All methods are available at the main hospital and health center IV, at health center III, they provide IUDs, Injectables, in plants, pills and condoms, health center IIs only provide pills and condoms. It was noted that injectables that used to be out of stock are now available in all facilities starting from HC III including PNFP facilities and condoms were said to be on high demand.

Places were community member's access FP include but not limited to: Kamuli hospital, FLEP, Namwendwa Health center IVs, Namasagali, Kavulu, kitayunjwa Health center IIIs and Private clinics.

It was noted that lubaga hospital only provides information on FP but not the methods. Community members also noted that VHTs also provide condoms but also give information of FP and refer. **To a small extent young people noted that youth friendly services are available at the general hospital and health center IIIs. They can now openly discuss RH/FP issues with health workers**.

6.5 Unmet Need for Family Planning: changes, challenges and solutions

It was noted that the number of young people accessing family planning services increased. They commented that health workers now provide FP services without asking for their boyfriends. They further said that health workers are readily available in kamuli general hospital. It was also observed that there has been a rapid general increase in the number of people accessing family planning.

Community members noted that sensitization at community level has been done and peer to peer learning has been encouraged. It was highlighted that health workers are silent about emergency contraceptives yet a lot of cases that need such intervention are happening.
They recommended for more sensitization about emergency pills. It was also recommended for religious leaders to be brought on board as change agents and sensitized on family planning.

6.6 Challenges related to access and use of family planning in communities

Information access: There is little information flow on family planning. It was noted that communities have heard about family planning but majority of them do have the right information on family planning. Most women rely on roumers which most of the time are negative. These have hindered majority of women from taking on FP. This creates poor attitudes, myths and misconception about family planning.

Youth friendly services: Despite the fact that some health facilities have started providing youth friendly services, all of them should embrace them starting with health center IIs. Young people still find challenges of accessing family planning because they have not fond specific areas for youth friendly services in health facilities. These should be equipped with right information commodities and supplies with medical personnel in charge of youth friendly services.

Religion Vs family Planning: community members and religious leaders still have a strong objection towards modern family planning methods. They are seen as altering the creation of God. Since majority of community members are staunch Christians, there is to bring religious leaders on board to accept, appreciate and understand the

need to for diverse faith approaches to family health and wellbeing. Once religious leaders embrace that approach it would be easier for followers to take on FP.

Side effects: Women noted that there have been persistent complaints about side effects of FP. This has resulted into women getting off family planning but also they have gone ahead to discourage other women from taking up the services. Women who have experienced constant bleeding have been stopped by there husbands. Women and men should be encouraged to visit a health facility and seek medical attention in such scenarios. They should be encouraged to take up other methods of FP which would not bring side effects.

Less Male involvement: Men were highlighted as a group of people that is not supporting family planning. Women take up family planning stealth fully which has resulted into domestic violence in homes. . A young person married in Kamuli was using injectables without the consent of the husband, when she started over bleeding she was forced to tell the husband who immediately instructed her to stop using contraceptives. Men should be brought on board and sensitized about the need to support their women to take up family planning

Distance; the closest health centers to the community are health center IIs. These only provide pills and condoms. Community members need to walk long distances in case they need to take other methods of family planning which are in HC IIIs, IVs and general hospitals. Permanent methods are only provided in health center IVs and general hospitals which have operation theaters. Ministry of health's concern and recommendation to upgrade HCIIs to IIIs for easy access of reproductive health services is strongly supported[11].

6.8 Recommendations from Kamuli

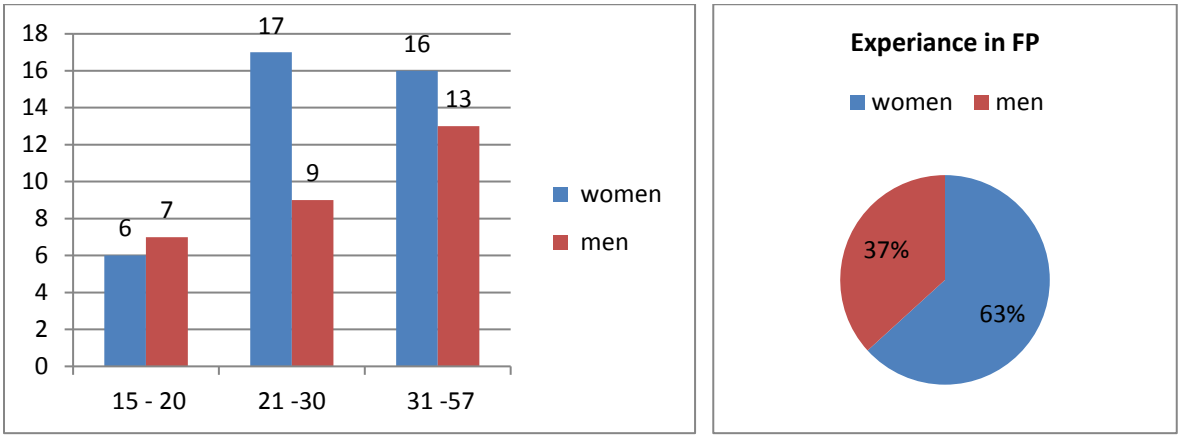
With all the above FP issue raised by the community, they recommended that:
1) Development partners, health facilities should mobilize young people to go for FP services.
2) Focus should be put on community awareness through peer to peer learning
3) All FP services and methods should be provided at all levels of health facilities to avoid moving long distances nut it also addresses the issue if access.

[11] Health Ministerial Policy statement FY 2015/16

4) Health workers should be equipped with the right information about FP to be able to provide all the necessary information on all the FP methods to FP users.

7. Focus group discussions Mityana district

Figure 10: attendance by age/FP experience



Source: Miyana FDGs 2015

Figure 11: reflects that more women in the various age rages turned up for the focus group discussions. Between 15-20 years were 6 women and 7 men, between 21 to 30 years were 17 women and 9 men and between 31 to 57 years were 16 women and 13 men. From figure 2: 63 % of women have used and are still using family planning, 37% of men are using family planning.

7.1 Attitudes to Family Planning in Mityana district

During the focus group discussions members noted that previously local leaders, women and young people were not supporting family planning. But now local leaders strongly support family planning and this resulted from the pressure that they have in their homes in terms of providing for their families. The LCs of Kabuwambo sub-county has been involved the distribution of condoms in their villages. It was strongly reported that young people have come up to support family planning mainly girls at a school going age in fear of getting pregnant and HIV.

The Anglican Church was highlighted as one of the strong supporters of Family planning. It was noted that this has been done during preaching session on how to

plan for families and providing space among children. People living with HIV/AIDS were also pointed out as strong supporter of family planning. *Secondary schools in Kabuwambo sub-county are strongly supporting reproductive health. In one of the schools is a health club that was created by the head master. Information on SRH/FP is given and they have access to condoms.* However it was also noted that most teachers in schools have not yet embraced SRH/FP issues. They have taken students who have been found with condoms or pills to disciplinary committees. There are still some institutions and individuals who still do not support family planning. These include the Catholic Church, older reach people in the community between the age of 50 and 65[12].

7.1 Method Mix: Regarding methods of family planning- change

The commonly used contraceptive methods in Mityana include:

1) Injector plans
2) Condoms
3) Pills
4) IUD
5) In plants
6) Condoms
7) Tubuligation

It was noted that medical officers now distribute condoms in the community. Young people do access them since they are free. Places were community member's access FP include but not limited to: Mityana hospital, Hosfa, St charlse clinic, Santa Maria clinic, Reproductive health Uganda clinic, Maristopes, Clinics Drug shops and VHTs. It was also noted that some of the VHTs in Mityana have been trained in administering Injecta plans. It was noted that there services have provided access to FP services.

7.2 Unmet Need for Family Planning: changes, challenges and solutions

It was noted that young people before were scared of using condoms because they thought it would get stuck in a woman. But due to increased awareness creation there has been increase in demand of condoms by young people. In Kabuwambo sub-county young people said that health workers have now changed attitudes towards them. They can now access FP services freely. However they recommended that there

[12] Community members

is need to use the cascading approach through peer to peer to ensure that all young people have access information and knowledge on FP/SRHR. The need to change mindset and attitudes of parents and teachers was also highlighted. Community members still have challenges of side effects by women who have given negative feedback to the community. They also noted that distance to the health facilities is very long especially if one wanted to access long term methods. They also noted that in order to have increased numbers of women accessing FP, there is need to bring men on board.

7.3 Recommendations from Mityana

Community members recommended that:

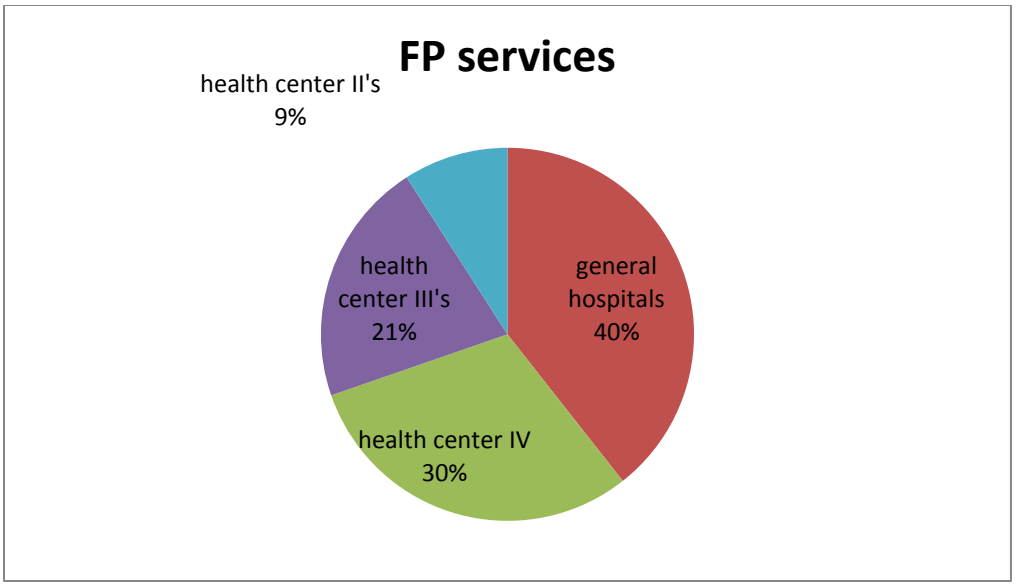
- There is need for more community sensitization and information on family planning by NGOs, government and private sector.
- There is need to introduce peer to peer approach for young people to ensure that information of FP reaches them.
- NGOs should dialogue with the district to prioritize FP in their plans and budgets
- Community outreaches, awareness events and media campaigns on FP should be prioritized by both government and partners in the district.
- Government should train health workers to become specialists of FP.
- Promoters of family planning should target all institutions that have access to the community should be considered in promoting FP. These include: religious leaders, teachers and local leaders.
- All health facilities should provide at least three methods of FP that are widely used by the community. Including pill, injecta plans and IUD's.

8. District facility assessment findings

The review included health facility assessment categorized in Health centre IIs, IIIs, IVs and General Hospitals. In kamuli one general hospital was assessed, one health center IV in Namwendwa, 3 health center IIIs, Namasagali, Kitayunjwa and FLEP. In Mityana, one health centre II (Kabuwambo), RHU Mityana and Supreme were assessed.

8.1 FP Services available at health facilities

Figure 11: facility assessment in kamuli district



Source: DSW computation

The assessment shows that in kamuli health center IIs provide 9% of FP services, health center IIIs provide 21% of FP services, health center IVs provide 30% of FP services and general hospitals provide 40% of the FP services. The percentages are affected by a number of reasons including: the health facility standards according to the HSSP. According to the health standards, Health center IIs provide pills and condoms. Health center IIIs provide pills, condoms, emergency pills, in plants. Health center IVs and General hospitals provide all FP services. Some of the services are not provided due to stock outs of particular commodities and because some commodities are not preferred by the community. In Namwendwa, Kamuli district, it was noted that Pills have continued to expire due to poor attitude towards them.

It was noted that the Kamuli general hospital have not carried out any specific FP outreaches in 2014/15. Health center IIIs have carried out specific FP outreaches. Most health facilities conduct integrated services since they claimed not to have enough money to enable them conduct independent FP out reaches.

According to the assessment, Kamuli general hospital, Namasagali health center III and Kitayunjwa HC III provide youth friendly services. They have designated areas and have a pointed a person in charge of youth friendly services.

8.2.1 Facility observation

In Kamuli general hospital, has a sign post advertising all services available. The waiting shed was available but with limited space. They had specific notice advertising for availability of youth friendly services. Namwenda health center IV had a general sign post advertising for all services, specific sign post on provision of FP services, MNCH and ANC. It also had a waiting shade.

8.2.2 Staffing levels in Kamuli

Kamuli general hospital had 29 nursing professionals, 20 midwives and one health educator**.** Namwendwa health center IV had 3 nursing professionals, 2 mid wifery professionals and one health educators. Namasagali HC III had one nursing professional, 5 midwifery professionals and 10 midwifery associate. Kitayunjwa HC III has ten nursing professionals, 4 midwifery professionals, 12 midwifery associates, 10 community health workers and 2 health educators. .

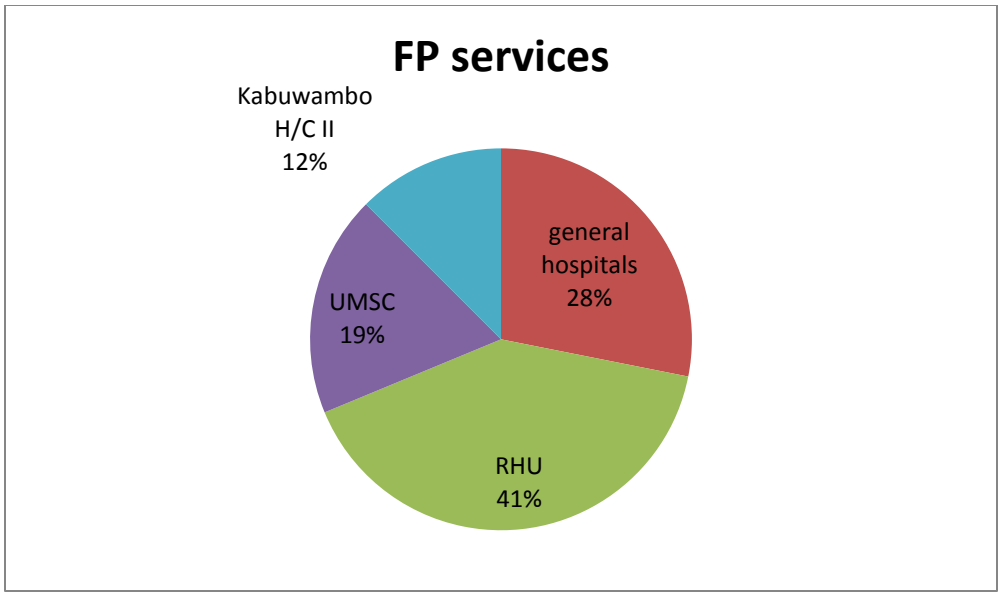
8.3 Family Planning Key delivery challenges

1. The issue of myth and misconception about family planning still exists.
2. Distance travelled to access FP services is long.

8.4 Recommendations from health workers

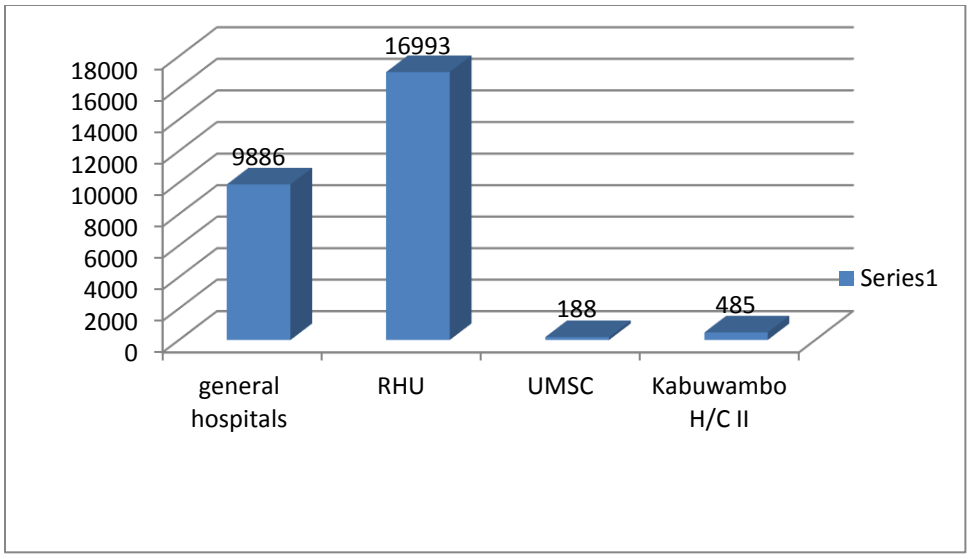
- Build capacities of health workers to become experts in FP
- Key stake holders should bring men on board
- Need to conduct regular FP out reaches
- Information dissemination of FP information among the community.
- Government needs to increase on the PHC fund to enable health facilities plan for more out reaches.
- Motivation and facilitation of health providers during community out reaches.
- Information materials should be developed in local languages
- Train and facilitate VHTs to provide more FP services since they reach a wider community.

Facility assessment in Mityana District.



In Mityna district, four health facilities were assessed including. Mityana General Hospital, Reproductive Health Uganda clinic, Uganda Muslim Supreme Council and Kabuwambo health center II. Mityana General Hospital and Kabuwambo health center II is government hospitals while RHU and UMSC are private hospitals. The general hospital provides 28% of FP services, RHU provides 41% of FP services, UMSC provides 19% of FP services and Kabuwabo provides 12% of FP services. FP services considered include: FP community out reaches, adolescent reproductive health services and the methods of contraception provided at each facility. Last year RHU provided all methods part from cycle beads, the general hospital did not provide cycle beads, progestin pills, progestin injectables, female condoms and male sterilization. UMSC provided combined oral contraception pills, progestin only contraceptive pills, combined injectables, IUD and in plants.

Number of people reached



Source: Health facilities Mityana

In 2014, the general hospital reached out to 9886 people on family planning, Reproductive Health Uganda Clinic reached out to 16993 people, Uganda Muslim Council reached out to 188 people and Kabuwambo health center II reached out to 485 people**.**

Mityana general hospital and Reproductive Health Uganda clinic have a designated area where FP and other reproductive health services to young people are provided. While in Kabuwambo health center II and UMSC do not have it.

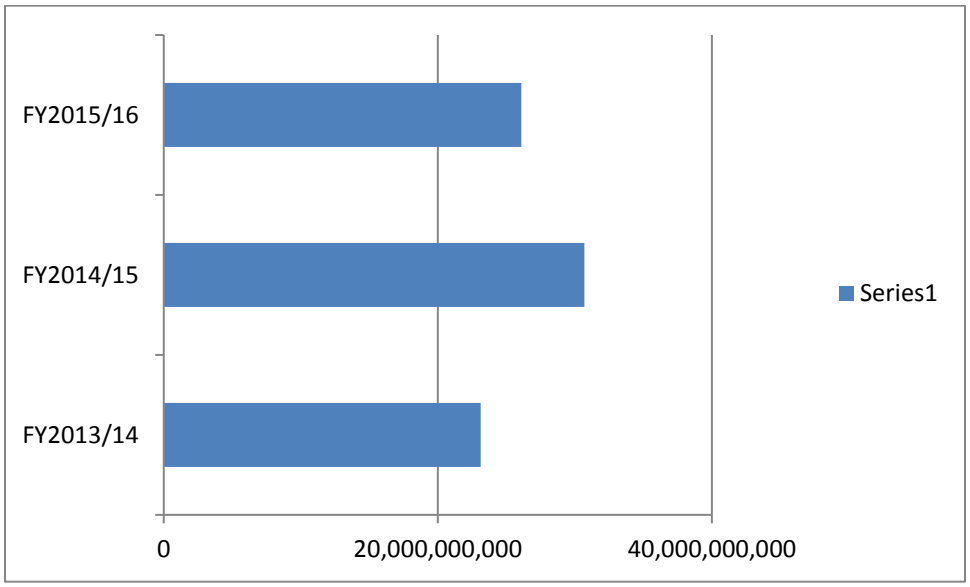
Staffing Levels in Mityana

In Mityana general hospital 2014 they had 45 nursing professionals and 2 part-time and 2015 have 49 nursing professionals. 2014 had 52 midwifery professionals and in 2015 the same. 2014 had 10 nursing associates and still the same in 2015. Reproductive health Uganda has 2 midwifery professionals; UMSC H/C III has one nursing professional, 2 nursing associate professionals and 2 part-time health educators. Kabuwambo health Center II has one nursing professional and one partime,one midwifery , one nursing associate and 12 community health workers

9. District Budget Analysis

9.1 Mityana District budget by financial year

Figure 12: Mityana District budget by FY



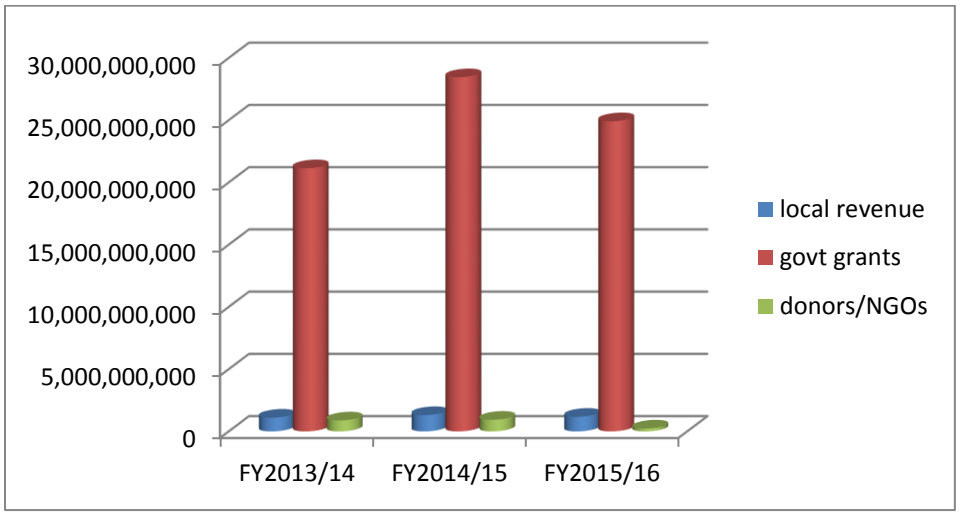
Source: Mityana district local government performance contract

The Mityana district budget FY 2015/16 indicates a lower budget of UGX 26,086,038,000bn compared to a higher figure in FY 2014/15 of UGX 30,692,282,000bn. Several of the District departmental budgets indicate a lower budget figure for financial year 2015/16 as compared to that of FY 2014-2015. The decline in the budget was due to the reduction in the local revenue by 11%, other transfers government transfers reduced by 36% , conditional transfers reduced by UGX 3,076,137bn and donor funding reduced by UGX 703,237,000 million.

Sectors: health, education, natural resources, planning and administration suffered huge budget cuts. Statutory bodies had an increase of 200% with an argument of a having a new budget line for pension.

9.2 Mityana District Budget by funding source

Figure 13: Mityana district budget by source

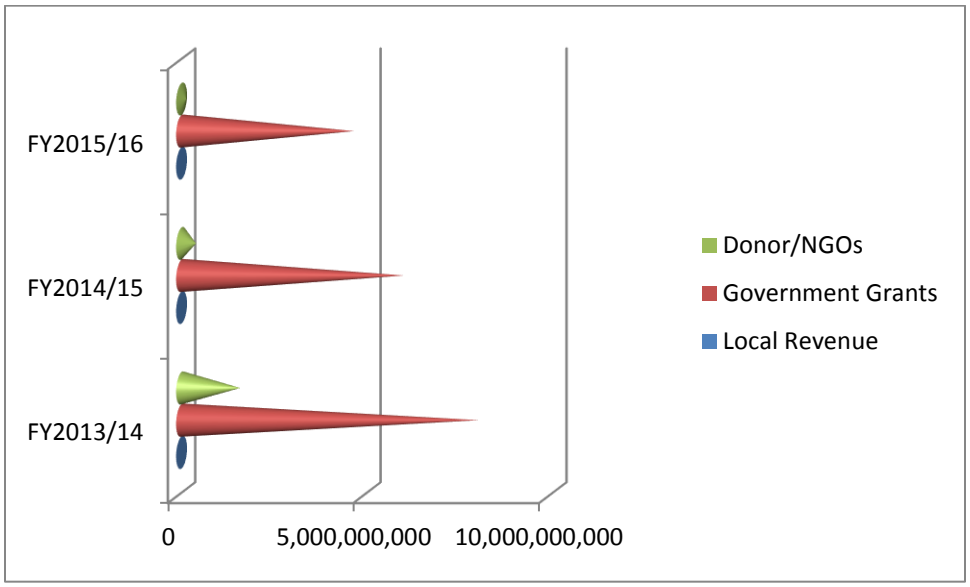


Source: Mityana local government PC

The graph shows the district budget by funding sources. Government is reflected as the major financing source for the district. This has been supported by donors and local revenue. Compared to FY2014/15, government and donor contribution to the district declined in FY 2015/16. This was brought by a reduction in local revenue, government grants and donor financing. As mentioned above local revenue reduced by 11%, conditional grants by 3,076,137bn, donor by UGX 703,237,000 million. (75%) And other government transfers by 36%. Donors and government cutting funding greatly affects district services. It should be noted that this not a punishment to the budget holders but killing children and women out in the villages who are in dire need of service delivery.

9.3 Mityana Health sector Budget FY 2015/16

Figure 14: health sector financing by source

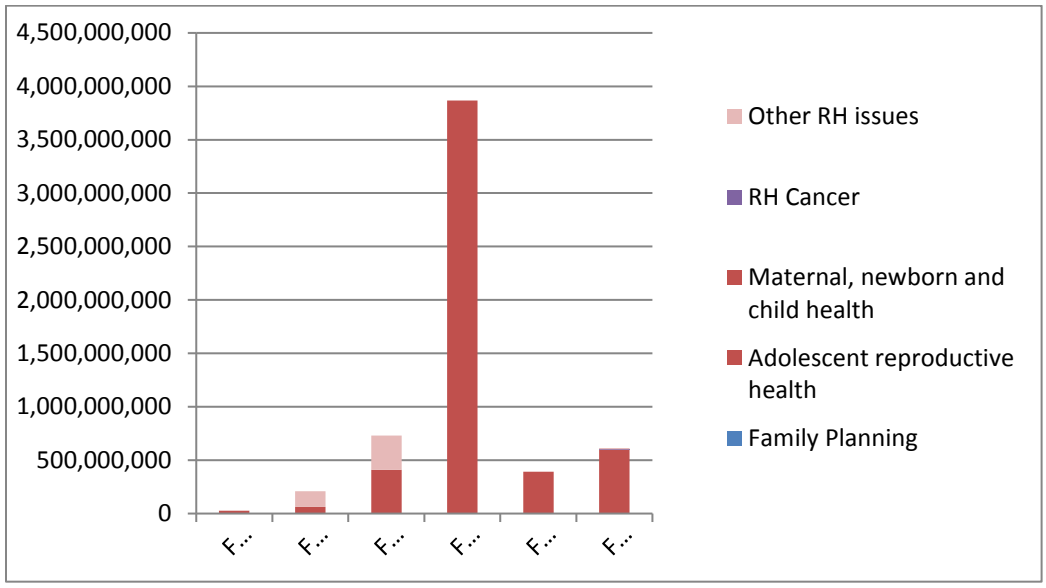


Source: Mityana district LG PC

The graph indicates health sector funding by source. Government is reflected as the major source of revenue for the sector. The graph indicates a fall in government funding to the sector FY 2015/16. It also reflects a fall in donor financing and hardly any contribution from the local revenue. There was a fall in the health sector budget by 25% compared to the previous FY 2014/15. It was reported that the decline was due to some donors like Strides for family Health wounding up the project and 80%decrease in indicative planning figures for PHC development, 25% PHC Salaries.

9.3.1 Mityana District Reproductive health budget

Figure 15: Mityana RH budget



Source: DSW Composition.

The graph presents the RH components and how they are prioritized in Mityana district. Maternal, new born and child health take a big percentage of the RH budget. Family planning is hardly reflected in the graph. The district FP activities identified were planned for in the HDDP FY 2014/15 to 2015/16. 6,000,000 m was planned for condom promotion and routine provision of FP services at facility and community level. These activities are not directly reflected in the district budget apart from maternal, newborn and child health. It was realized that the structure of the district budget does not provide for FP, RH issues, Adolescent health. These are not even reflected in the indictors. It was observed that at facility level, It would be easier to trace for FP, adolescent, RH cancer if all health facilities developed work plans in line with the facility budget.

9.3.2 Percentage Share of health budget to the district, RH of the health budget and FP budgets of RH (Mityana)

Table 5: percentage share health, RH, FP

Item	FY2013/14	FY2014/15	FY2015/16
Health percentage of national budget	20.5%	20.8%	18.3%

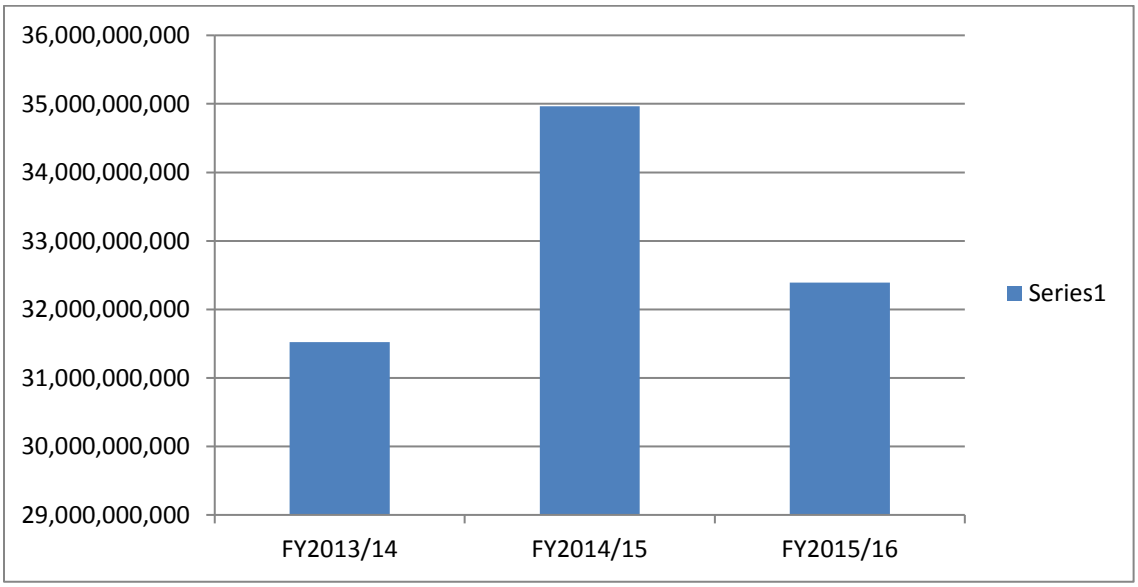
RH percentage of health budget	**81.5%**	**4.7%**	**13%**
FP percentage of RH budget	**0%**	**0%**	**1%**

Source: DSW computation

The percentage of the health sector budget of the district budget declined to 18.3% FY 2015/16 compared to 20.8% the previous year. This was due to a reduction to the health sector budget as explained above. The reproductive health budget of the health sector budget increased to 13% FY 2015/16 compared to 4.7% the previous year. In FY 2014/15 the district only planned for RH cancer and maternal, new born and child health. In FY 2015/16 FP, adolescent health, maternal and child health and RH cancer was prioritized. This led to the increase in the entire reproductive health budget. The 1% increase in FP of the RH budget is due to the health department plans to ensure and conduct regular provision of family planning services at facilities and community level. It also planned to carry out promotion on condom use. [13].

10. Kamuli District Budget by Financial year.

Figure 16: Kamuli district budget by FY



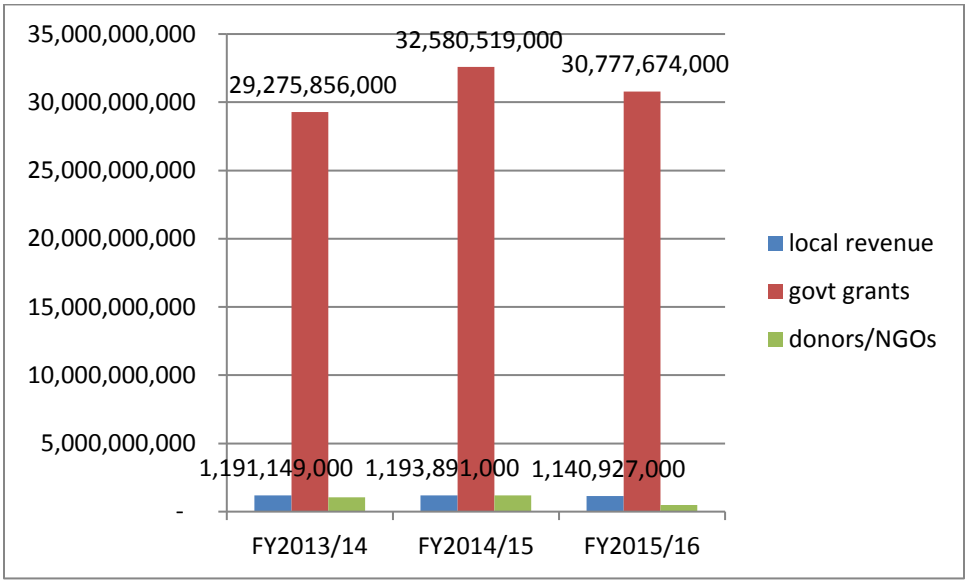
Source: Kamuli local government performance contract FY 2015/16

[13] Mityana health DDP FY 2014/15 to 2019/20

FY 2015/16 district budget indicates a lower figure of UGX 32,393,260bn compared to UGX 34,965,897,000bn. The decrease is mainly attributed to reduced donor funding and census funding. Local revenue UGX 1,140,927,000 (3.5%), Central government transfers UGX .30, 777, 674,000 (95%) and donor funding UGX474, 659,000 (1.5%). Apart from Internal audit and water sector other sectors experienced budgets cuts.

10.1 Kamuli District Budget by Source

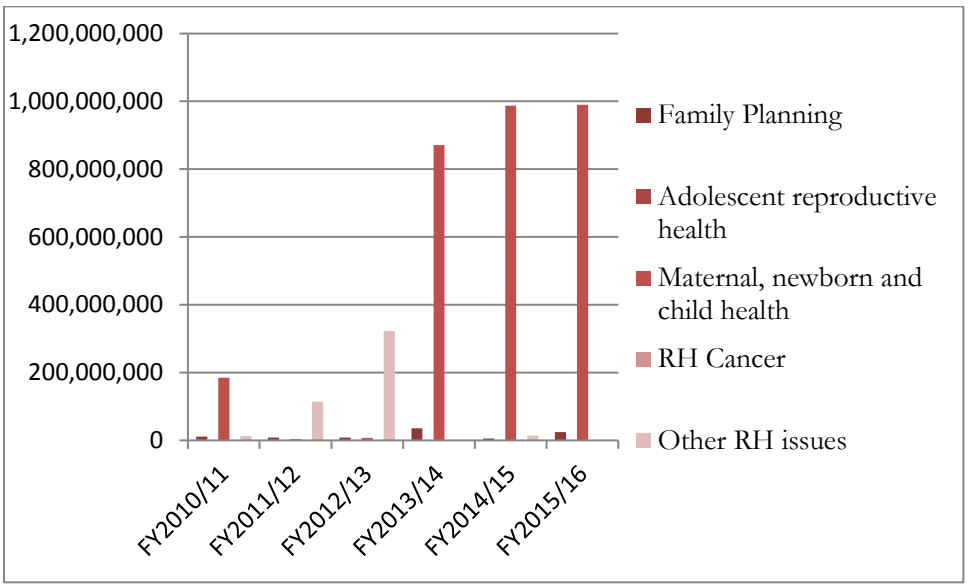
Figure 17: Kamuli district budget by source



The graph shows the district budget by funding sources. The district is majorly funded by central government transfers. FY 2015/16 allocated Shs.30, 777,674,000 (95%), followed by local revenues Local revenue Shs. 1,140,927,000 3.5% and donors with UGX 474,659,000 (1.5 %.). the graph justify the decrease in the district budget. FY 2014/15 local revenue amounted 1,193,891000 bn and FY 2015/16 reduced to 1,140,927,000, Government grants FY 2014/15 amounted UGX 32,580,519,000bn and FY 2016/16 reduced to UGX 30,777,674,000bn, Donor funding FY 2014/15 amounted 1191487000 bn and reduced to UGX 474,659,000 million. Sectors that suffered budget cuts include but not limited to Administration reduced by 35,51,5000 m, production reduced by 412,477,000m, health reduced by 674,323,000m and education reduced by 274,159,000m.

10.2 Kamuli reproductive health budget

Figure 18: kamuli RH budget



Source: DSW computation

The graph presents the RH components and how they are prioritized in Kamuli district. Maternal, new born and child health take a big percentage of the RH budget. This is seen in FY 2013/14, 2014/15 and 2015/16. Family planning is hardly reflected in the graph. The district FP activities identified were planned for in at the health facility level.. It was realized that the structure of the district budget does not provide for FP, RH issues, Adolescent health. These are not even reflected in the indictors. It was observed that at facility level, that if health facilities are supported to develop their work plans in line with the budget. It would be easier to trace for FP, adolescent, RH cancer if all health facilities developed work plans in line with the facility budget.

10.2.1 Percentage Share of health budget to the district, RH of the health budget and FP budgets of RH (Kamuli district)

Table 6: percentage share Health, RH,FP

Item	FY2013/14	FY2014/15	FY2015/16

Health percentage of national budget	**16.45%**	**16.30%**	**15.52%**
RH percentage of health budget	**17.50%**	**17.65%**	**20.19%**
FP percentage of RH budget	**3.97%**	**0.51%**	**2.45%**

Source: DSW computation

The health sector percentage share of the district budget reduced to 15.52% FY 2015/16 compared to 16.30% FY 2014/15. Areas that suffered budget cuts include: multsectoral transfers which reduced by 489,000 Shs, PHC salaries reduced by 51,439,000m, unconditional grant reduced by 30,000,000m and PHC development reduced by 83,436,000m. The RH percentage to the health budget increased to 20, 19% FY 2015/16 from 17.65% FY 2014/15.

The total RH budget increased to 1,015,038,601 bn FY 2015/16 from 1,006,019,701 bn. the increase was caused by a 79 %(19,686,900m) increase in the FP budget and 0.3% increase in the maternal, newborn and child health budget. Kamuli district is one of the champions in RH. The district in FY 2015/16 ensured that health facilities plan and budget for RH activities within their FY work plans. Health facilities in total allocated 24862400 to family planning, 6,560,000m from PHC and 18,302,400 m from development partners.

11. General observations/ recommendations

Over the past four years, the government of Uganda (GoU) has demonstrated an increased commitment to increase funding for family planning and reproductive Health (FP/RH) commodities. Policies on FP/RH have been developed thus availability of an enabling environment. There is need to enforce and mainstream there implementation but also review those whose life span is ending.

At the national level under central government transfers, family planning has not come out as stand alone. It's integrated within other activities. Thus reflecting the exact funds spent on family planning in heard both at the national and district level. Adolescent reproductive health is not reflected in the budget both at the national and district level.

Family planning needs to be prioritized and increase funding both at national and district level. Due to limited funds health facilities are not able to conduct enough community FP out reaches. They depend on the little PHC grant which is usually divided among other health component and FP is usually not a priority.

Through the focus group discussions and facility assessment, health facilities need more health workers who are qualified and trained in the relevant fields to improve on the quality of health services provided.

Despite the availability of reproductive health commodities, there is need to ensure that all commodities are available in all health facilities to allow users make FP choices. The procurement and supply chain should be improved to ensure there availability.

Communities still need right and correct information on Family planning. Development partners, government and NGOs need to ensure that there is access to FP information. There is need to promote and nature change in social and individual behavior to address myths and misconception, side effects.

In kamuli district it was observed that health facilities especially IIIs and general hospital are working towards improving adolescent health. They have specific spot where young people access RH/FP services and they have attached a health worker in charge of youth friendly services. It was noted that this has increased uptake of health services by young people. Government should work to ensure that all health facilities are youth friendly.

Methodology

DSW every year conducts a budget review on Family planning to find out how far government and development partners priorities family planning both at the national and district level.

The budget tracking explores whether the district and its development partners are making the necessary financial investments to enable implementation of family planning activities.

The tracking also explores:

1. How community members assess family planning services and what are their demands
2. If health facilities provide family planning services according to government standards
3. If Ugandan policies adequately cover family planning services

Data analysis: data is collected and entered into an excel spread sheet and analyzed for both the district and national level.

The DSW team conducted face-face interaction with the sector heads and facility in charges in the district. During the interviews, the heads of sectors together with other staff examine the budget and work plan to identify FP related areas and how much is allocated

Focus group discussions were held in each district. Three groups were interviewed. (Men, Women, youth). These support the qualitative part of the report.

Information is entered into a tool (excel) format. The tool captures information on all specific and sensitive FP/RH related spending. (RH cancer, Maternal new born and child health, Adolescent reproductive health and other RH issues).

After review and triangulation, data is analyzed in excel generated tool that enable the writing of this reports .

References

Ministerial policy statement for health FY 2015/16

National advocacy strategy towards a quality population 2013-2022 POPSEC/MoFPED

The state of Uganda population report 2014 POPSEC

Health Sector Strategic Plan II

Approved budget estimates for central government FY 2015/16

Mityana Local government Performance contract FY 2015/16

Mityana Local government BFP FY 2015/16

Mityana district development plan FY 2014/15 to 2019/20

Kamuli district performance contract FY 2015/16

Uganda Family Planning costed implementation plan FY 2014/15 to FY 2019/20