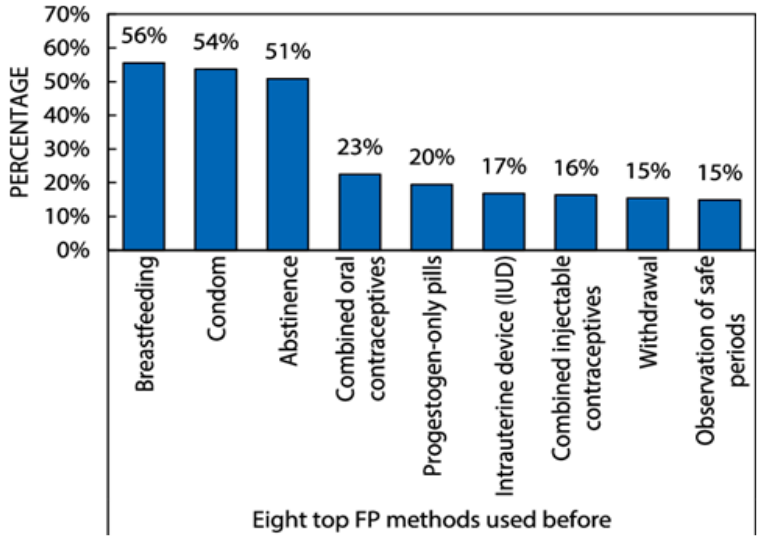
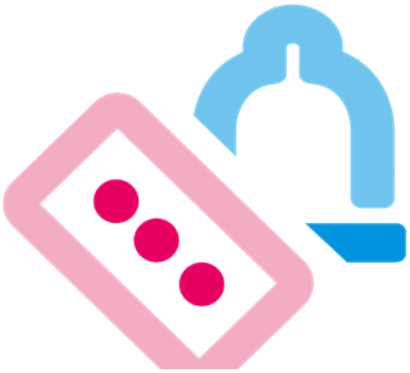
SPARTIAL STUDY ON FAMILY PLANNING BUDGET, POLICY ANALYISIS AND INTERGRATED FAMILY PLANNING SERVICE DELIVERY IN KYENJOJO & KYEGEGWA DISTRICTS 2021/2022.

DECEMBER
2022





BUDGET ANALYSIS STUDY FY 2021/2022

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LIST OF ACRONYMS AND ABBREVIATIONS

BCC	Behavioral Change Communication
COVID 19	Corona Virus Disease 2019
CSO	Civil Society Organization
DCIP	District Family Planning Costed Implementation Plan
DHO	District Health Officer
DLG	District Local Government
FP	Family Planning
FPCIP	Family Planning Costed Implementation Plan
FY	Financial Year
FGDs	Focus Group Discussions
GoU	Government of Uganda
HC	Health Centre
HCD	Human Capital Development
IFMS	Integrated Financial Management System
IEC	Information Education and Communication
KIIs	Key Informant Interviews
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MDAs	Ministries Departments and Agencies
mCPR	modern Contraceptive Prevalence Rate
NMS	National Medical Stores
MPS	Ministerial Policy Statement
PHC	Primary Health Care
PIAP	Programme Implementation Action Plan
PNFP	Private Not for Profit RH Reproductive Health
RHCS	Reproductive Health Commodity Security
RHs	Referral Hospitals
RMNCAH	Reproductive Maternal New-born Child and Adolescent Health
SOPs	Standard Operating Procedures

SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UDHS	Uganda Demographic and Health Survey
USD	United States Dollars
UGIFT	Uganda Intergovernmental Fiscal Transfers
URMCHIP	Uganda Reproductive Maternal and Child Health Improvement Project
VHTs	Village Health Teams
WRA	Women of Reproductive Age
GOU	Government Of Uganda
MOH	Ministry of Health

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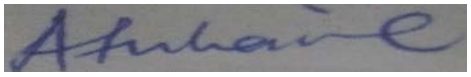


Rev. Atuhaire Moses

Executive Director

EXECUTIVE SUMMARY

Uganda is the third fastest-growing country globally, with a population of 45 million, and 48% of the people are under the age of 15years. On average, women bear approximately seven children, with nearly half of all pregnancies being unplanned. The ability of women and couples to decide when to have children, and how many to have is crucial for the productivity and well-being of the population.

Therefore, Family Planning (FP) is an essential practice in society as it provides knowledge and information that allows women and couples to decide when they are ready to have children based on their preparedness. FP has presented several benefits to the women, their families, and the community at large.

The Government of Uganda (GoU) recognises and has prioritised FP in broad development and health policies and strategies. At the Human Capital Development Programme and Ministry of Health level, relevant policy and planning frameworks exist to guide FP interventions. With that said, previous research by Western Uganda FBO Network and other FP programming partners have shown that challenges in the implementation of FP related policies and investing in FP at both the national and sub-national level persist.

As with previous years, Western Uganda FBO Network conducted a budget analysis study to document FP investment status and trends at both the national and sub-national levels. The study's findings aim to support evidence-based advocacy for increased investments in FP.

Methodology

The study was conducted at the national and district level in Kyegegwa and Kyenjojo districts. It examined allocations for FP in FY 2021/22 compared to those of FY 2020/21 and FY 2019/20 and the expenditures in FY 2020/21. Both quantitative and qualitative data was collected. Methods used to collect the data included reviewing FP-related policy and budget documents, Key Informant Interviews, and Focus Group Discussions. The quantitative allocations and expenditure data were analysed using an MS Excel Based tool. In contrast, the qualitative data was transcribed into MS Word and grouped into themes on FP uptake and access to various methods

Findings of the study

Implementation status of FP-related policies, the study found poor dissemination and application of FP-related policies, standards, and guidelines at all levels of health care, with laxity in the provision of Youth/ Adolescent-friendly services and dissemination at service delivery points in boththe public and private sector. Additionally, providers had not been sensitized on the updated FP-related policies. Several national FP-related policy documents have been approved but not yet launched, while others are still in development. Through advocacy from the sub-national level and support from partners, the second National FP-CIP (FY 2021/22- FY 2025/26) will be launched and disseminated as the National Health Policy for Adolescents, and the Adolescent Health Strategy follow closely in the next year.

Financing to the Health Sector and FP interventions The health sector budget in Uganda has since the FY 2019/20 increased to UGX 3,331.02 billion in FY 2021/22 from UGX 2,589.49 billion, with the Ministry of Health (MoH) taking the largest proportion of the health sector budget, followed by the Primary Health Care (PHC) Grant that is routed to the Local Governments for health service delivery. The National Medical Stores and the Referral Hospitals (cumulative) come third and fourth, respectively.

The study found a higher commitment from donors to fund FP commodities and interventions than the Government of Uganda (GOU). Donor funding to FP in Uganda had increased more than ten-fold since 2021 and gone beyond the USD 20 Million annual targets that GOU had made in the FP2020 commitments.

The availability of these funds likely led to the laxity in GOU investments. As a result, donor-supported, implementing partner-driven and dominated interventions exist for several components of the FP program such as commodity security, service delivery, especially FP outreaches, Behavioural Change Communication (BCC) interventions, and adolescent health interventions.

The National Medical Stores (NMS) vote 116 saw a budget increase between the FY 2020/21 and FY 2021/22 from UGX 14.72 billion to UGX 20.46 billion. The UGX 5.74 billion budget increase, came when there were increased reports of conception among teenagers and couples in union to promote family planning. However, this increase did not necessarily translate into increased allocations for FP commodities and supplies, which, together with Maternal commodities and supplies are catered for under this vote.

The estimated allocations to FP programs under the Ministry of Health (MOH) vote 014 increased by approximately UGX 210 million from UGX 394.4 million in FY 2019/20 to UGX 604.3 million in FY 2020/21. These allocations were only estimates as FP interventions are integrated with other programs in the Reproductive and Infant Health Division's annual work plan. The allocation for FP under the referral hospitals increased between FY 2020/21 and FY 2021/22 from UGX 209.754 million to UGX 229.974 million, with more resources allocated to FP commodities than services.

In FY 2020/21, all the FP commodities were procured with external support from the World Bank, United States Government (USG), and other development partners. Safe Delivery Kits (Maama Kits) were noted to consume over 90% of the Reproductive Health Supplies (RHS) output budget (UGX 14.72 billion); however, in the FY 2020/21 RHS output spend, Maama Kits accounted for only 56% (UGX 8.23 billion) of the budget.

The districts' allocation and expenditure for FP services are covered under the integrated outreaches for FP and other programs like immunization and HIV/AIDS. We noted no explicit reference to the district Family Planning Costed Implementation Plan (FP-CIP) in the annual work plans for FP services. Development partners also heavily funded the National (2015-2020).

The National FP-CIP did not have clear linkages with other strategic documents like the RMNCAH investment case. In the National FPCIP II, there was an effort to harmonize it with

the RMNCAH investment case II. Despite the benefits of FP, the study established that there are still negative perceptions of FP hindering its use and uptake among community members Kyegegwa and Kyenjojo districts. This showed the need to increase investments in mindset change to alleviate the myths and misconceptions and contribute to the improvement of FP indicators.

CONCLUSION

There is continued reliance on external financing to implement interventions in the health sector, including FP. This shows the lack of ownership of FP programming by GOU and likely gives way to development and implementing partners to decide which projects and interventions to focus funding, which might not necessarily be the priorities aligned in the National and District FP-CIPs.

Therefore, taking steps to transition from complete donor dependency towards domestic financing for national and sub-national levels is crucial. Although the NMS - Reproductive Health Supplies budget increased from UGX 14.72 billion to UGX 20.46 billion in FY 2021/22, the split between Mama Kits and FP commodities remains skewed towards the former.

This significantly impedes the strides that could be gained in the form of increased uptake for FP. There is hardly any financing from GOU that is focused on improving FP outcomes for adolescents and young people, yet they constitute more than 50% of the country's population and are the key to helping the country to achieve the Demographic Dividend (DD). In the management of COVID-19, government expenditure fell by 40% in the 2nd half of the FY 2020/21. This was justified by the need to divert resources to COVID-19 response measures. This caused gaps in service delivery and access to FP commodities that had already been procured. However, there was no budget cut to Vote 116 underthe RHS output due to COVID-19.

The programming for FP is majorly health-centred, and funding explicit to FP can only be explicitly traced in the health department. Even when the role of other departments is clear in dealing with teenage pregnancies, there is little effort in implementing a multi-sectoral approach to reducing teenage pregnancy and increasing the access to and right usage of contraception methods.

Individuals, couples, families, parents, communities, health workers, school leadership and teachers, FP champions, opinion, religious and cultural leaders also need to be accountable for their roles in improving FP use. Recommendations Given the ever-increasing population of Uganda, it is evident that GOU needs to be intentional about increasing allocations specific to FP at the national and sub-national levels. NMS should also increase the quantity of FP commodities provided and a wider method mix to enable clients to access methods of their choice easily.

To avoid reliance on external financing, which is unpredictable and unsustainable, GOU should take on alternative financing avenues at the national level. Districts should continue to invest in FP programming from their local revenue and advocate for all departments to contribute to this cause as the improvements in FP indicators affect the health, well-being and productivity of all people who ultimately contribute to the district's development.

The lack of evidence regarding GOU's performance on the FP2020 commitment to allocate 10% of the annual RMNCAH (GFF) budget to Adolescent Health calls for the need to increase investments in FP interventions for adolescents and young people. Allocations specific to FP under NMS Vote 116 should increase their aggregation under RH commodities to include Safe Delivery Kits (Maama Kits), and FP does a disservice to the latter.

Alternatively, CSOs should advocate for a 50% split between these two broad items so that when the overall vote budget is increased, FP commodities also gain from it. The capacity of officers, especially at the sub-national level, should be built-in advocacy for increased investments in FP at the districts to take ownership of the program.

This can be done using their District FPCIPs. A multi-sectoral approach needs to be strengthened at both the national and sub-national levels as FP is not just a health issue but a developmental aspect that cuts across sectors, departments, religions, levels of leadership, communities, families, and individuals.

This also speaks to increasing male involvement in FP related issuesthrough their sensitization in settings where they are relaxed to show them the benefits of planning for their families through having manageable household members. Transparency and access to expenditure data at the national and subnational levels to inform advocacy efforts are vital in improving FP programming.

Investments should be made for the recruitment and training of Health Workers in providing FP information and services at all levels of care. Additionally, Village Health Teams (VHTs) should be trained to provide FP information and services and their stock replenished in a timely manner. They are the first line of call for most FP users in the community.

1.1 Objectives of Study

1. To track health and FP budget allocations at the national level and in four project districts includingKyenjojo and Kyegegwa for FY 2021/22 compared with FY 2020/21 and FY 2019/20.

2. To conduct an expenditure analysis for FY 2020/21 against the approved budget.

3. To identify and evaluate the implementation of existing family planning policies at the national and sub-national levels

4. To document the effect of COVID-19 on the allocation of resources and delivery of FP services.

5. To document community attitudes towards FP and barriers to access and use of FP services, particularly of women and men of reproductive age, religious leaders, influencers, and traditional leaders.

6. To provide a background on key FP indicators at the national and sub-national level, identifying bottlenecks/barriers to access and utilization of FP services.

7. To provide recommendations that will inform evidence-based policy advocacy toward increasing FP financing at the national and district levels

2.0 STUDY METHODOLOGY

2.1 Study area and study group

Western Uganda FBO Network annually tracks family Planning budgets to ascertain whether there is an increased Government of Uganda (GOU) commitment to FP programs and commodities. This budget study sought to track FP allocation at the national and district level. Four districts, namely Kyenjojo and Kyegegwa, where Western Uganda FBO Network operates, were chose to enable comparison across all the years of the study.

2.2 Study design overview

The study employed both quantitative and qualitative methods, which included a review of relevant documents (budgets, expenditure reports and policies), Key Informant Interviews (KIIs), and Focus Group Discussions (FGDs). The qualitative information was used to support the budget and expenditure analysis as it filled information gaps and captured stakeholders' perceptions. The study collected sampled user feedback (through FGDs) on the barriers to access and utilization of FP services, interacted with facility in-charges and FP focal persons to identify FP access and utilization gaps and solutions from the service providers' perspectives, reviewed the budget and policies that facilitate FP service delivery at district and national level.

2.3 Sample size and sampling plan

FP funding from government budgets and expenditure at the national level from the Ministry of Health (MOH), National Medical Stores (NMS), and Referral Hospitals from all the regions were considered. In the four districts, the study covered selected government-supported health facilities with consideration of all hospitals, health center-IV and selected health centres IIIs and IIs. Budget allocations for FY 2021/22 and expenditures for FY 2020/21 were analysed. Data from annual work plans, budget allocations, expenditure reports and other relevant information was collected and analysed using the FP budget and expenditure analysis tool in an MS Excel database.

Table 1: Scope of work:

Level	Institution	Data collection method
District	**Kyenjojo**	Document review, FGDs&KIIs (2 HC IVs, 9 HC IIIs, & 1 HC II)
District	**Kyegegwa**	Document review, FGDs&KIIs (2 HC IVs, 9 HC IIIs, & 1 HC II)

2.4 Data collection tools and procedures Document review:

This involved collecting and reviewing all relevant documents at the national level (MOH, NMS, and referral hospitals) and district level (Kyenjojo and kyegegwa). These included: FP Costed Implementation Plan end term assessment report; approved Annual Work Plans, approved Annual Budgets; Q4 cumulative budget performance reports, RMNCAH sharpened plan I performance assessment. The Budgets and work plans covered FY 2019/20 to FY 2021/22. Key Informant Interviews (KIIs): KIIs were conducted with relevant government officials at national and district levels, mainly to understand the processes of prioritisation and resource allocations for FP and validate and confirm the analysed information. The respondents for the KIIs are proposed as below

Table 2: List of Key Informant Interview respondents

Level	Key Informant
National	Assistant Commissioner Reproductive Health -MoH Chief Procurement Officer – NMS Referral Hospital Directors
District level	District Health Officers and health facility in-charges Chief Administrative Officers

Focus Group Discussions:

FGDs were conducted in each district in numbers not exceeding 10 while maintaining COVID-19 SOPS. The participants were categorized by age and gender: male and female separate, age 15-24 years and then 25 years and above alone. The following categories were included in the FGDs.

2.5 Data management and analysis

The collected data was cleaned and organized using MS Excel. The quality of the results depended on the accuracy of the work plan/ budget and expenditure information obtained. Thus, precautions were taken to avoid double counting or misrepresenting the FP funding and spending through a validation exercise with government officials. Where FP activities were integrated into other budgets/ expenditure lines (i.e., for Reproductive Health), a 'subjective' percentage share of the FP component was determined in consultation with the relevant health facility officials. The subjectivity was based on the proportion of planned total outputs to those specific to FP. The proportion was then applied to the output allocation and or expenditure.

2.6 Ethical considerations

The study was sanctioned by the director for clinical services at the MOH and all the District Health Officers (DHOs) in the participating districts. Consent was sought from all the participants of the Focus Group Discussions. Well-trained research assistants collected all the required data from the participants in the FGDs.

2.7 Study strengths and limitations

Since the study was sanctioned by the MOH, the response rate from the Referral Hospitals (RHs) was good through the Directorate of Clinical Services. Where data gaps were occasioned by the non-responsiveness of the respondents, the budget website (www.budget.go.ug) was used to access the relevant budget data. The assignment was conducted when COVID-19 was still prevalent hence strict observation of Standard Operating Procedures (SOPs).

The National Medical Stores was also not forthcoming with information on the breakdown for FP expenditure from the Reproductive Health Supplies output. The data we needed was the monthly stock status reports from FY 2019/20 to FY 2020/21.

2.8 Structure of the report

This report is divided into eight parts, as outlined here. The first part gives the study's background, objectives, and methodology. Part two provides the study methodology while part three briefly analyses FP-related policies in Uganda. Part four provides a review and analysis of budget allocations and spending on FP. Part five includes information from the Focus Group Discussions on access to and utilization of FP services in the four districts. Part six contains the general discussion of the study, while part seven outlines the conclusion. Part eight states recommendations based on the findings, while the references come last.

Chapter 1: Background and Introduction

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

The trend of FP services in Uganda is improving, according to the HSDP 2015/16 – 2019/20. But while the adolescent fertility rate, the unmet need for FP, and the CPR are all on an upward curve, the improvements are happening "too slowly to achieve country targets."7 FP services are crucial in efforts to reduce and prevent maternal, infant, and child mortality, and have both direct and indirect links and contributions to broader health, social, and economic outcomes. Trimming down the incidence of unintended pregnancies could avert maternal deaths, for example. Access to FP programmes has the potential to lessen poverty, enhance gender equity, check the spread of HIV, drive down unwanted teenage pregnancies, and reduce infant deaths. Investment in FP could generate savings for households and countries on health, housing, water, and public services generally.

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

The comprehensive set of FP interventions the GOU is pursuing is spurred by the recognition that addressing the current situation requires a multi-pronged approach. For instance, as noted in the FP-CIP, the CPR rate is an outcome of a combination of factors: access to information, education, and counseling; FP commodity security; staff availability and skills; as well as social and cultural influences. Boosting the CPR rate therefore requires improving access to contraceptive information especially for adolescents and young people, as well as expanding the range ofcontraceptive options available to users. Yet, the use of condoms and IUDs and FP as a whole are afflicted by certain myths and misconceptions not only in the general population but also among health workers. In addition, the delivery of FP services in Uganda as in East Africa generally is constrained by the shortage of skilled providers and frequent stock-outs of contraceptive commodities.10 Yet the challenges notwithstanding, the MOH reports that based on the CYP as a measure of FP use, Uganda recorded an 18% increase in the CYP from2,156,240 in 2016/2021 to 2,540,251 in

2021/2022. There was a noteworthy rise in the use of IUDs and implants but a decline in the number of users of all other methods.

Key Demographic and Socio-Economic Statistics According to 2014 National Population and Housing Census:

⇐ Uganda's population was projected to be 40.3 million by mid-year 2019

⇐ Annual population growth rate between 2002 and 2014 censuses was 3.03%

⇐ Population density was 174 persons per square kilometre

⇐ Sex ratio was 94.5 percent in 2014 According to the 2016 Uganda Demographic and Health Survey:

⇐ Total fertility was 5.4 children per woman

⇐ Infant mortality rate was 43 deaths per 1,000 live birth

⇐ Under-five mortality rate was 64 deaths per 1,000 live birth

⇐ Life expectancy at birth was 63.7 years.

Source: 2019 Statistical Abstract. Uganda Bureau of Statistics

Innovation is considered a cross-cutting domain in this strategy. The scaling up of innovative FP products and methods of delivering services such as the Sayana Press self-injectable, voucher scheme, postpartum IUD, and postpartum FP are elevating the levels of access to FP. Operational innovations such as task shifting and task sharing can increase access to and

Most of the existing structures for partnership engagement are largely moribund, and not providing the needed forums for sector engagement. Some partners are therefore sidestepping these structures, and providing support that is not coordinated and harmonized. The SWAp process and the Health Policy Advisory Committee (HPAC) functionality are therefore compromised, with current focus primarily on statutory actions (e.g. endorsing proposals) as opposed to being forum for dialogue. The Technical Working Groups (TWGs) and Intersectoral coordination functionality are sub optimal, and there is limited real engagement of some stakeholder groups. Merit however needs to be given to the tenacity of the partnership and coordination structures, like HPAC and Health Development Partners (HDPs) forum which have largely continued to exist in spite of this environment."13

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

OVERVIEW

Building on the achievement and momentum built as a result of Uganda's commitments to FP2020 partnership, the sustainable development goals and renewed global strategy for

women's and children's health, the government of Uganda undertakes the following commitments:

- The Government of Uganda commits to increase the modern contraceptive prevalence rate (mCPR) for all women from 30.4% in 2020 to 39.6% by 2025 and reduce unmet need from 17% in 2020 to 15% by 2025.
- Noting that Uganda is one of the youngest countries in the world, the Government of Uganda re-commits to annually allocate at least 10% of Maternal and Child Health (MCH) resources to adolescent responsive health services by July 2025.
- Government of Uganda commits to annually ring fence 50% of the domestic resources allocated for procurement, warehousing and distribution of FP commodities from the reproductive health (RH) commodities budget (NMS Vote 116 under Output 15- Supply of Reproductive Health Items) by 2025
- The Government of Uganda commits to improve FP data quality through ensuring use of DHIS2/Health Management Information System (HMIS) data for decision making at Service Delivery Points (SDPs) in the public and private sectors.
- The Government of Uganda commits to improve quality of FP counselling (available FP options, possible side effects, their management and switching) among SDPs, community health workers and peer-to-peer from the current Method Information Index Plus (MII+)i of 42% (2020) to 60% by 2025.

ANALYSIS OF NATIONAL POLICIES AND OTHER LEGAL INSTRUMENTS IN RELATION TO THE STUDY

Uganda is the third fastest-growing country globally, with a population of 45 million. 48% of the population is under the age of 15 (The Republic of Uganda, 2019). On average, women will have approximately seven children (6.9) if contraceptive and fertility patterns do not change.

Nearly half of all pregnancies in Uganda are unplanned, and that narrative needs to change if the country is set on averting a population explosion (The Republic of Uganda, 2019).

If the mindset and behaviour of the populace do not change and investments in FP/SRH do not increase, the Maternal Mortality Rate (MMR) is likely to rise to a point where 435 women will die for every 100,000 live births, because of pregnancy-related causes. It is

estimated that 8,200 Ugandan women die annually from pregnancy-related causes (Ensuring Access to Family Planning for All in Uganda, n.d.).

There are more than 6.5 million Ugandan Women of Reproductive Age (WRA) from 15-49 years. Among them, 39% use any method of contraception, and 31% use a modern, more effective method (09.08.21 Performance Review Report of Uganda's FP2020 Commitments, n.d.-a) The most used methods are contraceptive injectables (15.5%) and oral contraceptive pills (4.6%).

An estimated 37% of Ugandan women want to prevent pregnancy but do not use modern contraception—this is the unmet need. Of those women with unmet need, 57% desire to wait at least two years before having a child (or another child), and 43% want to stop childbearing altogether.2 Despite government actions to increase coverage, two out of every three Ugandan women who want family planning do not have access to modern methods of contraception. (Ensuring Access to Family Planning for All in Uganda, n.d.)

A review of the performance of some RH indicators further amplifies the need for adequate public financing for Reproductive Health, and in particular, Family Planning. The Maternal Mortality Rate (MMR) averaged 429 per 100,000 live births between 2001 and 2016.2 This rate increased from 418 to 438 per 100,000 live births between 2006 and 2011 before reducing to 336 per 100,000 live births in 2016. 28% of currently married women and 32% of sexually active unmarried women had an unmet need for family planning. However, this is not a significant change in relation to the unmet need of 29% of married women recorded in the 1995 UDHS.

This could be due to changes in the computation for unmet need over the years and many other reasons that need further interrogation, funding being one of them. The modern Contraceptive Prevalence Rate (mCPR) is increasing.

Still, Uganda did not reach its target of 50% by 2020 (30.4%3 as at the end of 2020) as was set in the Family Planning Costed 2 Uganda Demographic Health Surveys; 2001 - 2016 3 National Family Planning Costed Implementation Plan 2020/21 - 2024/25

UGANDA'S PERFORMANCE ON FINANCIAL COMMITMENTS AND INVESTMENTS FOR FP

FP2020 financial commitments

As committed at the FP2020 London summit, and subsequently recommitted in 2021, the Government of Uganda (GOU) was to allocate $5 million annually from domestic resources for procurement and distribution of a range of FP supplies and RH commodities up to the health facility level.

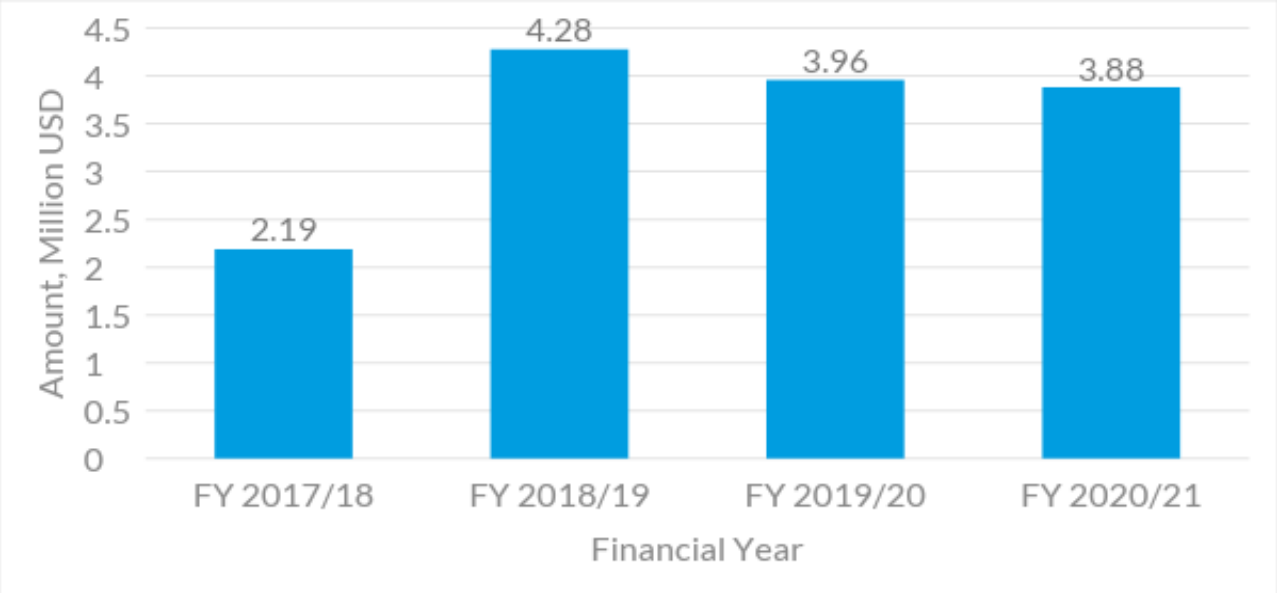
The annual financial allocations show that this commitment was only met in FY 2013/14 and 2014/15. In FY 2020/21, the allocation was for the procurement, storage and distribution of Medroxyprogesterone and Safe Delivery Kits (Maama Kits).

From FY 2020/21 to FY 2020/21, allocations fell short of the FP2020 commitment of USD 5 Million leaving funding gaps of USD 2.81, 0.72, 1.04 and 1.12 million, respectively. Notably, in the FY 2020/21, 56% of the annual allocation under the National Medical Stores (NMS) Vote 116 under the RHS output went to Mama Kits, while GOU spent nothing on FP commodities.

This highlights the fact that without an exclusive budget line for FP commodities, the GOU expenditure will always be re-prioritized since FP commodities are heavily and externally supported through donations. The USD 5 Million commitment of FP expenditure made in 2012 and renewed in 2021was never met.

An in-depth review of the RHS output under NMS, as highlighted later in this report, reveals this. The GOU allocations for RH commodities and supplies from FY 2020/21 to FY 2019/20 are displayed in the figure below.

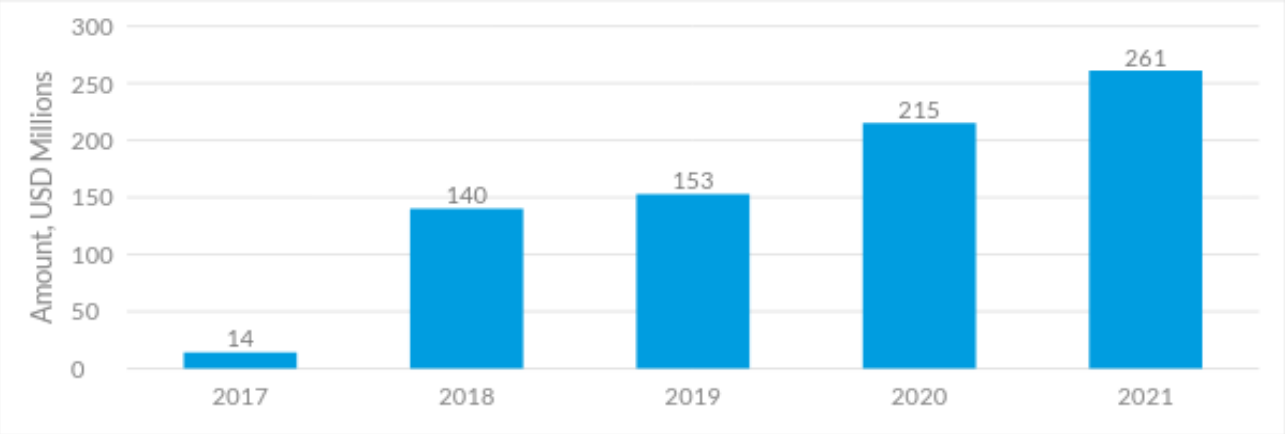
Figure 1: GoU allocations to RH supplies from FY 2020/21 to FY 2020/21 (Million USD)



Source: Consolidated Ministerial Policy Statements, Vote 116 NMS performance reports

The financial data shows a higher commitment of donors relative to the GOU on procurement of FP commodities, as shown by the Family Planning/ Reproductive Health Commodity Security (FP/RHCS) working group quarterly reports. This is further emphasized by the FP2020 commitment to raise $20 Million annually through continued partnership with development agencies and the private sector. The annual amounts raised for RH from development partners from 2021 to date are displayed in the figure below.

Figure 2: Amounts raised from development partners for RH from 2021 to 2021, USD Million



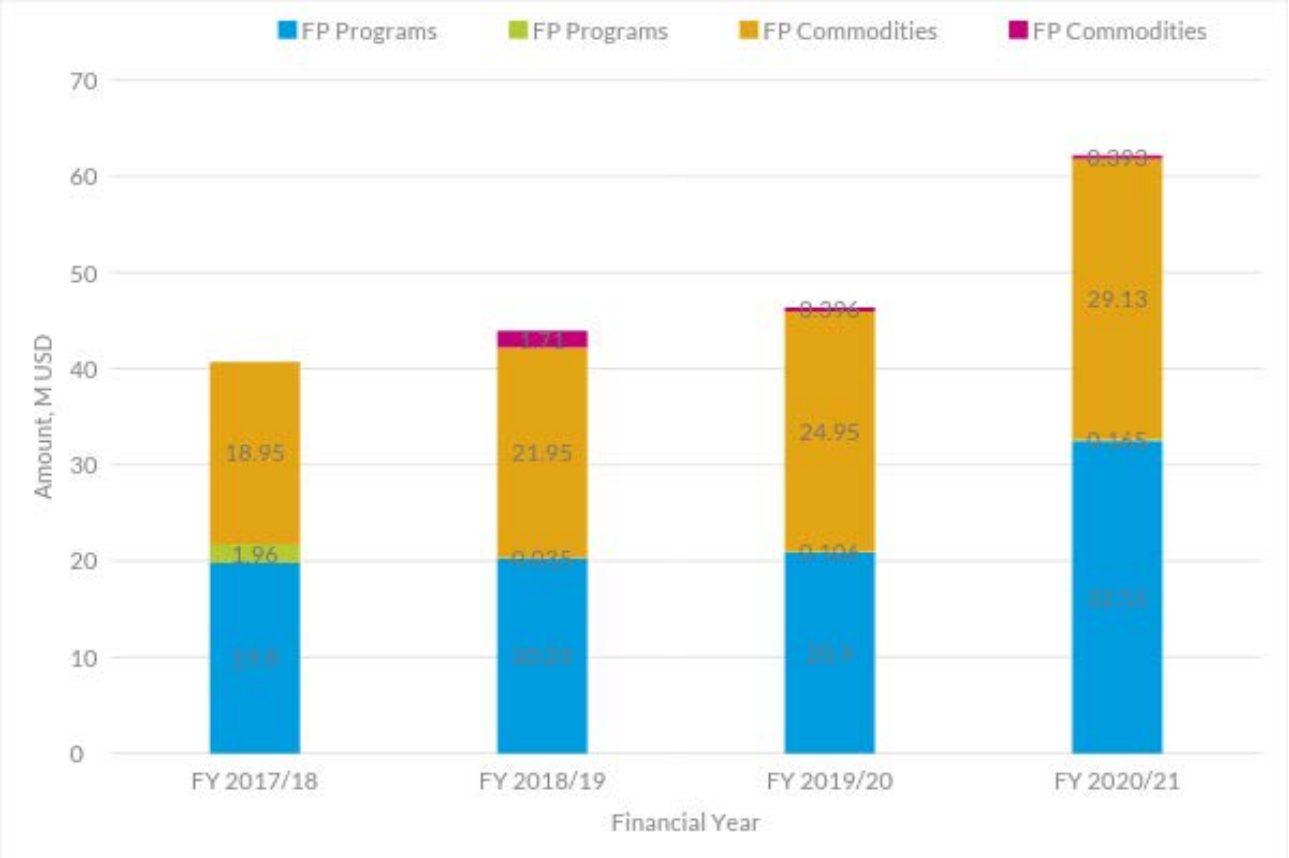
Donors and implementing partners support several components of the FP program such as commodity security, service delivery, especially FP outreaches, Behavioural Change Communication (BCC) interventions, and adolescent health interventions. The amounts raised from donors have increased more than ten-fold since 2021 and exceeded the USD 20 Million annual target. The availability of these funds has ledto laxity in GOU investments and, as a result, caused a sustainability risk. Countries like India and Rwanda intend to move from donor to public-funded FP commodity security, demonstrating greater sustainability of the FP program and a growing mCPR. Therefore, taking steps to transition from complete donor dependency towards domestic financing for national and sub-national levels is crucial.

FINANCIAL PERFORMANCE OF THE NATIONAL FP CIP (2015 - 2020)

The development of the first National FPCIP was informed by the investment case for the RMNCAH sharpened plan. The estimated overall cost of implementing the FP-CIP over the five years was USD 235.1 Million. FP CIP stipulated the costs of implementing interventions under the six thematic areas of Stewardship, Management and Accountability, Financing, Contraceptive (Commodity) Security, Policy and Enabling Environment, Service Delivery, and Demand Creation.

It further divided Contraceptive security costs into commodities and contraceptive programs. The RH/FP allocations are divided into the FP programs (Stewardship, Management and Accountability, Financing, Contraceptive programmes, Policy and Enabling Environment, Service Delivery, Demand Creation) and FP commodities and supplies. Figure 3 below compares the cost estimates for the implementation of FP programming with the allocations from FY 2020/21 to FY 2020/21.

Figure 3: Estimated costs and allocations for FP from FY 2020/21 to FY 2020/21 in USD Millions



Sources: FP CIP I, FP CIP II, Reproductive & Infant Health Division work plans, MOH commodities Stock Status Reports

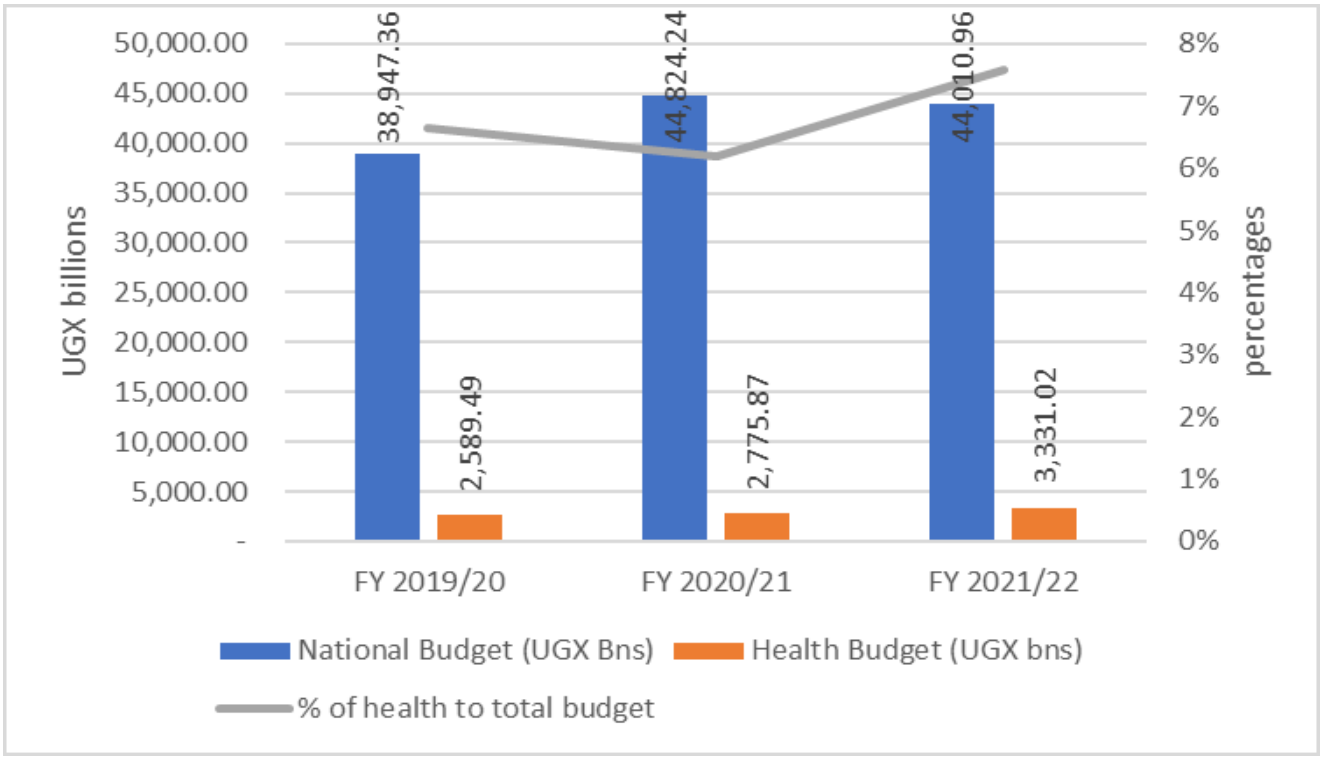
*100% allocation went to Safe Delivery Kits (Maama Kits) as NMS had leftover stock of FP commodities from the previous years. Domestic budgets per FY were significantly below the estimated costs (allocations between 0.2% and 1% for FP programs) and (1% and 8% for FP commodities) thereby contributing to the gaps in the implementation of FP interventions, especially in Stewardship, Management and Accountability, Policy, and Enabling Environment, as well as Demand Creation. Development partners supported the implementation of these areas through partnerships with GOU and projects based on their interests.

BUDGET ANALYSIS FINDINGS

This section presents annual budget allocation trends for the national level and selected districts. This section also covers an in-depth analysis of the FY 2020/21 for the health sector and particularly Family Planning. 4.1 Review and analysis of health budget allocation trends at the national level.

The government of Uganda approved a national budget of UGX 44,010.96 billion in the FY 2021/22, of which 3,331.02(8%) was allocated to the health sub-program, an increase from UGX 2,775.87 billion in FY 2020/21. For the period under review, the Ministry of Health (MOH) took the largest proportion of the health sub-program budget, followed by the Primary Health Care (PHC) Grant that is routed to the Local Governments for health service

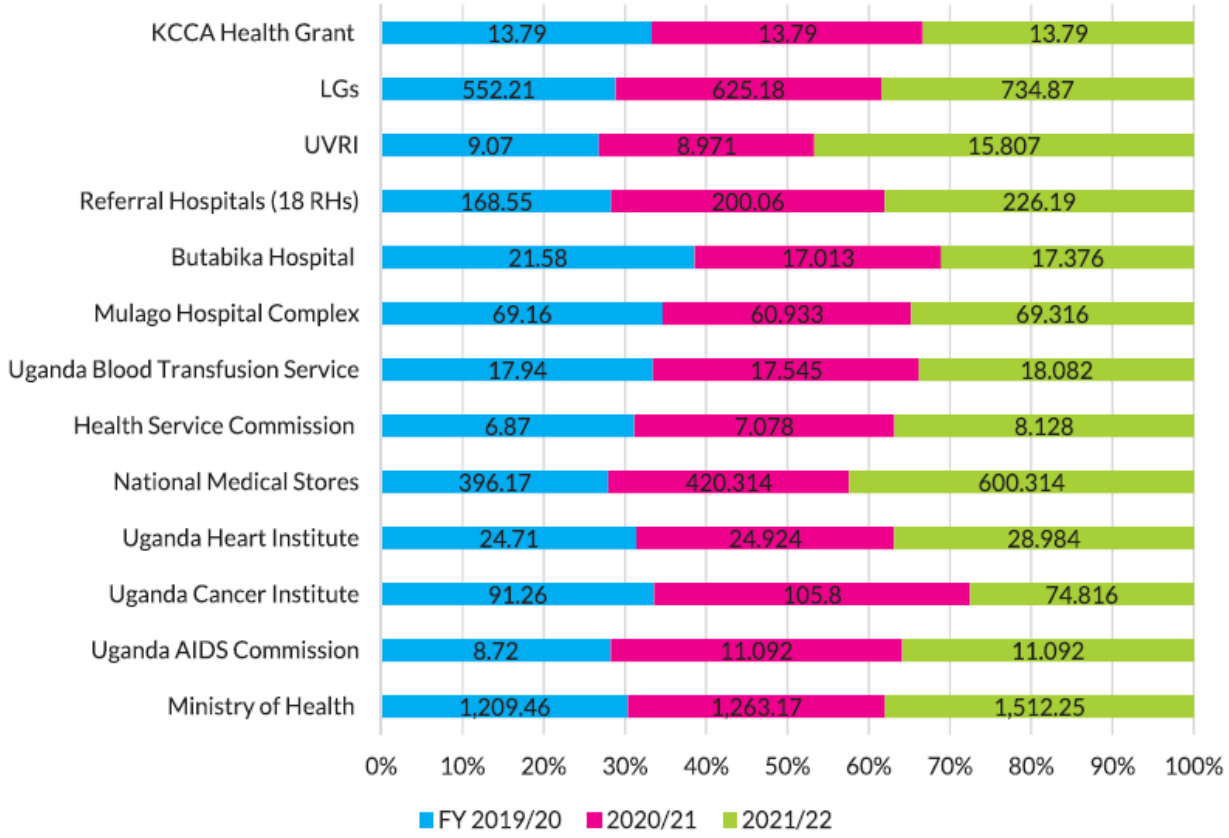
delivery. The National Medical Stores and the Referral Hospitals (cumulative) come third and fourth, respectively.



Source: Western Uganda FBO Network own computations and calculations

The health sub-program budget is further divided among 13 MDAs and LGs as indicated in Figure 5 below. The Ministry of Health and the National Medical Stores are taking the biggest share of the budget.

Figure 5: Health sub-program budget allocation trend FY 2019/20 - 2021/22 (UGX Bns)



Source: Approved budget estimates FY 2019/20 – FY 2021/22

REVIEW AND ANALYSIS OF THE HEALTH BUDGET EXPENDITURE FOR FY 2020/21 AT THE NATIONAL LEVEL

This section highlights the allocation and expenditure analysis for the FY 2020/21 for national and district budgets. Table 4: Expenditure analysis for FY 2020/21 against the approved budget, Billion UGX**,** The work plans were reviewed for activities such as policy reviews, coordination meetings, sensitisation sessions, review, pre-test and update of supervision and mentorship tools, on-job supervision, mentorship and coaching for service providers in selected districts on the integration of FP into other services, quarterly FP meetings, commodity security meetings, supporting the development of district FP-CIPs, commemorating International FP day, supporting the roll-out of DPMA-SC (Depo Provera) and tracking implementation of FP procurement plan. Where FP activities were integrated with others in the division work plan, a proportion attributable to FP was taken based on the advice of officials in the division.

REVIEW AND ANALYSIS OF FAMILY PLANNING BUDGET ALLOCATION TRENDS AND EXPENDITURE AT THE NATIONAL LEVEL.

In tracking budgets for FP, the two components that are considered are FP programs and FP commodities. The budget allocation for Family Planning at the national level has been taken, for this study to cover allocations in the National Medical Stores under the Reproductive Health Supplies, the estimated amount budgeted for FP-related activities in the Ministry of

Health Reproductive and Infant Health (R& IH) Division annual work plan and the proportion of funds in RHs that are allocated and spent on FP to deliver on the "number new and old FP users" indicator.

While the FP commodities are catered for under vote 116, FP programs, including Service Delivery and Access, Financing, Stewardship, Management and Accountability, Policy and Enabling Environment and Demand Creation, are under vote 014 (Ministry of Health) and the Referral Hospitals. The R&IH Division of the Ministry of Health has no budget line specific for FP. As such, estimates of the allocations for FP programs were derived from integrated activities in the annual work plans of the R&IH Division.

Table 5: Estimated Budget allocations for FP Programs under Vote 014 in UGX

Table 5: Estimated Budget allocations for FP programs under Vote 014 in UGX

Financial Year	2018/19	2019/20	2020/21
FP programs	130,767,000	394,400,000	604,332,000

Source: MOH Integrated Annual work plans for Reproductive, Maternal and Child Health Department FY 2018/19, FY 2019/20, FY 2020/21.

The work plans were reviewed for activities such as policy reviews, coordination meetings, sensitisation sessions, review, pre-test and update of supervision and mentorship tools, on-job supervision, mentorship and coaching for service providers in selected districts on the integration of FP into other services, quarterly FP meetings, commodity security meetings, supporting the development of district FP-CIPs, commemorating International FP day, supporting the roll-out of DPMA-SC (Depo Provera) and tracking implementation of FP procurement plan. Where FP activities were integrated with others in the division work plan, a proportion attributable to FP was taken based on the advice of officials in the division.

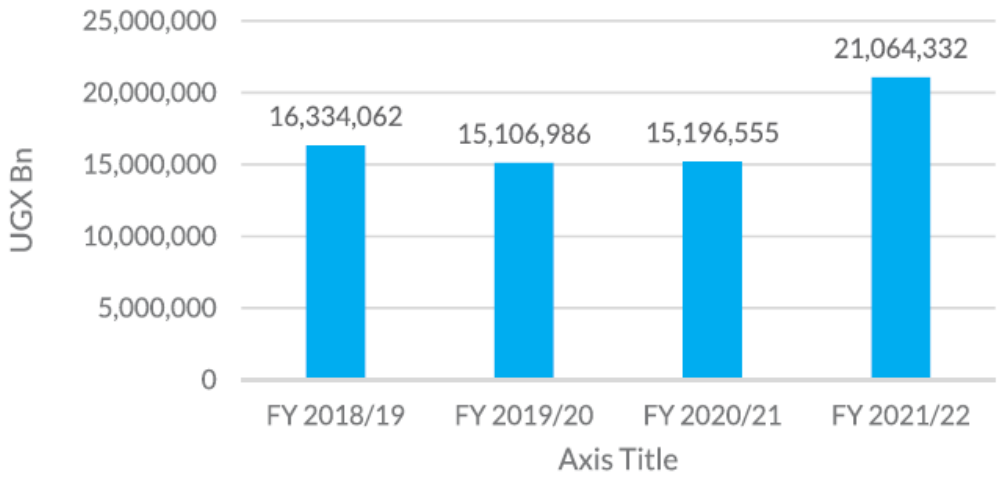
Table 6: National FP Budget allocation trend FY 2021/2022 – 2021/22 (UGX '000)

Table 6: Table 5: National FP Budget allocation trend FY 2021/2022 - 2021/22 (UGX '000)

	Category	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
National Medical Stores (RH supplies)	Commodities	16,000,000	14,720,028	14,720,000	20,460,000
RHs	Service Delivery	233,089	386,885	394,418	229,974
MoH	FP programs	100,973	73	82,137	604,332
Total		16,334,062	15,106,986	15,196,555	21,064,332

Source: Approved Budget Estimates, Ministerial Policy Statement and FP Budget Analysis Report FY 2020/21

Figure 6: National FP Budget allocation trend FY 2019/20 - 2021/22 (UGX '000)



Source: Approved Budget Estimates, Ministerial Policy Statement and FP Budget Analysis Report FY 2020/21

The allocation for FP under the referral hospitals increased between FY 2020/21 and FY 2021/22 from UGX 209.754 million to UGX 229.974 million, with more resources allocated to commodities than services. The National Medical Stores saw a budget increase between FY 2020/21 and FY 2021/22 from UGX 14.72 billion to UGX 20.46 billion.

The UGX 5.74 billion budget increase came when there were increased reports of conception among teenagers and couples in the union to promote family planning. To further understand the allocation under the RH budget line in the NMS, we reviewed the Ministry of Health monthly stock reports that revealed all the procured commodities were not funded by GOU funds, as highlighted below. Table

Table 7: FP Commodities procured in FY 2020/21 (UGX)

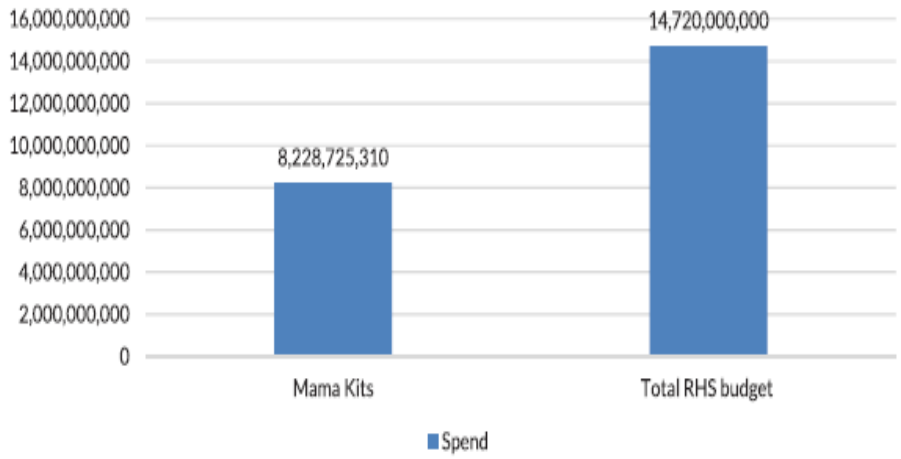
FP Commodity	Annual Spent	Source of Funding
Ethinylestradiol 0.03+Levonorgestrel 0 .15mg 3 cycles	952,585,198	External
Medroxyprogesterone Acetate. 150mg/Ml Inj with Syringe	3,107,313,456	External
IUD-Copper Containing Device Tcu380a	177,183,199	External
Levonorgestrel 1.5mg Tabs	125,889,757	External
Levonorgestrel 2 x 75 Mg, Implant (Jadelle)	2,332,477,826	External
Etonogestrel 68mg Implant (Implanon)	8,066,154,338	External
Levonorgestrel 0.03mg Tab 3 Cycles	51,769,520	External
Sayana Press 104 mg/Ml 200 x 0.65	3,603,994,193	External
Levonorgestrel 0.75mg Tabs	19,690	External

Source: MoH monthly stock status reports

From the table above, all the FP commodities were procured with external support, either from the US-Government (USG) or Donations (TPT). From the literature reviewed, Mama Kits were noted to consume over 90% of the RHS output budget (UGX 14.72 billion). With

the FY 2020/21 RHS output spend review, Safe Delivery Kits (Maama Kits) accounted for only 56% (UGX 8.23 billion) of the budget.

Figure 7: FY 2020/21 FP expenditure Vs Mama Kits off the RHS budget (UGX)



Source: Monthly MoH Stock reports FY 2020/21

4 Monthly MoH Stock Reports FY 2020/21

REVIEW AND ANALYSIS OF FOUR SELECTED DISTRICT HEALTH AND FAMILY PLANNING BUDGET ALLOCATION TRENDS AND EXPENDITURE

Districts receive medicines from the national medical stores against a health facility's budget for the essential drugs. The health budget at the district level is funded through grants from the central government through the DHO's office and directly to the Health Facilities. Upon quarterly requests, funds are released to the districts. Family Planning at the district level is funded through the integrated outreaches and through the commodities delivered by the National Medical Stores.

This study sampled four districts of Kyenjojo and Kyegegwa, and their allocations trended from FY 2019/20 to FY 2021/22. All the districts under review had increasing health department budgets between FY 2020/21 and FY 2021/22 except for KyenjojoDLG. The health department budget for Kyenjojowas reduced from UGX 12.877 billion to 12.048 billion between FY 2020/21 and FY 2021/22.

The allocation for FP in the districts is explicitly situated in the health facility budgets under the reproductive and maternal health sub-programme. The explicit GOU activity tagged to FP is integrated facilitation for outreaches that are central to demand creation and providing services (counselling and dispensation of commodities) to underserved populations in the communities.

PRIORITIZATION OF FAMILY PLANNING

The key to determining family planning prioritization is reviewing National and District Planning and Policy documents. A review of different plans and policies showed that the country recognizes a wide range of family planning benefits and prioritizes provision of family planning services.

Vision 2040:In this blueprint, the country captures a wide range of aspirations that Ugandans have. One of the aspirations that links directly to family planning is the desire for better quality of life. According to the blueprint, *"Ugandans desire to have access to affordable quality health and education services. They aspire for a healthy, literate and well-informed society, a desire to live in clean and well-planned settlements with access to all social amenities. They aspire to be a society free of hunger with strong social safety nets*." The blueprint is alive to the fact that the majority of Uganda's population is young. Vision 2040 reflects this reality and focuses on leveraging this demographic dividend as the strategy for moving the country forward.

National Development Plan III.In this plan, Uganda recognizes the high unmet need for family planning services and seeks to facilitate sexual and reproductive health care services. These include family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030. To harness demographic dividends, the country plans to implement policies that accelerate rapid decline in fertility and ensure the resulting surplus labour force is well educated, skilled, healthy and economically engaged. To achieve this, the country commits to focus on improving access to various services including family planning services.

***National Population Policy, 2008*:** In this policy, Uganda lays down strategies for reducing the unmet need for family planning. These strategies include i) Advocacy to make family planning services affordable, available and accessible ii) Provision of family planning information and increased utilization of family planning and iii) Promotion of reproductive health commodity security.

***Health Sector Development Plan (2015/16 – 2019/20)*:** This plan prioritizes improving a wide range of health services including Reproductive, Maternal, Neonatal, Child, and Adolescent health services to reduce avoidable deaths of mothers and children and improve their health status.

District Costed Implementation Plans (DCIPs) - The two focus districts have DCIPs that show how much investment is required to make family planning services accessible to women and girls in the district each year. The DCIPs provide five strategic family planning priorities and costings as follows:

FP Priorities and Annual Allocations

	Kyejojo District	Kyegegwa District

Priority	2020/2021 (in millions)	2021/2022 (in millions)	2020/2021 (in millions)	2021/2022 (in millions)
Demand Creation	74.94	104.66	*131.3*	117.3
Service Delivery & Access	191	207	263	230
Policy & Enabling Environment	24.3	22.3	27.9	18.2
Contraceptive Security	29.6	41.8	68.6	45.5
Financing	56	65.6	82	154
Stewardship, Management & Accountability	186.4	188	170	213
	562.24	**629.36**	**742.8**	**778**

Source: Costed Implementation Plans –KyenjojoDistrict, and Kyegegwa district action plan-Charter

The DCIPs are supposed to guide family planning allocations in the Districts. However, analysis of actual FP allocations in the two districts showed that FP allocations remain low and that there is a high likelihood that DCIPs may not be informing FP investment. Districts do not have clear FP budget lines and while the amount allocated to FP is provided in the workplan, it is difficult to determine how much money is allocated for each strategic FP priority.

BUDGET ALLOCATION TOWARDS FAMILY PLANNING IN KYENJOJO AND KYEGEGWA DISTRICTS.

There are efforts to make Family Planning services accessible to women aged between 15 and 49 years by the District Local Governments. Those efforts are reflected in budgetary allocations, disbursements and absorption.This chapter discusses key findings made in budget allocation towards family planning in the two focus districts. The following documents were reviewed to establish family planning allocation:

- Approved Budgets for Kyegegwa and Kyenjojo Districts - 2020/21 and 2021/2022 financial years

- Approved Annual Work Plans for Kyegegwa and Kyenjojo Districts - 2020/21 and 2021/2022 financial years
- District Costed Implementation Plans for Kyenjojo Districts
- Health Facility Financial Data for Kyenjojo District

In the two years under review, allocations towards the health sector in the two focus districts increased. However, our analysis showed that the increase in the health budget was not commensurate to the increase in the total district budget. At the same time, the increase in health sector budget allocation did not always result in an increase in the family planning budget. Below are key observations made in each focus district.

HEALTH SECTOR BUDGET VS TOTAL DISTRICT BUDGET

Case 1: KyegegwaDistrict

KyegegwaDistrict government allocated 21% and 24% of the total district budget to the health sector as shown in the table. In the 2021/2022 financial year, the health sector budget allocation increased by 3% against a 25% increase in the total district budget in the same financial year.

Table 2: Percentage Share of Health Budget inKyegegwa

Financial Year	Total District Budget 000'	Health Sector Budget 000'	%age Share to Budget
2020/21	22,688,130	4,871,965	21%
2021/2022	30,143,189	7,352,459	24%

Source: Kyegegwa District Approved Budget for 2020/21 and 2021/2022

Case 2: Kyenjojo District

In the two years under review, Kyenjojo District allocated 16.6% and 20.5% of its total budget to the health sector as shown in the table below. Further analysis of the district budget showed that in the 2021/2022 financial year, budget allocation towards the health sector increased by 3.9% against a 19% increase in the total district budget during the same period.

Table. 3: Percentage Share of Health Budget in Kyenjojo District

Financial Year	Total District Budget	Health Sector Budget	%age Share to

	000'	000'	Budget
2020/21	27,249,979	4,532,684	16.6%
2021/2022	33,739,360	6,924,317	20.5%

Source:*Kyenjojo District Approved Budget for 2020/21 and 2021/2022 Financial Years*

SHARE OF FAMILY PLANNING BUDGET IN THE HEALTH SECTOR BUDGET

Case 1: Kyegegwa District

A review of the approved work plan for Kyegegwa district showed that the district allocated a portion of the health sector budget towards family planning. In the two financial years under review, Kyegegwa District allocated 3.8% and 2.5% of the health sector budget to family planning as shown in the table below.

Table 4: Amount dedicated to Family Planning in Kyegegwa District

Financial Year	Health Sector Budget 000'	FP Allocation 000'	%age FP Share to Health Budget
2020/21	4,871,965	189,325	3.8%
2021/2022	7,352,459	185,023	2.5%

Source: Kyegegwa District Approved Work Plan 2021/2022

According to the approved work plan, these resources were to be spent on community mobilization and sensitization, outreach services, health education, procuring and managing logistics, mapping of reproductive age group and recording and reporting.

Further analysis of the health sector and FP budgets showed that Kyegegwa district's allocation towards FP dropped by 1.3% in the 2021/2022 financial year despite the 3% increase in the health sector budget the same year. The fact that the allocation to FP reduced even when the total health budget increased means that the FP budget allocation is not protected and is prone to fluctuate due to varying factors.

It was also noted that the Kyegegwa District budget does not have an express budget line for FP. The percentages were computed based on amounts provided in the work plan.

Case 2: Kyenjojo District

A review of health facility financial records showed that Kyenjojo District allocated 0.17% of its health sector budget to family planning in both 2020/21 and 2021/2022 financial years as shown in the table below. Though the FP percentage share to the total health budget remained the same in the two financial years, further analysis showed that allocation to FP increased by 57% in the 2021/2022 financial year.

Table 5: FP Allocation as a Percentage of Health Sector Budget

Financial Year	Health Sector Budget 000'	FP Allocation 000'	%age FP Share to Health Budget
2020/21	4,532,684	7,708	0.17%
2021/2022	6,924,317	12,137	0.17%

*Source: Kyenjojo District Health Facility Financial Data***

Even so, it was noted that Kyenjojo District does not have a clear FP budget line. The percentages above were computed based on financial data available at facility level. Considering the low percentage share of the health budget, FP appears not to be a priority even within the health sector.

ACTUAL FP INVESTMENT VS INVESTMENT RECOMMENDED IN THE DCIP

Case 1: Kyenjojo District

An analysis of actual amounts allocated to in Kyenjojo District and the amounts recommended in the District Costed Implementation Plan for FP showed that the actual FP budget allocations were significantly low in the years under review.

This is a clear indication that the DCIP is not informing FP budget allocation in the district. Based on the analysis, KyenjojoDistrict's investment towards FP was about 13.7% and 19.3% of the amounts recommended in the DCIP in 2020/21 and 2021/2022 financial years respectively as captured in the table below.

Table 7: Actual FP Investment vs Kyenjojo'sDCIP's Recommended FP Investment

Financial Year	Recommended FP Allocation - DCIP 000'	Actual FP Investment 000'	%age of Recommended Investment
2020/21	56,224	7,708	13.7%

2021/2022	62,936	12,137	19.3%

*Source: Kyenjojo District DCIP and Health Facility Financial Data***

SOURCE OF FAMILY PLANNING FUNDS

We sought to establish the source of funds that the two focus districts allocate towards family planning. While this information is not available on the budget and health sector work plans, it was possible to extract it from health facility data. We were not able to get health facility data in Kyegegwa District at the time of this study. However, this data was available in Kyenjojo District and its analysis and findings gives an idea of the family planning financing landscape in the two districts.

Case 1: Kyenjojo District

Kyenjojo District appears to be relying heavily on donors to fund the family planning component. A review of health facility financial data showed that in the two financial years under review, only 15% of family planning funds budgeted for in 2021/2022 came from government sources and in 2020/21, the district did not contribute any funds towards family planning as shown in the table below.

Table 8: Source of FP Funds

Financial Year	Approved Budget 000'	Support from Donors 000'	Support from Gov't 000'
2020/21	7,708	7,708 (100%)	0
2021/2022	12,137	10,357 (85%)	1,780 (15%)

*Source: Kyenjojo District DCIP and Health Facility Financial Data***

Based on this data, FP financing in Kyenjojo District appears not to be sustainable due to the high level of donor dependence. This puts FP services at risk of lacking financial support in the event that donors decide to pull out.

FAMILY PLANNING BUDGET DISBURSEMENT

To provide FP services, Districts need to receive the funds allocated to the health sector disburse it to health facilities where citizens access services. Where budgeted amounts are not disbursed, the quality of services that citizens receive can be affected significantly because it means Districts or health facilities have to adjust their plans downwards. Our analysis looked at disbursement at two levels - disbursements made to the districts in focus and disbursements made by the districts to health facilities.

DISTRICT REVENUE SOURCES AND AMOUNTS DISBURSEMENT

The tables below summarizes the amounts disbursed to the districts from various revenue sources based on the approved budgets.

Case 1: Kyegegwa District

Based on the figures below, the district received 99% and 92% of the total budgeted amounts in 2020/21 and 2021/2022 financial years. The amount of funds transferred to the district by donors was 21% and 16% respectively, which is significantly low. This means the district was not able to undertake some activities that it had budgeted for. Kyegegwa district has no CIP for family planning.

Table 9: Funds received by Kyegegwa District from different sources

	2020/21		2021/2022	
Revenue Source	**Approved Budget**	**%age Disbursed**	**Approved Budget**	**%age Disbursed**
Locally Raised Revenues	690,372	76%	838,352	87%
Discretionary Government Transfers	3,026,944	98%	3,500,374	100%
Conditional Government Transfers	18,298,987	95%	21,825,161	99%
Other Government Transfers	0	0	1,437,735	104%
Donor Funding	671,827	21%	2,541,567	16%

Total Revenues shares	22,688,130	99%	30,143,189	92%

Source:*Kyegegwa Quarter 4 Annual Performance Report for 2020/21&2021/2022*

Case 1: Kyenjojo District

The district received 97% and 94% of the approved budgets for the 2020/21 and 2021/2022 financial years. Just like in Kyegegwa District, disbursement from donors was significantly low in Kyenjojo with our analysis showing that only 49% and 34% of the budgeted amount was received in the two consecutive years under review.

Table 10: Funds received by Kyenjojo District from different sources

	2020/21		**2021/2022**	
Revenue Source	**Approved Budget**	**% age Disbursed**	**Approved Budget**	**%age Disbursed**
Locally Raised Revenues	242,500	77%	242,500	90%
Discretionary Government Transfers	4,655,250	100%	5,539,790	100%
Conditional Government Transfers	19,007,390	94%	23,031,563	100%
Other Government Transfers	898,739	289%	4,121,985	67%
Donor Funding	2,446,100	49%	803,522	34%
Total Revenues Shares	**27,249,979**	**97%**	**33,739,360**	**94%**

Source:*Kyenjojo Quarter 4 Annual Performance Report for 2020/21&2021/2022*

HEALTH SECTOR BUDGETS DISBURSED TO LOCAL GOVERNMENTS

A review of District Quarterly Performance Reports showed that the districts did not receive all the Health Sector funds they budgeted for in the two years under focus as follows.

Case 1: Kyegegwa District Case

Based on the table below, 6% and 5% of amounts allocated to health were not disbursed to the district in the 2020/21 and 2021/2022 financial years. This may have been a trickle-down effect of the funds that the district did not receive from various sources as shown in table 9 where the district only raised 76% of anticipated local revenue and received just 21% of anticipated revenue from donors in 2020/21 and raised 87% from local revenue and 16% from donors in 2021/2022.

Even so, the fact that the district did not receive all the funds it budgeted for means the health department in Kyegegwa District was not able to implement all activities planned in the two financial years. As such, citizens of Kyegegwa did not receive all the health services as anticipated.

Table 11: Health Sector Budget received by Kyegegwa District from Central Government

2020/21			**2021/2022**		
Health Sector Budget 000'	Disbursed to District 000'	Amount not Disbursed to District	Health Sector Budget 000'	Disbursed to District 000'	Amount not Disbursed to District
4,921,529	4,610,047 (94%)	311,482 (6%)	7,381,328	6,992,032 (95%)	389,296 98 (5%)

Source:*Kyegegwa District 4th Quarter Performance Report for 2020/21 and 2021/2022 Financial Years*

Considering that the family planning allocation constituted 3.8% and 2.5% of the approved Health Budget in the 2020/21 and 2021/2022 financial years respectively, it means that the number of resources received by Kyegegwa District for family planning were UGX 175,182,000 and UGX 174,801,000 in the two financial years as shown in the table below.

Table 12: Actual FP Funds Received by Kyegegwa District

Financial Year	Health Budget Received 000'	FP %age Allocation	Actual Amount Received for FP
2020/21	4,610,047	3.8%	175,182
2021/2022	6,992,032	2.5%	174,801

Source: *WUFBON Own Computation*

Case 2: Kyenjojo District

Based on the table below, 7.3% and 4.5% of amounts allocated to the health sector were not disbursed to Kyenjojo District in the 2020/21 and 2021/2022 financial years. This may have been due to funds that the district did not receive from various sources as shown in table 10 where the district raised 77% of anticipated local revenue and received just 49% of anticipated revenue from donors in the 2020/21 financial year and 67% as other government transfers and 34% from donors in 2021/2022 financial year.

The fact that the district did not receive all the funds it budgeted for health means the health department in the district was not able to implement all activities planned in the two financial years. The implication of this is that citizens of Kyenjojo District did not receive all the health services anticipated.

Table 13 : Health Sector Budget received by Kyenjojo District from Central Government

2020/21			2021/2022		
Health Sector Budget 000'	Disbursed to District 000'	Amount not Disbursed to District	Health Sector Budget 000'	Disbursed to District 000'	Amount not Disbursed to District
4,532,684	**4,203,821** (92.7%)	328,863 (7.3%)	**6,924,317**	**6,611,748** (94.5%)	312,569 (4.5%)

Source:*Kyenjojo District 4th Quarter Performance Report for 2020/21 and 2021/2022 Financial Years*

ACTUAL FP FUNDS DISBURSED TO HEALTH FACILITIES

Actual disbursements to health facilities from Kyenjojo Districts amounted to UGX 13,648,000 and UGX 11,637,000 in 2020/21 and 2021/2022 respectively. In the 2020/21 financial year, Kyenjojo District's disbursements to the health facility exceeded the approved budget amount by 77%. While it is a good thing that health facilities received more funds than allocated in the budget, it is important that sources of such funds are planned for adequately to ensure proper utilization.

Analysis of the excess disbursement revealed that health facilities were not able to absorb all the amount disbursed - only 61% was spent (see table 17 in the next chapter). This could have been due to the fact that they had not planned for those resources in the District Annual work plan. In the 2021/2022 financial years, 4% of the FP approved budget was not disbursed to health facilities

Table 14: Actual Amount of FP Funds Disbursed to Health Facilities in Kyenjojo District

Financial Year	Approved FP Budget in '000	Amount Disbursed to Health Facilities in '000	Disbursements as a %age
2020/21	7,708	13,648	177%
2021/2022	12,137	11,637	96%

*Source: Kyenjojo District FP Service Tracking Document***

FAMILY PLANNING BUDGET ABSORPTION

At district level, health has three main programmes namely primary healthcare, district hospital services and health management and supervision. Each of these programmes receives a share of the health budget. A review of quarterly performance reports showed that the largest share of the health budget is often apportioned to the health management and supervision programme, followed by district hospital services and primary health care respectively.

Budget Absorption Rate for Health Programmes

Case 1: Kyegegwa District

A review of Kyegegwa's Quarterly Performance reports shows that each health programme has a family planning component. However, it is not clear what percentage of the programme budgets is spent on family planning activities. The table below shows the budget absorption rate for each health programme in Kyegegwa District in the 2020/21 and 2021/2022 financial years.

Table 15: Budget Absorption Rate - Kyegegwa District

Programme	2020/21			2021/2022		
	Approved Budget 000'	Expenditure 000'	Absorption Rate	Approved Budget 000'	Expenditure 000'	Absorption Rate
Primary Healthcare	256,214	214,238	84%	806,864	592,046	73%
District Hospitals Services	362,602	333,608	92%	313,458	313,458	100%
Health Management and Supervision	4,302,713	4,062,201	94%	6,261,006	6,086,528	97%
Total	**4,921,529**	**4,610,047**	**94%**	**7,381,328**	**6,992,032**	**95%**

Source:*Kyegegwa District 4th Quarter Performance Report for 2020/21 and 2021/2022 Financial Years*

Based on the data above, overall health budget absorption rates for the two financial years were 94% and 95% respectively. Considering that 6% and 5% of the approved budget amounts were not transferred to the district, each program experienced budget cuts to cater for the budget deficit.

Though primary health care appears to have the lowest absorption rates at 84% and 73% in 2020/21 and 2021/2022 financial years respectively, all funds disbursed to the District in the two financial years were spent. Based on the program absorption rates, the program appears to have been affected most by the budget cuts. Each health programme had to give up some activities that were considered non-essential in favor of the most essential services.

A reduction in the budget means the department of health was not able to provide all the services as planned. This means that citizens did not receive all the health services, particularly those that are considered non-essential because resources for those were shifted to cater for the most essential services. Failure to have a defined family planning

budget or a percentage cap for the same makes it difficult to determine whether service delivery in this component is protected or affected by budget cuts.

Case 2: Kyenjojo District

A review of Kyenjojo District showed that the budget absorption rate for the health sector in the district was 92.7% in 2020/21 and 85.5% in 2021/2022 financial years. The table below shows the budget absorption rate for each health programme in the 2020/21 and 2021/2022 financial years.

Table 16: Budget Absorption Rate - Kyenjojo District

Programme	2020/21			2021/2022		
	Approved Budget 000'	Expenditure 000'	Absorption Rate	Approved Budget 000'	Expenditure 000'	Absorption Rate
Primary Healthcare	807,645	462,638	57%	2,008,292	1,004,440	50%
District Hospitals Services	450,813	475,342	105%	140,274	140,274	100%
Health Management and Supervision	3,274,226	3,265,841	100%	4,775,751	4,775,751	100%
Total	**4,532,684**	**4,203,821**	**92.7%**	**6,924,317**	**5,920,465**	**85.5%**

Source:*Kyenjojo District 4th Quarter Performance Report for 2020/21 and 2021/2022 Financial Years*

While all the resources disbursed for District Hospital Services and Health Management and Supervision were spent in both years, the absorption rate for resources allocated and disbursed under the primary healthcare program was low. It stood at 57% and 50% during the 2020/21 and 2021/2022 financial years respectively. Considering that family planning is an integral part of healthcare, there is a high chance that FP services to citizens may have been hampered by the low absorption rate.

Absorption of Disbursed FP Funds

However, further analysis showed that only 61% of FP funds disbursed by the district to health facilities during the 2020/21 financial year were spent as shown in the table below.

Table 17: Actual Absorption of FP Funds Disbursed to Health Facilities in Kyenjojo District

Financial Year	Approved FP Budget in '000	Expenditure in '000	%age Budget Spent	Amount Disbursed	%age of Disbursement Spent
2020/21	7,708	8,348	108%	13,648	61%
2021/2022	12,137	11,637	96%	11,637	100%

*Source: Kyenjojo District FP Service Tracking Document***

Based on the data provided earlier, health facilities in Kyenjojo district received 177% of the budgeted amounts in the 2020/21 financial year - 77% that had not been planned for. This may have made it difficult for the health facilities to spend the excess funds availed to them.

Chapter 6: Findings from FGD/KIIs

In the course of this study, we collected information on family planning financing, disbursement and absorption using key informant interviews and focus group discussions. The key informant interviews targeted government officials health facilities in charges, mid wives, VHTs , DHOs , youth , men and women while the focus group discussions were used to gather data from community members. The purpose of this information was to establish how disbursements and absorption rates affect delivery of family planning services. In this chapter, we highlight the key findings of the key informant interviews and focus group discussions.

Findings from Key Informant Interviews

Kyenjojo district

The participants in the KIIs for Kyenjojo district listed the challenges faced in accessing FP as follows;

• Failure to access the FP method of choice from the health facilities due to stock-outs. The FP method that participants mentioned as being out-of-stock were injectables. In the absence of injectables, some women would go without FP as they were not open to switching to another method like contraceptive pills.

• Understaffing of health workers which led to their being overwhelmed by the number of FP clients. As a result, clients would have to wait long to receive FP services, and others would end up leaving without them if they had to attend to other activities.

• The negative attitude of men towards family planning. Very few men supported family planning in the area, which meant that women needed to find a way to access the health facilities without their husbands' knowledge. On days when they could not "escape" they would not be able to access the services. Additionally, the lack of support from some men meant that they would not provide transport for their partners to go to the health facilities for FP services.

• Long distances to higher level health facilities. Many women had to walk long distances to access a variety of FP services as the lower-level health centres (Health Centre IIs) did not have all the FP methods they were interested in.

• Language barrier: Respondents mentioned that some health workers did not speak the local language, which made it difficult for clients to get the information they needed and the services they preferred.

• The negative attitude of some health workers: Some participants noted that some health workers, particularly midwives, were rude to clients, which led to difficulty in accessing services and eventual discouragement

Kyegegwa district

The participants in the KIIs for Kyegegwa district listed the challenges they faced in accessing FP as follows;

• Lack of information about family planning. This means that many potential clients do not know what services they can get and sometimes where to get them from, especially those who live in forests where megaphones do not reach. Additionally, some health workers do not counsel clients before providing the FP methods, leading to misinformation.

• The negative attitude of some health workers. Some participants noted that some health workers, particularly midwives, were rude to clients, which led to difficulty in accessing services and eventual discouragement.

• Long-distance to health facilities. This hinders some clients' access to FP services, and some end up waiting for the services to be brought nearer through partner outreaches that might not be regular.

• Men are not fully sensitised on FP. This has led to little support for their partners accessing FP services.

FINDINGS FROM FOCUS GROUP DISCUSSIONS

Public Perception towards FP

Most people in the two districts have a positive attitude towards FP and view it as an important approach to planning their families, spacing children and preventing unwanted pregnancies. This perception was reflected in community responses such as:

"If your income level is low, family planning is important. You can sit and agree on the number of children you want to have and when you should have them. If you don't do this, you could end up with many children that you cannot take care of." FGD Participant in Kyenjojo

In Kyegegwa, one FGD participant said,

"When you have few children, your expenditure is not as high as that of a person who has more children. This enables you to save more money, which would not be possible if you have many children. FGD Participant in Kyegegwa

Common FP Methods

District Health Management Information System data showed that male condoms, pills, IUDs and injectables are the most commonly used FP methods in the two districts under review. In Kyenjojo district, male condoms and injectables accounted for more than 50% FP method usage in both 2021 and 2022 as shown in the table below.

Table xx: No. of People Accessing Various FP Commodities in Kyenjojo - 2021 and 2022

FP Commodity	No. of Clients	%age	No. of Clients	%age

	Served - 2021		Served -2022	
IUDs	8,576	15.7	6,106	11.4
Implants New Users	6,123	11.2	6,168	11.5
Implants Revisits	1,359	2.5	1,317	2.5
Injectables	16,279	29.8	11,277	21.1
Oral: Other	27	0.0	132	0.2
Oral:Ovrette or Another POP	96	0.2	35	0.1
Oral:Lo-Feminal	203	0.4	50	0.1
Oral: Microgynon	1,804	3.3	2439	4.6
Male Condom	19,786	36.2	24,741	46.3
Female Condom	434	0.8	1187	2.2
Total	**54,687**	**100**	**53,452**	**100**

Source: Kyenjojo DHIS, 2021-2022 Data

The situation is different in Kyegegwa District where injectables alone constituted 51% of FP methods that women used in 2022 alone as reflected in the table below.

Table: No. of People Accessing Various FP Commodities in Kyegegwa District - 2022

FP Commodity	No. of Clients Served	%age
Female Condoms	257	0.8
IUDs	881	2

Injectables	15,754	51
Male Condoms	5,805	18
Natural	597	1.9
Oral : Other	211	0.7
Oral :Ovrette or Another POP	57	0.1
Oral: Lo-Feminal	28	0.09
Oral: Microgynon	1,636	5.3
Other Methods	816	2.7
Female Sterilisation (TubeLigation)	56	0.2
Implant New Users	3,167	10.3
Implant Revisits	1,409	4.6
Male Sterilisation (Vasectomy)	18	0.1
Total	**30,692**	**100%**

Source: DHIS

This choice for this FP method was supported by community responses during the FGDs. For instance, an FGD participant in Kyegegwa said

"There are women who choose to use injectables because it is not possible for men to know that they are using an FP method. Those who don't want their husbands to know they are using family planning prefer this method." .

HOW DELAYED DISBURSEMENTS AND ABSORPTION RATES AFFECTS FP SERVICES

FGD sessions held with community members revealed that delays in disbursing funds to health facilities and failing to absorb all allocated funds affects the quality of FP services that people receive. Some key effects are discussed below:

1. Inaccurate Information about Family Planning

While a high number of people have heard about family planning, it is clear that the information they have about FP during counseling sessions is scanty - which creates misconceptions about family planning. Inaccurate information tends to spread fast through local communities as women share information amongst themselves without confirming its accuracy with health workers. An example of this is the information shared by one woman who got a deformed child - here's a quote:

"In my village, there is a woman who got a crippled child. Because she had been using family planning, she said it was because of FP that she got a deformed child. A lot of women are now afraid to use family planning." FGD participant, Kyenjojo District

2. Minimal Education about Family Planning

Citizens said that public education on family planning methods are minimal.While health facilities are providing family planning services, there are people who are not aware on how the different FP methods work as captured by this feedback by an FGD participant in Kyegegwa.

"Some young people do not know how to use condoms. They go to health facilities and they are given FP commodities of their choice - but they don't know how the commodities are used." FGD participant in Kyegegwa

3. Cost of FP Services

Accessibility of FP services is partly influenced by the cost of the services. Though the service is available in primary healthcare facilities like level two facilities, there are times that women have to travel long distances to get to the facilities, Some FP methods such as injectables have a cost attached to them, which discourages some people. Below is a quote that captured this aspect:

“The long distance that some of us have to cover to reach government facilities, you find that most facilities in villages offer family planning. Most people want injectables and pills, but these methods have a financial implication so mothers that can’t afford to give up.” FGD participant in Kyegegwa

4. Commodity Stockouts

There are instances where women visit health facilities to get FP services and when they get there, they find their preferred commodity missing as an FGD participant in Kyenjojo indicated:

"Sometimes women travel all the way to a health facility only to find out that there are stocks out. They are then referred to other facilities and yet they have no transport to go to the referred facility." FGD participant in Kyenjojo

5. Training of Health Workers

Instances of health workers lacking in FP knowledge and treating patients rudely were reported in both Kyegegwa and Kyenjojo districts. In Kyegegwa, there were reports of health workers failing to counsel women when they seek FP services.

"*They do not do any counseling when you come for family planning. When you prefer a particular method, the nurse says rudely that "Eehhokagala, kale kafunenayetodda". Meaning that 'fine, you want it, have it but don't come back*"

In Kyenjojo, the issue of health worker competence was raised as follows:

"*Some health workers at the facilities lack knowledge about family planning, so we leave the facility when we are not contented or satisfied with the information*" FGD Participant, Kyenjojo

The issue was also raised in Kyegegwa where one participant said:

"*Some clinics do not have guidelines for family planning. Though there are nurses present, their technical knowledge of FP is limited and they end up administering FP commodities the wrong way. That's why sometimes women get pregnant while on family planning*" FGD Participant, Kyegegwa

POLICY GAPS & RECOMMENDATIONS

Kyegegwa District

Policy Gap	Policy Recommendation
Kyegegwa District should develop CIP for family planning to guide family planning interventions in the district.	There is need to develop DCIP and anchor the DCIP into law or integrate in the District Strategy Plans so that the district is obligated to implement it
The district does not have a clear FP budget line and while the amount allocated to FP is provided in the work plan, it is difficult to determine how much money is allocated for each strategic FP priority.	There is a need for Kyegegwa district to have a clear FP budget and use the the DCIP to inform family planning allocations
Allocation towards FP dropped by 1.3% in the 2021/2022 financial year despite the 3% increase in the health sector budget the same year. This means the FP budget allocation is not protected and can fluctuate downwards even when the total health budget increased	There is need for the district to set a percentage capping for the FP budget to ensureit is protected and increases as the overall budget increases,
6% and 5% of amounts allocated to health were not disbursed to the District in the 2020/21 and 2021/2022 financial years. The district only received just 21% of anticipated revenue from donors in 2020/21 and 16% in 2021/2022 - which creates a budget deficit. When this happens, facilities are forced to reduce their activities and there is a high chance that services that are considered non essential services - FP experience budget cuts.	The local government in Kyegegwa District needs to put in place mechanisms to increase receipts from donors

Kyenjojo District

The district implemented CIP for family planning. Prior to developing the new CIP for family planning 2022, the district has had a DCIP that shows how much investment is required to make family planning services accessible to women and girls in the district each year. Analysis of Kyenjojo''s2020/21 and 2021/2022 budget documents showed that the district's FP allocation constituted 13.7% and 19.3% of the investment recommended by the DCIP in the two financial years. This could mean that the DCIP is not informing FP allocations in the district.	There is need to anchor the DCIP into law or integrate in the District Strategy Plans so that the district is obligated to implement it
Kyenjojo District allocated 0.17% of the health sector budget to family planning in the two financial years under focus. Kyenjojo district budget does not have an FP budget line and this percentage was computed based on financial data available at facility level.	There is a need for Kyenjojo district to have a clear FP budget and use the the DCIP to inform family planning allocations
Actual FP allocation towards FP in 2020/21 and 2021/2022 was UGX 7,708,000 and UGX 12,137,000 respectively. These amounts constituted 13.7% and 19.3% of the required FP investments. This is extremely low compared to the amount recommended in the District Costed Implementation Plan in the respective financial years.	While in the annual planning processes, there is need to always consult the already existing running plans so that allocations are not reduced to affect access to services
The district has only 4 active youth corners in the district out 31 Health facilities in the district.	The district should prioritize reactivating youth friendly corners in all health facilities and increase FP integrated outreaches.
In the two financial years under review, the district only invested 15% of family planning funds budgeted for in 2021/2022. In 2020/21, the district did not contribute any funds towards family planning. Donor dependence is extremely high - which puts FP services at risk of lacking financial support in the event donors decide to pull out.	There is need for Kyenjojo district to increase domestic investments in FP to ensure sustainability of FP services
7.3% and 4.5% of amounts allocated to health were not disbursed by the central government to Kyenjojo District in the 2020/21 and 2021/2022 financial years. Based on the revenue received for the two financial years, it's evident that	The local government in Kyenjojo District needs to put mechanisms in place to ensure that funds that are committed in the budget are

government is not disbursing the total amount budgeted for thus creating budget deficits. In most cases non essential services - FP experience budget cuts.	received
Actual disbursements to health facilities from Kyenjojo Districts amounted to UGX 13,648,000 and UGX 11,637,000 in 2020/21 and 2021/2022 respectively. There was a drop in FP funds disbursed to health facilities. This means that some FP services were not offered to citizens	To ensure that the FP budget allocation is protected and increases as the overall budget increases, there is need to have a percentage capping
In the 2020/21 financial year, Kyenjojo District's disbursements to the health facility exceeded the approved budget amount by 77%. While it is a good thing that health facilities received more funds than allocated in the budget, it is important that sources of such funds are planned for adequately to ensure proper utilization. Analysis of the excess disbursement revealed that health facilities were not able to absorb all the amount disbursed - only 61% was spent (see table 17). This could have been due to the fact that they had not planned for those resources in the District Annual work plan.	There is need for Kyenjojo district to plan adequately for available resources prior to disbursing them to health facilities
In the 2021/2022 financial years, 4% of the FP approved budget was not disbursed to health facilities. The implication of this is that health facilities had to scale down their FP activities which means citizens did not receive the all-FP services as planned due to budget deficit	There is need for Kyenjojo district to ensure that all funds allocated to FP are disbursed to health facilities in a timely manner
Each health programme has a family planning component but it is not clear what percentage of the programme budgets caters for Family Planning. It is not clear what percentage of resources allocated to each health programmesis spent on FP service provision. This makes it difficult to determine the extent to which family planning services are affected in the event of budget deficits.	To ensure that the FP budget allocation is protected and to facilitate transparency and accountability, thereis need to have a percentage capping for FP budgets
Absorption rate of resources allocated and disbursed under the primary healthcare program was low in the two financial years under review. Considering that family planning is an integral part of healthcare, there is a high chance that FP services to citizens may have been hampered by the low absorption rate	There is need for Kyenjojo district to put in place mitigation measures to curb low absorption rates in delivery of primary health care services

Only 61% of FP funds disbursed by the district to health facilities during the 2020/21 financial year were spent. Health facilities received 177% (ref. table 11) of the budgeted amount that had not been planned for. This made it difficult for them to spend the excess funds availed to them	There is need for Kyenjojo district to plan adequately for available resources prior to disbursing them to health facilities

GENERAL DISCUSSION

The ability of women and couples to decide when to have children is crucial for the population's well-being. Family planning has been viewed as an essential practice in society. It provides women with the ability to have children when ready. This has presented several benefits to the women, their families, and the community at large. Participants shared this view in the Focus Group Discussions and Key Informant Interviews.

Despite the benefits of family planning, the study established that a certain section of the participants had negative perceptions of FP, hindering its use and uptake. This showed the need to increase investments in mindset change to alleviate the myths and misconceptions and contribute to the improvement of FP indicators.

The influence of religious and cultural beliefs on the use of modern FP methods is an aspect that should not be ignored as it has far-reaching implications on the choice to use FP by sections of the population.

The findings did not identify specific funding to sensitize religious and cultural leaders on FP such that they may, in turn, pass on positive messages to their followers. The side effects experienced from using FP were mentioned as another significant reason for stopping use of modern FP and hesitation of some non-users in adopting them. This is an indication for the need to invest in training and mentoring health workers in managing side effects at all levels of care. There was a perception among the community members that FP promoted sexual immorality among young people and adolescents. There were also concerns that some young women and girls were more focused on methods that prevent pregnancy while ignoring the exposure to HIV/AIDS.

This calls for increased investments in developing and disseminating IEC materials at both the national and sub-national level, BCC, and providing FP/SRH information to adolescents and young people. Gender-Based Violence came up as another unintended outcome arising from men disagreeing with their partner's use of FP.

Due to the lockdowns in the COVID-19 pandemic, cases of GBV have gone up due to several reasons, some of which might be FP related. This calls for multi-sectoral coordination and investment in FP between MOH and the Ministry of Gender, Labour, and Social Development and between the District Health and Community Development departments. Several challenges in accessing FP services and information were identified through the FGDs.

Among these was the failure to access the preferred FP method from the health care providers due to stock-outs and a limited variety of commodities. This could be related to GOU allocating no more than 10% of the Vote 116 to FP commodities and being complacent that external funding will cover them.

There were significant challenges in service delivery, such as understaffing and lack of training in providing FP information at services. The inadequacy in numbers meant that

possible users of FP might miss out on getting services if the health workers are swamped with other work that takes precedence over FP.

A related challenge was the lack of training of Village Health Teams (VHTs), who would help fill human resource gaps at the community level. The existence of communities that could not readily access FP services due to long distances and poor road networks requires more investments in outreaches to avail FP information and services to people living in hard-to-reach areas.

Despite Uganda's being a signatory to global and regional initiatives that support RH/ FP and the existence of several policies and other instruments for FP programming, there are gaps in disseminating these instruments and sensitization in their use at the sub-national level. This creates a gap in the application of these instruments as a guide for the district leadership and health workers as they implement FP programs.

There is also a mismatch between Uganda's population age structure (50% young people) and the priorities in allocating funds to provide information and services specific to their needs. This was partly evidenced by GOU failure to progress on the FP2020 commitment to allocate 10% of the RMNCAH budget to adolescents. If this trend continues, any strides achieved in FP will likely be minimal at best.

CONCLUSIONS

There is continued reliance on external financing to implement interventions in the health sector, including family planning. This shows the lack of ownership of FP programming by GOU and likely gives way to development and implementing partners dictating which projects and interventions to focus funds on, which might not necessarily be the priorities aligned in the National and District FP-CIPs.

Although the NMS - Reproductive Health Supplies budget increased from UGX 14.72 billion to UGX 20.46 billion in FY 2021/22, the split between Mama Kits and FP commodities remains skewed towards the former. This significantly impedes the strides that could be gained in increased uptake for FP.

A major challenge that persists is the lack of full disclosure of the expenditure breakdown for the Reproductive Health commodities output in Vote 116. The lack of transparency significantly affects budget tracking efforts especially at the national level, thereby taking away what would be evidence to identify gaps, and challenges and ultimately inform budget advocacy efforts.