Rapid Assessment of Bottlenecks Inhibiting the Scale-up of Evidence-based-Practices for Family Planning Practices in Uganda

Report

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List of Acronyms

BNA	Bottle Neck Analysis
CHW	Community Health Workers
CIP	Costed Implementation Plan
DHS	Demographic Health Survey
EBP	Evidence-Based Practices
FP	Family Planning
HIV	Human Immuno-compromising Virus
HIPs	High Impact Practices
HMIS	Health Management Information System
KAPB	Knowledge, Attitudes, Practices and Behaviour
KII	Key Informant Interviews
MakSPH	Makerere University School of Public Health
MNH	Maternal Newborn Health
MNCH	Maternal Neonatal Child Health
MEC	Medical Eligibility Criteria
mCPR	Modern Contraceptive Prevalence Rate
MoH	Ministry of Health
NGO	Non-Governmental Organization
ODK	Open Data Kit
PAFP	Post-Abortion Family Planning
PMA	Performance Monitoring for Action
PMTCT	Prevention of Mother to Child Transmission
PPFP	Postpartum Family Planning
REC	Research Ethics Committee
RH	Reproductive Health
SBC	Social Behavioural Change
SBCC	Social Behavioural Change Communication
SPR	Selected Practice Recommendations
SRHR	Sexual Reproductive Health and Rights
TS	Task Sharing
UHC	Universal Health Coverage
UNCST	Uganda National Council of Science and Technology
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive Summary

Background

Evidence-based practices (EBPs) for family planning (FP) are replicable, scalable, potentially applicable in various settings, sustainable, cost-effective, and significantly impact FP outcomes. Although there is a high level of understanding, awareness, and acceptance of the EBPs by national stakeholders, scale-up has been challenging due to various bottlenecks at both community and health system levels. It was important to document the learning and progress made for a better national context-specific understanding of factors that may help or hinder scale-up and sustaining the EBPs. We conducted a rapid assessment to understand enablers and inhibitors to the scale-up of three EBPs (task sharing, postpartum FP and social, behavioural change communication) to inform strategies to accelerate the FP Programme in Uganda.

Methods

This was a cross-sectional assessment of national and sub-national levels across the entire health services delivery channel in the public, private, and/or non-governmental sectors. We conducted a desk review of national policies and guidelines and national datasets for indicators on all the 3 EBPs. We also conducted a key informant interview (KII) survey with 25 participants for PPFP, 24 for SBCC and 30 for task sharing. During the KII survey, participants were required to rate different bottlenecks across the health system building blocks as very important, important, minor or not bottlenecks. Mean and median scores were calculated and presented in tables and box plots. We held workshops with national stakeholders to build consensus on the most important bottlenecks and solutions. Workshop participants were further required to rate the bottlenecks and agree on the solutions for the most important bottlenecks that needed to be prioritized for action. The National Family Planning Technical Working Group further validated the findings from the workshop.

Results

The assessment shows bottlenecks inhibiting each of the EBPs across the health system building blocks of governance and financing, medicines and technologies, services delivery, human resources, people and information. A lack of a national policy, regulatory framework, financing mechanism, and data on some indicators for task sharing in Uganda highlights the dire need for clear directions and guidance. There was no adequate health infrastructure to deliver PPFP, nor were there commodities, equipment, and supplies at the health facilities and for community health workers. Additionally, there are no adequate interventions to promote PPFP or communication on FP is integrated with health promotion activities like ANC. There is a need to re-evaluate the scale, reach, structural and service delivery quality of the SBCC. To guide the targeted redesign of SBCC programmes to address bottlenecks and ensure that the programme improves family planning outcomes in the country.

Conclusion

There are bottlenecks inhibiting the scale-up of Task sharing, PPFP and SBCC across all the health system building blocks, which need to be addressed by the MoH and FP implementing partners to improve FP outcomes in the country. Across all the health system building blocks, bottlenecks regarding equity, spending and allocation, leadership and commitment, management, infrastructure and supplies, client/SBC/IEC materials, and knowledge and awareness were cross-cutting the most important bottlenecks which needed urgent attention for all the 3 EBPs.

1.0 Background

Evidence-based practices (EBPs) in family planning were vetted by experts and established to be replicable, scalable—potentially applicable in a wide range of settings, sustainable, and cost-effective. The EBPs are documented as measurable and of high impact in achieving various family planning (FP) outcomes, including modern contraceptive uptake, reduction of unintended pregnancy, reduction in overall fertility, or at least delay of marriage or sexual initiation for adolescents, or enhancement of birth spacing, exclusive breastfeeding and postpartum abstinence [1]. Contraception and family planning are essential to the health and human rights of all individuals, as it gives individuals the autonomy to decide if and when to have children to attain the desired family size. Therefore, access to a broad range of safe, affordable, and acceptable contraceptive options helps them to exercise this right [2-4].

EBPs are categorized as enabling environment, service delivery, social, behavioural change, and enhancements. Enabling environment EBPs address systemic barriers that affect individuals' ability to access FP. Service delivery EBPs improve the availability, accessibility, acceptability, and quality of FP services. Social and behaviour change EBPs influence knowledge, beliefs, behaviours, and social norms associated with FP. In enhancements, two or more EBPs are used to increase the reach and access to specific audiences [1].

From 2019 to 2022, the World Health Organization (WHO) worked with partners and ministries of health through the WHO Family Planning Accelerator project to help ensure access to quality rights-based FP services for all women, regardless of their diversity, to promote bodily autonomy through rights-based and gender-responsive access and utilization of contraception. The project enhanced the implementation and scale-up of the EBPs by sharing new knowledge, skills, or approaches between programme managers and policymakers from across geographies. With this approach, policymakers and programmers were expected to identify new practices/service delivery skills, advocate for a relevant policy or programme change to introduce new practices, and/or build to implement or scale up the EBPs [5].

The WHO FP Accelerator Plus project focuses on the following areas: self-care interventions for Sexual Reproductive Health and Rights (SRHR), including for FP; post-pregnancy FP (post-partum FP and post-abortion FP); task sharing/ expansion for FP, social behaviour change communication (SBCC); adolescent and youth sexual and reproductive health; technical assistance (TA) coordination mechanism and development of guidance for emerging contraceptive options to increase coverage for methods that are not included in medical eligibility criteria (MEC) or selected practice recommendations (SPR). In addition, gender responsiveness and digitalization of the tools are systematically integrated across all focus areas of the project. [5].

In 2020, through the second national FP costed implementation plan (CIP II) and the FP2030 commitment plan, the Government of Uganda committed to increasing equitable access and voluntary use of modern contraceptive methods by implementing a rights-based approach to FP through scaling up the EBPs [6,7]. The goal is to improve family planning (FP) outcomes, including increasing the modern contraceptive prevalence rate (mCPR) and reducing the unmet need for FP and total fertility rate by addressing inequities in FP access and use, particularly for vulnerable populations like refugees, adolescents, and young people. It sought to overcome barriers to FP uptake, such as myths and misconceptions, lack of knowledge about contraceptives, common side effects of contraceptives and their management, financial challenges, prohibitive social

norms, negative attitudes of health professionals, inadequate staffing, physical inaccessibility to services, and poor communication between health professionals and users.

Although there is a high level of understanding, awareness, and acceptance of these practices by national stakeholders, their scale-up has been challenging due to various bottlenecks at both community and health system levels [6,14-15]. This study on the analysis of bottlenecks is a key action to have a context-specific understanding of factors that may help or hinder scale-up and sustain these interventions and to document the learning and progress made thus far [5]. The study considered bottlenecks inhibiting the scale-up of a) Post-pregnancy FP (postpartum and post-abortion), b) Task-sharing to community health workers and auxiliary nurses for FP, and c) Social and behaviour change (SBC) programmes for FP.

With support from the Human Reproductive Programme at WHO and the United Nations Population Fund (UNFPA), the Ministry of Health, WHO Uganda and UNFPA Uganda, together with Makerere University School of Public Health (MakSPH), conducted a study on the bottleneck analysis (BNA) focusing on the 3 EBPs (PPFP, Task-sharing and SBC) in family planning in Uganda. This assessment was built on systematic reviews summarizing the barriers and facilitators of scaling up these interventions in Africa and globally. The assessment findings will inform collective action among relevant policymakers and programme managers—at the national and subnational level—to overcome the identified bottlenecks to scale up the EBPs and increase equitable access to high-quality voluntary FP services for all for universal health coverage (UHC).

2.0. Rationale for Conducting the Bottleneck Analysis

Uganda has made very slow progress regarding increasing the number of women of reproductive age using contraceptives overall to achieve the national target of 50% by 2030. The modern contraceptive prevalence rate among married women (15-49 years) is at 38.2%, and the unmet need for family planning is at 24% (mainly spacing-15%). The use of family planning in the first year of birth is lagging, exposing women to unplanned pregnancies and a high rate of abortions estimated at 34/1000 [6-9]. Teenage childbearing is persistently high (24%), TFR of 5.2 with regional variation (3.7 in Kampala to 6.7 in Karamoja). Besides, scaling up the implementation of WHO-recommended evidence-based practices in FP has been slow and has yet to be sustained in Uganda.

According to available evidence, users have consistently indicated that health system barriers were impeding their access to and uptake of FP. To ensure increased equitable access and voluntary use of modern contraceptive methods by implementing a rights-based approach to FP and, ultimately, UHC, we needed to assess the bottlenecks inhibiting the scale-up of EBPs (Post-pregnancy FP [postpartum and post-abortion] (PPFP); b) Task-sharing to community health workers and auxiliary nurses for FP; and c) Social and behaviour change (SBC) programmes for FP). The findings can be used by MoH, donors, and the implementing partners at national and subnational levels to understand the facilitators and barriers to the scale-up of EBPs and design targeted interventions/strategies to enhance or address the challenges to EBPs. These efforts will subsequently improve the availability, accessibility, acceptability, and quality of family planning (FP) services and influence knowledge, beliefs, behaviours, and social norms associated with the uptake of FP in Uganda.

3.0. Objectives of the assessment

3.1. Broad objective

To understand enablers and inhibitors to the scale-up of three EBPs (PPFP, task sharing/expansion, and SBCC) and FP broadly through a BNA approach to inform strategies that can accelerate the uptake of family planning services and programme implementation in Uganda.

3.2. Specific objectives

1. To synthesize what is known about scaling up FP EBPs and broader FP in Uganda, including implementation status, alignment of guidance with national and international standards, and the lessons learned from successful implementation (including approaches that aim to address gender norms and inequalities).
2. To understand the perspectives of key stakeholders (policymakers, programme managers, healthcare managers, service providers and civil society) on the various health systems factors inhibiting the scale-up of the EBPs.
3. Build consensus among key stakeholders on the most important bottlenecks to EBP scale-up and on solutions that address the root causes inhibiting scale-up.

3.3. Research questions

The following are the research questions to be answered by the study:

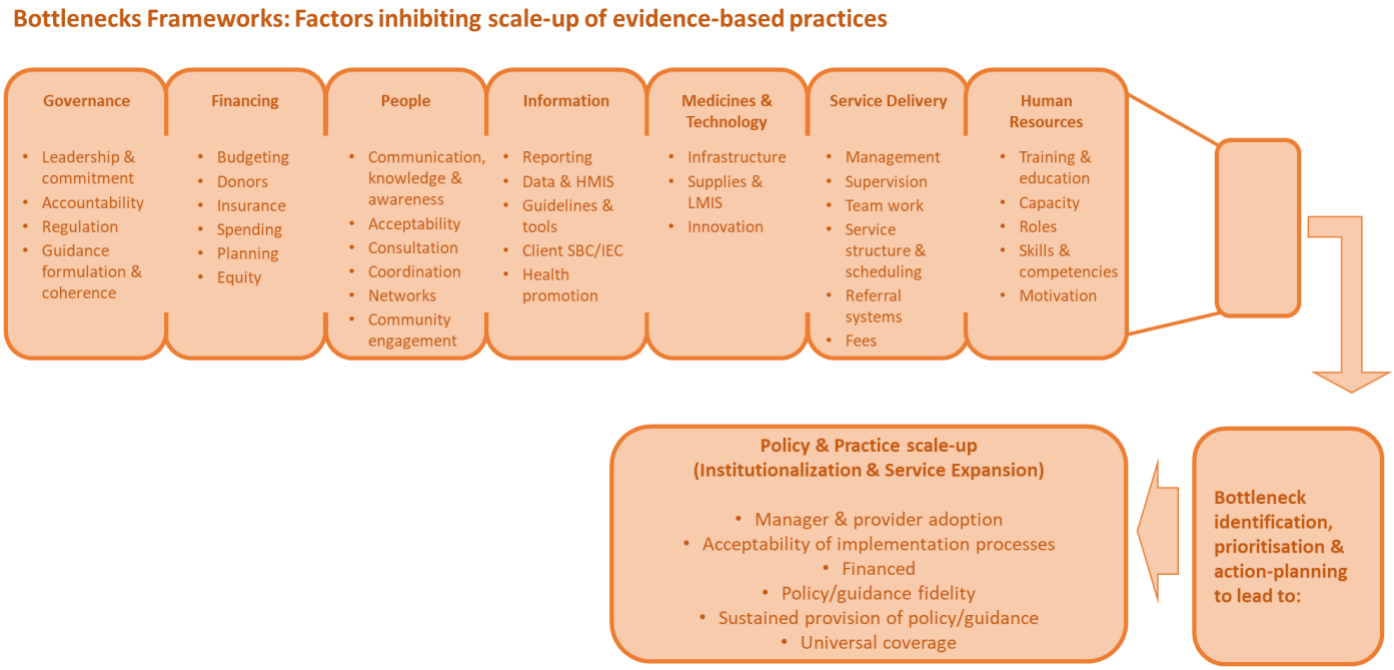
1) What is the current status of implementation of EBPs in Family Planning and how aligned are these practices to National and International standards of practice – including aspects of gender norms and equity?
2) What are the perspectives of key stakeholders (policymakers, programme managers, healthcare managers, service providers and civil society) on the various health systems factors inhibiting the scale-up of FP EBPs?
3) What are the possible solutions that can be applied to address the bottlenecks (root causes) that are inhibiting the scale-up of EBP in Family Planning in Uganda (drawing from the stakeholders' consultation and the key informant interviews)?

4.0. BNA Framework

The BNA framework is shown in

Figure 1. The framework shows factors influencing the scale-up of the three EBPs, organized into WHO's Health Systems Building Blocks Framework. The different factors (or potential bottlenecks) shown in the figure are drawn from a range of sources, including systematic reviews commissioned by WHO on bottlenecks to EBP scale-up [25]; frameworks in health implementation science [16,17] frameworks on assessment of scale-up of SRH or other health programmes [18-19, 22-24], and studies on guideline implementation [20,21]. A large volume of literature demonstrates that many of the factors highlighted in Figure 1 are common bottlenecks to the scale-up of EBPs within resource-constrained health systems [26-28]. This assessment tool helped FP stakeholders in Uganda to come to a consensus on the most important bottlenecks in their setting and then identify solutions to address them.

Figure 1: Bottlenecks Framework: to assess factors that may be inhibiting the scale-up of EBPs



5.0. Assessment Methodology

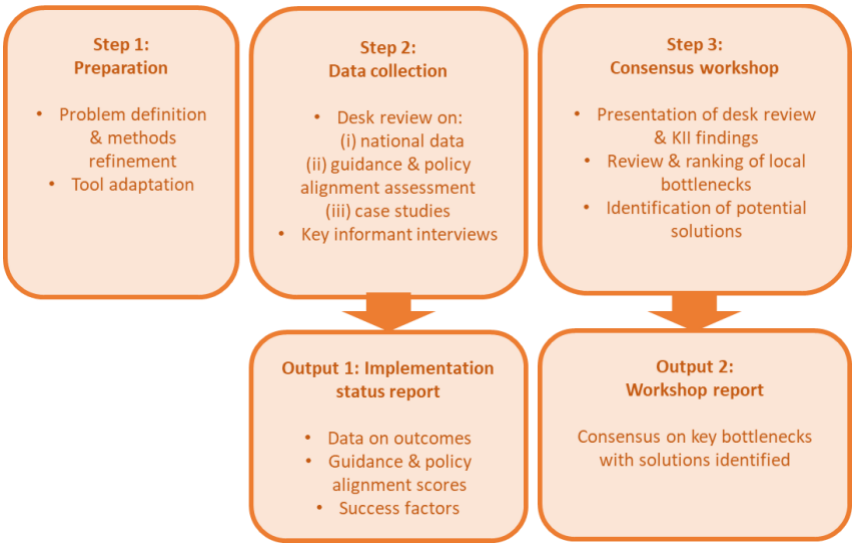
5.1. Study Design

This was a cross-sectional mixed methods study design using both qualitative and quantitative methodologies to conduct a programmatic assessment of the FP programme. Specifically, the following steps were utilized:

- Retrospective records review of national data on family planning programme performance against set indicators, review of policy guidance and alignment to international standards and guidelines, and review of country case studies of FP implementation.
- Key Informant Interviews (KIIs) were conducted with purposively selected policymakers, programme managers, healthcare managers, service providers and members of civil society.
- A workshop was held to validate the desk review and KIIs results and build consensus on the most important bottlenecks and solutions.

The assessment adapted the WHO-BNA generic protocol customized to Uganda's context and methodology used a combination of secondary data review (of key outcome and implementation indicators), guidance review (guidelines and tools), a review of implementation case studies, a survey with key stakeholders, and a workshop with key stakeholders for consent. The methodology comprised three key steps followed for the assessment, which are explained in depth in the sections that were followed. The assessment sought to understand the gaps in coverage and guidance, the bottlenecks in identification, and the result in solution planning for a way forward for each of the 3 EBPs.

Figure 2: BNA Methodology



5.2. Study Setting and Study Population

The BNA was carried out at both the national and subnational levels in Uganda. A multi-stage sampling strategy was applied to select the regions and different levels of health facilities to participate in the study. For the sub-national level, a sample of eight (8) districts was purposively selected for this assessment—to represent the Eastern, Western, Northern, and Central as the main geographical regions based on performance indicators (unmet need for FP) per the Demographic Health Survey 2016 as shown in Table 1. Only facilities and community health workers that provide MCH/FP services were sampled in these districts. We ensured that health facilities have representation from the public, private, and/or non-governmental service delivery channels.

Table 1: Selected districts across the geographical regions.

Geographical Region	Low Unmet Need District	High unmet need District
Central	Butambala	Buvuma
Northern	Moroto	Zombo
Western	Kanungu	Buliisa
Eastern	Mbale	Buyende

The study population for the key informant interview was purposively selected based on expertise and experience and included MOH commissioners, family planning and health programme managers (implementing partners), implementers (Health facility in-charges and health providers), as well as the range of key players in civil society, who have served for more than one year.

5.3. Step 1: Preparation

The WHO-Uganda Office coordinated the FP-BNA, and the MoH regularly updated stakeholders in FP in the country on the progress of the assessment through regularly scheduled meetings and in the TWG meetings. The stakeholders were involved in the assessment right from the inception

to the dissemination of the findings to ensure ownership and use of the findings. The teams selected context-relevant modules for each of the EBPs and adapted the BNA framework, data collection methods and data collection tools to suit Uganda's context and priorities. All adaptations were done in consultation with WHO/HQ to ascertain that the methodology still adheres to the standards of the global protocol. The teams discussed and reviewed standards or policy intentions and adapted indicators that align with Uganda's context.

5.3.1. Adaptation of Tools

Three sets of tools were adapted for the assessment of the three EBPs: Post-Pregnancy Family Planning (PPFP), Task Sharing (TS), *and Social and Behavioural Change (SBC).*

- For PPFP: The adaptation was made to include post-abortion and HIV to assess and ensure integration between FP and PMTCT/HIV care and treatment programmes for postpartum women.
- For task-sharing: This included task-sharing of injectables to community health workers (CHWs), including self-injection and task-sharing of prescription of pills to CHWs or pharmacists. We also included the task sharing of implants and injectables to auxiliary nurses (enrolled midwives and nurses) in the health facilities.
- For SBCC: The adaptation considered the forms of SBC programming that are recommended nationally and included a decision on which ones to include in the BNA.

5.3.2. Preparatory facility visits

The WHO, MOH, UNFPA, and MakSPH teams conducted two to three scoping visits to selected health facilities to discuss their local challenges to EBP implementation. These visits informed us of the framework and tools adaptation process and provided insights into the mechanisms of practice implementation on the ground. The facilities were in Mukono District, with representation of urban, rural, and island health facilities.

5.4. Step 2: Data collection

Data collection consisted of a desk review with three elements (national data review, guidance/policy review, and case study review) and a key informant interview, as shown in Table 2.

Table 2: Summary of BNA research methods, rationale and aims.

Objective	BN Assessment method	Rationale	Gaps in coverage	Gaps in guidance	Bottlenecks identification	Solution planning
To synthesize what is known about scaling up FP EBPs in Uganda, including implementation status, alignment of guidance with national and international standards, and the lessons learned from successful implementation (including approaches that aim to address gender norms and inequalities).	Desk Review: indicators	Provide background info and identify outcome gaps.	X			
	Desk review: Policy/guidelines review	Assess whether EBP is clear and consistent in guidelines & tools.		X		
	Desk review: Case studies	Identify factors in successful projects that have enabled the implementation.			X	
To understand the perspectives of key stakeholders (policymakers, programme managers, healthcare managers, service providers and civil society) on the various health systems factors inhibiting the scale-up of the EBPs.	Key informant survey	Understand the perspective of key stakeholders on potential bottlenecks to scale-up and identify local factors that must be considered during the BNA consensus workshop.			X	X
Build consensus among key stakeholders on the most important bottlenecks to EBP scale-up and on solutions that address the root causes inhibiting scale-up.	BNA workshop	Different stakeholders provide a range of perspectives on bottlenecks to scale up and identify and rank the most important factors. They propose solutions to address the most important bottlenecks.			X	X

5.4.1. Desk review

A desk review was conducted using a MS Excel extraction sheet to synthesize what is known about scaling up of FP EBPs in Uganda, including implementation status, alignment of guidance with national and international standards, and the lessons learned from successful implementation (including approaches that aim to address gender norms and inequalities).The desk review comprised a policy and guidance alignment assessment, national data review, and case studies assessment. The documents reviewed also included the broader MCH documents ssand other health strategic documents relevant to a particular EBP. A total of 15 documents were reviewed for PPFP; 15 for SBCC and 12 for Task sharing (See appendices 1-3).

i). Policy & guidance alignment assessment

The policy & guidance alignment assessment aimed to investigate whether the range of guidelines and tools used in different departments and levels of the health system align with WHO and/or MOH recommended practices. For SBC, as there are no consolidated WHO guidelines, the assessment has been aligned with the recommendations in the high-impact practices (HIPs) initiative. As a first step, WHO and MOH collected existing guidelines and tools, as shown in Table 3 below. In addition, efforts were made to gather documents from a representative cross-section of the health system, including National, State/regional, District, Hospital/facility, and Private sector documents. We only considered documents in active use rather than historical or defunct policies, guidelines, and tools. However, older versions were included as they are still used in health facilities. The policy standard was:

- Fully aligned with international standards if it was mentioned in the documents without any omission/s.
- Partially aligned if some parts of the standard were missing.
- Not aligned if the standard was not mentioned at all.

Table 3: Types of Documents reviewed.

PPFP	Task-sharing	SBC
• Policy documents on MNCH. • Policy documents on FP. • Policy documents on abortion/post-abortion. • Costed implementation plans for FP, MNH.	• Policy documents on FP and/or MNCH/RH care. • Policy documents on TS. • Policy documents on training CHWs. • Policy documents on Community Health. • Costed implementation plans for FP, TS, Community Health.	• Policy documents on health promotion and/or SBC Policy documents on FP. • Policy documents on MNH. • Costed implementation plans for FP.
• Clinical guidelines on MNH (including ANC, delivery, post-natal care, infant feeding, and immunisation). • Clinical guidelines on FP.	• Clinical guidelines on FP. • Community health policies or guidelines.	• Community health policies or guidelines.

ii). National data review

A national data review was conducted to help determine the current state of EBP coverage and to review national data on FP Indicators, including outcomes and service delivery process indicators. The team used existing data sources, as indicated in Table 4 below. Where possible, we collected disaggregated data to look at the indicators by rural/urban (or by state) and by age (<20/≥20), in addition to presenting the summary statistic among all women of reproductive age.

Table 4: Sources of data on FP indicators.

General FP trends	+PPFP	+Task-sharing	+SBCC
All modules: • DHS, PMA, MICS, or other representative household survey data detailing women's contraceptive behaviours. • Facility survey assessment reports (e.g., DHS SPA, PMA service assessments, other recent WHO or local SRH project facility survey assessments). • Knowledge, attitudes, practices, and behaviour surveys (KAPB). • Available HMIS or other national health policy and practice data. • National health sector human resourcing data. • Online data aggregators. • Published national reports/papers with aggregated data and trends.			
DHS stat compiler https://www.statcompiler.com/en/ PMA Data lab https://datalab.pmadata.org/ FP Market Analyzer https://fpmarketanalyzer.org/ Track20 National FP Effort Index https://track20.org/pages/data_analysis/policy/NCIFP.php	WHO HMIS guidance	2020 Task-sharing status review (if country included) World Bank microdata catalog https://data.worldbank.org/indicator MoH's human resource dashboard for health https://hris.health.go.ug	Behaviour Change for Impact Database https://behaviorchangeimpact.org/#fpsrh

iii). Case studies assessment

We conducted a rapid search of published and grey literature to find local reports of the implementation of EBP. The review also considered reports of implementation failure, which contained important lessons about necessary supporting factors for implementation. We used WHO's recent systematic reviews on bottlenecks to help identify relevant studies from Uganda. We also reviewed PubMed/Medline for more recent reports and searched useful databases for relevant reports in the grey literature.

We selected 3 case studies (one per EBP) of successful implementation and/or scale-up for each module in Uganda, where applicable, and the lessons learned were summarized using a summary tool as provided by the WHO country office, categorised as:

- Title of project or programme .
- Short description of the project or programme.
- Where was the project or programme implemented? (States, regions, districts).
- Who implemented it?

- What were the achievements?
- What were some of the health systems factors that influenced programme outcomes? (Review Bottlenecks Framework).
- What were some of the challenges?
- Any other relevant information?

5.4.2. Key informant Interview survey

We conducted key informant interviews to understand the perspectives of key stakeholders (policymakers, programme managers, healthcare managers, service providers, and civil society) on the various health system factors that inhibit the scale-up of EBPs. Results from these interviews were then summarized and discussed further during the bottlenecks workshops to allow stakeholders to come to a consensus on the important challenges. The assessment guide was developed in alignment with WHO's standards and recommendations (PPFP and task-sharing), and international recommendations for SBC were used. We reviewed the questionnaire and adapted it to the local context.

i). Key Informant Interview Survey Sample Size

Each questionnaire (PPFP, Task-sharing, SBC) was administered to a total of 25 stakeholders for PPFP, 23 for SBCC, and 30 for task-sharing, all involved in the EBP scale-up. The sample comprised policymakers & programme managers at the national and the selected districts for sub-national levels, including government and/or implementing NGOs; clinicians: facility supervisors or managers; midwives and CHWs; and professional association representatives involved in policy formulation or practice guidance civil society representatives. These same three categories were invited to the BNA workshop.

Table 5: Stakeholders who participated (for questionnaire and workshop).

Workshop group	PPFP	Task-sharing	SBC
	Ensured representatives from:		
POLICY/PROGRAMME	• MoH from MNCH units (national & state level), ideally involved in postpartum and post-abortion FP. • MOH from FP units (national & state level). • Key donor agencies supporting MNH and/or FP. • Technical donor-funded SRH NGOs implementing PPFP programmes.	• MOH from the human resources team. • MOH from MNCH units (national & state level), ideally involved in task-sharing or human resources. management • MOH from FP units (national & state level). • Key donor agencies supporting task-sharing and/or human resources for health. • Technical donor-funded SRH NGOs which have implemented or tested task-sharing.	• MOH from MNCH units (national & state level), ideally involved in SBC or communication. • MOH from FP units (national & state level). • MOH from health promotion/education units. • Key donor agencies supporting SBC. • Technical donor-funded SRH or communications NGOs implementing SBC programmes. • Media/digital/communications experts involved in SBC. • Media associations.
CLINICAL	• Nursing/midwifery association or experts. • OB/GYN association or	• Nursing/midwifery association representatives.	• Health promotion directors or managers at district or facility levels.

	experts in postpartum. and post-abortion FP • Managers, senior & junior providers from: • Maternity hospital • District hospital • Secondary care facility • Primary care facility • Abortion providers • Private sector providers	• Community health worker association representatives. • OB/GYN association or experts. • Managers, senior & junior providers from secondary and primary care facilities (or targets of task-sharing). • Private sector providers engaged in task-sharing.	• Community health workers or other outreach staff involved in SBC. • Facility managers tasked with or experienced in SBC for FP. • Selection of health workers delivering FP services.
CIVIL SOCIETY	• SRH & MNH local NGOs. • Women's health advocates. • Abortion advocates. • Patient representative groups. • Community groups working on FP/MCH. • Etc.	• SRH & MNH local NGOs. • Community/lay health worker groups. • Women's health advocates. • Patient representative groups. • Etc.	• Local NGOs involved in community health, including RMNCH. • Health education or promotion NGOs. • Women's health groups • Community groups working on FP/MCH. • Religious groups working on FP. • SRH Advocacy groups. • Etc.

ii). Key Informant Interview Survey Format

Open Data Kit (ODK) programming of the questionnaire was done. The questionnaire was administered through face-to-face key informant interviews or virtual interviews, based on the participant's convenience, to go over it with the respondent. Consent was sought from the participants to be interviewed and audio recorded. After a few background questions, the respondents were asked to rate out of 5 how much they agree with a series of statements about policy and programme implementation and scale-up. Each statement represented a potential bottleneck to scale up. Since some of the statements were broad, they were asked to consider a series of points relevant to that statement, elaborating on what the statement meant.

iii). Key Informant Interview Survey Questionnaire Pretesting

The questionnaire was pretested in health facilities in Kasaganti Town Council in Wakiso District to ensure it is well understood by respondents and produces meaningful data in each country's context. The tools were pretested on a small sample of 6 key informants, 2 per EBP tool, and edits were made based on feedback from the process.

iv). Key Informant Interview Survey Analysis

An Excel file containing a data summarization sheet to support KII data analysis provided by the WHO was used. The ratings for implementation status and the 35 bottleneck factors were entered into a KII respondent column in the sheet. After all data had been entered, mean and median scores for implementation status and each bottleneck were generated. Scores were broken down by respondent type (policy/programme, clinician, civil society) to further understand the data.

Average scores were also categorized and charted in box plots. Conditional formatting was used in the Excel worksheet (column V) to colour-code scores for rapid data visualization:

- Mean score of 4.0-5: Dark red (very important bottleneck)
- Mean score of 3.0-3.99: Light red (important bottleneck)
- Mean score of 2.0-2.99: Light green (minor bottleneck)
- Mean score of 0.1-1.99: Dark green (not a bottleneck)

Scores were then produced in a format as this example shows:

Bottlenecks Category	KII Mean Score
Example Score	2.50
Implementation	3.50
Governance/Leadership& commitment	4.50
Governance/Accountability	1.00
Governance/Regulation	1.20
Governance/Guidance formulation	1.10
Financing/Budgeting	4.80
Financing/Donors	2.40
Financing/Insurance	3.50
Financing/Spending	4.50
Financing/Planning	2.10
People/Knowledge & awareness	2.40
People/Acceptability	5.00
People/Consultation	1.10
People/Coordination	3.20

5.4.3. Data Handling and Record Keeping

Data for the desk review was extracted from publicly available data sources, as well as any other data sources provided by the MoH and partners and entered into a database developed by the study team. The KIIs data were audio-recorded. They were later transcribed to facilitate analysis of the themes emerging as part of the BNA, draw conclusions on the challenges and facilitators of the FP programme, and capture recommendations for improvement.

The following measures were taken to ensure participant confidentiality:

- A unique anonymous ID number identified data for each participant in the KII.
- The study documents were kept securely under lock and key in the research offices and were not accessible other than to the researchers.
- Data was entered by trial ID number in the password-protected data management system to which only the research staff had access.
- The report of analysis does not contain the names of any participants.

5.4.4. Quality Control and Assurance

The quality and accuracy of the data used to inform the BNA analysis as part of the study was ensured through:

- Triangulation of the data from the different sources.
- Through validation during the stakeholders' meeting.
- Through adaptation and testing of the WHO generic tools to ensure that they capture.
- The key informant questionnaire was tested and locally adapted to ensure ease of use and

understanding.
- The framework and workshop tools were reviewed after the KIIs to ensure that they addressed the participants' bottlenecks.

5.5. Step 3: Bottlenecks Assessment Workshop

A one-day workshop was conducted to build consensus among key stakeholders on the most important bottlenecks to EBP scale-up and on strategies to address the root causes inhibiting scale-up in Uganda and to identify the root causes and solutions to address the challenges and barriers to scale-up.

5.5.1. Workshop preparation

Working together with the MOH and other partners, WHO drew up an invitee list with experts and representatives, including:

(i) Policymakers and programme managers at national & state/regional levels.
(ii) Facility managers, clinicians, and professional association representatives.
(iii) Civil Society representatives.

The workshop involved 45 participants in the plenary, during which we presented the findings from the desk review, case studies and KIIs and later broke away into 3 groups: a group per EBP to further discuss the bottlenecks and propose solutions.

Table 5 details the categories of participants for each EBP. We invited to the workshop KIIs who had completed the questionnaire, including the case studies identified during the desk review. We also invited participants involved in the implementation who could describe their experiences, successes, and challenges, including implementing partners. For the PPPF group, inclusion of experts was ensured in both postpartum and post-abortion provision.

Before the workshop, WHO and MOH re-reviewed the BNA framework and workshop tools to check if they were adequately adapted to the local situation, using insights from the desk review and key informant interviews. We also prepared findings from the desk review and KII survey to present at the workshop. In groups, the discussions were facilitated by experts in the policy and programmatic scale-up of each EBP. These were identified with the guidance of the MoH and key partners in FP implementation in Uganda.

5.5.2. Workshop Format

Using the workshop guide provided by WHO, small groups held sessions involving a group assessment and ranking exercise of the factors that may be inhibiting the EBP scale-up. The tool used a modified Delphi technique and asked participants to first rank bottlenecks on their own, then review each other's rankings and mean scores, discuss the differences, and then come to a consensus on the important challenges.

During discussions and consensus-building, the groups considered the following criteria:

1. How big of a problem is this factor in preventing the scale-up of the EBP?
2. If it was addressed, would we see likely improvements in the EBP access?
3. Is this problem preventing nationwide scale-up of the EBP?
4. How urgently does this bottleneck need to be solved?

5. How many other bottlenecks does this problem cause?
6. Can this bottleneck be resolved with careful planning and resource allocation?

Once the most important bottlenecks had been agreed upon, the participants in their groups went on to identify underlying causes and solutions to address them using a solution grid. Solutions given were considered for feasibility and likely impact of suggested interventions/actions.

5.5.3. Workshop Outcome

By the end of the workshop, the stakeholders had reached a consensus on the most important bottlenecks per EBP in Uganda and identified solutions to overcome them.

6.0. Dissemination and progress monitoring

Following the module workshops, the WHO-Uganda office and the MOH liaise for the dissemination of the findings to the national FP-TWG and other national and subnational stakeholders. The research team continues to disseminate the findings from the study using the following ways and avenues available:

- Presentation to the national MCH Technical Working Group (TWG).
- Development of Policy briefs for Policymakers and programme planners.
- Presentation at National and international conferences.
- Development of a Manuscript for publication in peer-reviewed Journals.

7.0. Ethical considerations

Ethical approval to conduct the key informant interviews was sought from the Makerere University School of Public Health Research and Ethics Committee (REC) of the Makerere University College of Health Sciences and from the Uganda National Council for Science and Technology, as applicable. All KII participants were required to provide written individual informed consent in English prior to their participation in the key informant interview sessions.

8.0. Findings

8.1. Findings from the Desk Review of Policy and Guidelines documents

i). Task sharing

A total of 15 documents on task sharing were reviewed. Currently, Uganda does not have a national task-sharing policy. A review of 15 FP-related national policies and guidelines showed that none of these were aligned with the WHO global task-sharing standards. This included being updated with the 2017 WHO task-sharing guidance, specifying the providers, and having clear, consistent definitions of CHWs and Auxiliary nurses. However, Uganda has a national policy that supports the development and deployment of CHW programmes that explicitly refer to CHWs, with a formal governance structure, funding support, training agenda, job description, and appropriate support from public health facilities. There is partial alignment (2/15) of the national FP and TS policies and guidelines provide clear and consistent requirements for CHWs and auxiliary nurses/midwives, specifying education & training, residency. (Table 6).

Table 6: Alignment of task-sharing standards with WHO global standards.

Standards and alignment	Number of documents	Reason
1. There is a national task-sharing policy for RMNCH, including FP.		
No	0	No task-sharing policy.
National FP guidelines have been updated with the 2017 WHO FP Task Sharing Guidance		
Full alignment	0/15	
Partial alignment	0/15	
No alignment	12/15	Updates not indicated.
National FP / TS policy and guidelines include "who can provide".		
Full alignment	0/15	
Partial alignment	0/15	
No alignment	12/15	None of the FP guidelines includes who can provide.
4**. National FP and TS policies and guidelines use clear and consistent definitions and labels/terms throughout for CHWs and auxiliary nurses/midwives.**		
Full alignment	0/15	
Partial alignment	0/15	
No alignment	12/15	No explicit definitions.
National FP and TS policies and guidelines provide clear and consistent requirements for CHWs and auxiliary nurses/midwives, specifying education & training, residency, etc.		
Full alignment	0/15	
Partial alignment	2/15	Specifies education in general terms.
No alignment	10/15	Education requirements not specified.
6. Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that Community health workers can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; and hormonal injectables, under targeted monitoring and evaluation.		
No	0	No task sharing policy.

Standards and alignment	Number of documents	Reason
7. Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that auxiliary nurses and auxiliary nurse midwives can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms, hormonal injectable, and contraceptive implants; and (for auxiliary nurse midwives) IUDs.		
No	0	No task sharing policy.
8.TASK-SHARING policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to the provision of FP information and services.		
No	0	No task-sharing policy.
9 There are national level/subnational policies that support the development and deployment of CHW programmes		
Yes		The National community health strategy exists and is supported by other FP policy documents, such as the CIP II.
10. There are national/subnational policies that explicitly refer to CHWs, with a formal governance structure, funding support, training agenda, job description, and appropriate support from public health facilities.		
Yes		The National community health strategy specifies all the criteria.
11. There are national and/or subnational standards on the duration and content of CHW/health workforce education and training.		
Yes		The National CH strategy specifies 3 3-day duration for training. A Training Curriculum for CHEWs also exists.
12. There are national and/or subnational mechanisms for accreditation of CHW/health workforce education and training institutions and their programmes.		
Yes		The national Uganda health professional councils and Department of health education and training, ministry of education.
13. There are national education plans for the health workforce aligned with the national health plan and the national health workforce strategy/plan, which match health worker competencies with population/health systems/labor market needs.		
No		
14. There are national systems for continuing professional development.		
Yes		Emphasized in the National health sector plan and health professional councils.
15. Clinical regulations, including licensure regulations, stipulate that implants can be provided by auxiliary nurses and injectables can be provided by community health workers.		
No		Guidelines do not stipulate who provides.

ii). SBCC

A review of 15 FP-related national policy and guideline documents showed that there was full alignment on policy documents recommending scale-up of SBCC interventions (5/15), use of community health workers for RMNCH health promotion, including FP (6/15), use of mass media to promote FP (6/15), use of community groups to promote FP (6/15). Fewer documents showed alignment of having clear indicators for the success of SBCC (2/15), addressing social and gender norms that may inhibit the use of FP (3/15), and involving people living with disabilities and refugees (3/15) in the promotion of healthy couples' communication. No policy and guidance documents advising mass media included guidance on formative research, pre-testing messaging, targeting communication, selection of appropriate channels, audience segmentation, working with local community platforms or infrastructure, and the need to address equity in SRH (Table 7).

Table 7: Alignment of SBCC standards with WHO global standards.

Standards and alignment	Number of documents	Reason
1. Policy & guidance documents recommend scale-up of SBCC interventions.		
Full alignment	5/15	Documents clearly recommend scale-up.
Partial alignment	1/15	Mentions interventions but not scale-up.
No alignment	6/15	No SBCC interventions indicated.
2. Policy & guidance documents recommend the use of community health workers for RMNCH health promotion, including FP.		
Full alignment	6/15	CHWs recommended FP promotion.
Partial alignment	1/15	Recommends use of CHW, but not specifically FP.
No alignment	5/15	CHWs not included.
3. Policy & guidance documents recommend the use of mass media to promote FP.		
Full alignment	6/15	Policy recommends the use of mass media.
Partial alignment	0/15	
No alignment	6/15	Not indicated in documents.
4. Policy & guidance documents recommend the use of community groups to promote FP.		
Full alignment	6/15	Community groups are recommended to promote FP.
Partial alignment	1/15	Community groups recommended it in general terms.
No alignment	5/15	Not indicated.
5. Policy & guidance documents on MNH recommend use of community groups for health promotion, including FP.		
Full alignment	4/15	Clear guidance.
Partial alignment	1/15	Not specific to FP.
No alignment	6/15	Not indicated.
6. Policy & guidance documents recommend use of digital health to promote FP.		
Full alignment	4/15	Digital health recommended.
Partial alignment	0/15	
No alignment	8/15	Not indicated.
7. Policy & guidance documents aim to address social and gender norms that may inhibit use of FP.		
Full alignment	3/15	Clear guidance in the documents.
Partial alignment	0/15	
No alignment	9/15	Not included in the documents.
8.Policy & guidance documents aim to involve men and promote healthy couple communication.		

Standards and alignment	Number of documents	Reason
Full alignment	4/15	Clear guidance in documents.
Partial alignment	0/15	
No alignment	8/15	Not indicated.
9.Policy & guidance documents aim to involve refugees and promote healthy couple communication.		
Full alignment	3/15	Documents advocate for their involvement.
Partial alignment	0/15	
No alignment	9/15	Not indicated.
10. Policy & guidance documents aim to involve people living with disabilities and promote healthy couple communication.		
Full alignment	3/15	Documents advocate for their involvement.
Partial alignment	1/15	Mentions about PWDs generically.
No alignment	8/15	Not indicated.
11. Policy & guidance documents aim to strengthen the knowledge, attitudes, beliefs and self-efficacy of individual women and girls.		
Full alignment	3/15	All clearly indicated.
Partial alignment	2/15	Only talks about knowledge.
No alignment	7/15	Not indicated.
12. Policy & guidance documents recommend working with religious leaders, or other trusted opinion leaders to promote FP.		
Full alignment	4/15	Recommended.
Partial alignment	0/15	
No alignment	8/15	Not indicated.
13. Policy & guidance documents set out standards for SBCC in family planning, including adherence to rights-based programming principles.		
Full alignment	4/15	Standards included.
Partial alignment	1/15	Emphasizes rights-based programming but not FP.
No alignment	7/15	No standards included.
14. Policy & guidance documents advise on effective approaches for SBCC in family planning, along with strength of evidence in the local context.		
Full alignment	3/15	Documents advise on effective approaches for SBCC.
Partial alignment	0/15	
No alignment	9/15	Not indicated
15. Policy & guidance documents advise structured processes for SBCC intervention design, including needs for formative research/insight gathering, (human-centered) design according to behavioral theory, monitoring/testing, or design iteration (or adaptive programming).		
Full alignment	3/15	Documents advise structured processes for SBCC.
Partial alignment	0/15	
No alignment	9/15	Not included
16. There are clear indicators for success for SBCC in policy and guidance documents.		
Full alignment	2/15	Indicators highlighted in documents.
Partial alignment	0/15	
No alignment	10/15	No clear indicators.
17. Policy & guidance documents advising mass media include guidance on formative research, pre-testing messaging, targeting of communication, selection of appropriate channels, audience		

Standards and alignment	Number of documents	Reason
segmentation, working with local community platforms or infrastructure, and the need to address equity in SRH.		
Full alignment	0/15	
Partial alignment	1/15	Element of pre-testing messages not included
No alignment	11/15	Guidance not included

iii). PPFP

A total of 15 documents were reviewed for PPFP. Of the policy and guideline-related documents, 2/15 were fully aligned with the recommendation to include FP counseling during the ANC Visits. One (1/15) maternity or PNC policy document fully aligned the recommendation to include FP counseling during the immediate post-partum period, while 2/15 recommended FP counseling during the postpartum period. None (0/15) of the MNH policy documents were aligned with providing guidance on how to reach women who did not have a facility delivery with FP, encouraged women to transition from LAM to another method of contraception at 6 months postpartum, aligned precisely with WHO's latest PPFP compendium and Handbook for postpartum and post-abortion FP and aligned with WHO Selected Practice recommendations and WHO Handbook on initiation criteria for breastfeeding amenorrhoeic women <6 months postpartum (Table 8).

Table 8: Alignment of PPFP standards with WHO global standards.

Standards and alignment	Number of documents	Reason
1. ANC policies, guidelines and tools recommend counselling on FP during at least one of the routine ANC visits.		
Full alignment	2/15	Policy documents recommend.
Partial alignment	0/15	
No alignment	4/15	Standard not mentioned.
2. Maternity or immediate post-natal care policies, guidelines, and tools recommend counseling on FP in the immediate postpartum period.		
Full alignment	1/15	Standards included in the documents.
Partial alignment	2/15	The policy recommends FP in all post-partum and not just immediate
No alignment	4/15	Not provided for in the documents
3. Post-natal care policies, guidelines, and tools recommend counselling on FP at the first post-natal care check-up.		
Full alignment	1/15	Policy recommendations.
Partial alignment	2/15	recommended counselling on family planning but does not mention to be done at first post-natal care check-up.
No alignment	4/15	Not recommended
4. Immunization policies, guidelines, and tools recommend counselling on FP during child health checks/immunization visits.		
Full alignment	2/15	Documents recommend.
Partial alignment	0/15	
No alignment	6/15	Not recommended.
5. MNH policies, guidelines and tools clearly state the 3 criteria for the Lactational Amenorrhoea Method (LAM).		

Standards and alignment	Number of documents	Reason
Prompt: LAM criteria are i.<6 months postpartum; fully or nearly fully breastfeeding; no return of menses.		
Full alignment	1/15	Clearly stated.
Partial alignment	2/15	The policy talks about breastfeeding but does not clearly state the 3 criteria for LAM.
No alignment	6/15	Not stated.
6. Infant feeding/nutrition policies, guidelines and tools clearly state the 3 criteria for Lactational Amenorrhoea Method (LAM). Prompt: LAM criteria are i.<6 months postpartum; fully or nearly fully breastfeeding; no return of menses.		
Full alignment	2/15	Clearly stipulated in the documents.
Partial alignment	1/15	It does not fully state the 3 criteria for LAM; but it mentions exclusive breast feeding.
No alignment	4/15	Not mentioned.
7. MNH policies, guidelines and tools provide guidance on how to reach women who did not have a facility delivery with FP.		
Full alignment	1/15	
Partial alignment	0/15	
No alignment	0/15	Standards not mentioned in policy documents.
8.MNH policies, guidelines and tools encourage women to transition from LAM to another method of contraception at 6 months postpartum.		
Full alignment	1/15	
Partial alignment	0/15	
No alignment	0/15	Not mentioned.
9.Do policies, guidelines and tools align precisely with WHO's latest PPFP compendium and Handbook for postpartum and post-abortion FP? Prompt: Does guidance allow immediate initiation of progestogen-only pills & implants after birth? And do they allow initiation of combined and progestogen-only methods immediately post-abortion (both surgical and medical))?		
Full alignment	0/15	
Partial alignment	1/15	
No alignment	0/15	Not indicated.
10. FP policies and guidelines align with WHO Selected Practice recommendations and WHO Handbook on initiation criteria for breastfeeding amenorrhoeic women <6 months postpartum. Prompt: Breastfeeding amenorrhoeic women less than 6 months post-partum can initiate POPs and implants at any time without need for a backup method. They can initiate DMPA between 6 weeks and 6 months postpartum without the need for a backup method.		
Full alignment	0/15	
Partial alignment	1/15	The policy recommends breastfeeding but does not talk about amenorrhoeic women
No alignment	8/15	Not indicated
11. FP policies and guidelines align with WHO Selected Practice recommendations on initiation criteria for post-abortion women. Prompt: IUD/IUS can be initiated immediately after 1st and 2nd tri abortion. All progestogen-only methods and combined hormonal method can be initiated immediately post-abortion.		
Full alignment	1/15	Guidelines align
Partial alignment	0/15	
No alignment	0/15	Not indicated

Standards and alignment	Number of documents	Reason
12. PPFP and PAFP Policies and guidelines align with WHO's human rights framework for the provision of contraception, including informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services. Prompt: Review WHO Human Rights for Contraceptive Services framework.		
Full alignment	1/15	The policy aligns with guidelines.
Partial alignment	0/15	None
No alignment	0/15	Not indicated.

8.2. Findings from the review of Databases

i). PPFP:

A summary of PPFP indicators is presented in Table 9. About 3 in 5 (59%) women of reproductive age (WRA) access family planning (FP) methods from public facilities, with greater access among adults and in rural areas. This indicates a need to engage stakeholders from the private sector when monitoring and advocating for EBPs to achieve optimal scale-up. Between 2016 and 2022, modern contraceptive prevalence slightly increased by 3 percentage points, underscoring slow progress in increasing modern contraceptive use. Reliance on long acting or permanent methods is notably low at less than 10% and lowest in rural areas (7.6%) relative to urban areas (8.2%), though slightly higher among current users in these areas. The total unmet need for FP among married (or living in the union) decreased by 10% comparing UDHS 2016 (28%) to 2022 (19%), but persistently higher in rural (UDHS 2016=30.1% and 2022=20.2%) relative to urban (UDHS 2016=23% and 2022=15%) areas. Over the same inter-survey period, the median birth interval also increased by about 3 months and remains higher in urban (3.2 years) compared to rural (2.8 years). In addition, the percentage of women who give birth in health facilities with a skilled birth attendant (88%) increased by more than 10% but is remarkably lower in rural (86%) relative to urban (94%). This high percentage is an indication that PPFP can be easily scaled up during the immediate post-pregnancy period once appropriate methods are available.

ii). Task sharing

From the World Bank microdata catalogue, the number of healthcare workers per 1000 people is low, while unfilled posts remain high, indicating that facilities are understaffed (Table 10). The limited facility staffing inhibits optimal task sharing for the already overwhelmed workers. Therefore, the recruitment of more healthcare workers may enable the scale-up of task sharing to address the health and care needs of the growing population.

ii). SBCC

A summary of SBCC indicators is presented in Table 11 below. Half of the FP users have a full method information index (MII), but this is lower in urban areas (46%) and among teenagers (38%). According to the 2022 PMA survey, about a quarter (24%) of female non-users intend to use FP in the future; higher in rural areas (26%) compared to urban areas (21%). More than 80% of all WRA are part of the FP use decision-making, either on their own or jointly with their sexual partners. Nearly 80% of women are exposed to different FP messages via various channels, but

the percentage is slightly lower in rural areas and among teenagers. Therefore, innovative approaches are used through leveraging channels that are easily accessed by the rural and teenagers or other subgroups with limited access to such information.

Table 9: Data review for PPFP

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Data source**	**Year**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
% of FP accessed in the public sector	All	DHS	2016	58.5	63.8	46.0	48.3	59.4
% of FP accessed in the non-profit private sector	All	DHS	2016	ND	ND	ND	ND	ND
% of FP accessed in the for-profit private sector	All	DHS	2016	ND	ND	ND	ND	ND
% of FP accessed in the profit private sector	All	DHS	2016	41.5	36.2	54.0	51.7	40.6
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS	2022	29.8	ND	ND	9.4	ND
		DHS	2016	27.3	26.1	30.5	9.4	32.7
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS	2022	ND	ND	ND	ND	ND
		DHS	2016	7.7	7.6	8.2	1.1	9.7
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	PMA	2022	13.0	13.9	11.0	4.5	15.3
		DHS	2016	25.6	26.3	23.9	10.6	26.8
% of women with unmet need for FP	All	PMA	2022	15.3	17.2	10.9	9.8	16.7
		DHS	2016	20.4	22.4	15.0	11.3	23.2
% of women with unmet need for FP (among married/living in union)	All	DHS	2022	18.5	20.2	15.1	12.2	ND
		PMA	2022	20.5	21.9	16.9	19.6	20.5
		DHS	2016	28.4	30.1	22.8	30.4	28.2
% of women with unmet need for FP for spacing births	All	PMA	2022	10.3	11.5	7.5	8.2	10.8
		DHS	2016	13.6	14.8	10.1	10.9	14.4
% of women with unmet need for FP for spacing births (among married/living in union)	All	PMA	2022	13.5	14.3	11.2	17.0	13.2
		DHS	2016	18.3	19.4	14.9	29.7	17.4
% of all WRA who are < 12 months postpartum and not using modern contraception	PPFP	Track 20	2024	11.0	ND	ND	ND	ND
		DHS	2016	10.3	9.8	11.8	4.7	11.1
% of women who give birth in facility who are <12 mo postpartum and not using MC	PPFP	Track 20	2024	8.0	ND	ND	ND	ND
		DHS	2016	11.2	11.0	11.8	5.2	12.0

% women < 2 years postpartum who discontinue contraception within 12 months of use	PPFP	DHS	2022	49.3	ND	ND	ND	ND
		PMA	2022	21.0	ND	ND	ND	ND
		DHS	2016	45.0	ND	ND	ND	ND
% women < 2 years postpartum who discontinue contraception within 3 months of use *(may require analysis of DHS calendar data)*	PPFP	DHS	2016	1.1	ND	ND	ND	ND
% of women who receive ANC from a skilled provider	PPFP	DHS	2022	98.6	98.5	98.7	98.4	ND
		DHS	2016	97.6	97.2	99.1	97.0	97.7
% of women with recent birth who have a post natal check up within 6 weeks	PPFP	DHS	2022	ND	ND	ND	ND	ND
		DHS	2016	82.8	84.7	77.7	79.3	83.0
Median duration (months) of exclusive breastfeeding	PPFP	PMA	2022	ND	ND	ND	ND	ND
		DHS	2016	4.0	4.0	3.9		
Median duration (months) of partially exclusive breastfeeding	PPFP	PMA	2022	ND	ND	ND	ND	ND
		DHS	2016	4.9	4.9	4.8		
Median birth interval (in months)	PPFP	DHS	2022	34.3	33.2	38.4	24.7	ND
		DHS	2016	31.9	31.1	36.2	24.2	
% of women who give birth with a skilled attendant	PPFP	DHS	2022	88.4	86.2	93.8	89.9	ND
		DHS	2016	74.2	70.0	89.6	78.3	73.4
% of women who give birth in a health facility	PPFP	DHS	2022	86.4	83.5	93.2	88.3	ND
		DHS	2016	76.5	73.0	89.5	80.8	74.7
% ANC visits where FP counselling occurs	PPFP	SDP/ HMIS						
% of women delivering in facility who receive FP counselling before discharge	PPFP	SDP/ HMIS						
% of women delivering in facility who receive FP method before discharge	PPFP	SDP/ HMIS						

% of women attending for post-abortion or abortion care who receive FP method before discharge	PPFP	SDP/ HMIS						
% of post-natal care clients (usually 2-6 weeks postpartum) who receive FP counselling	PPFP	SDP/ HMIS						
% of immunization clients who receive FP counselling	PPFP	SDP/ HMIS						
% of women delivering in facility who receive breastfeeding counselling before discharge	PPFP	SDP/ HMIS						

Table 10: Data review for Task sharing

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Data source**	**Year**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
% of FP accessed in the public sector	All	DHS	2016	58.5	63.8	46.0	48.3	59.4
% of FP accessed in the non-profit private sector	All	DHS	2016	ND	ND	ND	ND	ND
% of FP accessed in the for-profit private sector	All	DHS	2016	ND	ND	ND	ND	ND
% of FP accessed in the profit private sector	All	DHS	2016	41.5	36.2	54.0	51.7	40.6
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS	2022	29.8	ND	ND	9.4	ND
		DHS	2016	27.3	26.1	30.5	9.4	32.7
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS	2022	ND	ND	ND	ND	ND
		DHS	2016	7.7	7.6	8.2	1.1	9.7
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	PMA	2022	13.0	13.9	11.0	4.5	15.3
		DHS	2016	25.6	26.3	23.9	10.6	26.8
% of women with unmet need for FP	All	DHS	2022	18.5	20.2	15.1	12.2	ND
		PMA	2022	15.3	17.2	10.9	9.8	16.7
		DHS	2016	28.4	30.1	22.8	30.4	28.2

% of women with unmet need for FP for spacing births	All	PMA	2022	10.3	11.5	7.5	8.2	10.8
		DHS	2016	13.6	14.8	10.1	10.9	14.4
National Family Planning Effort Index (%)	All	Track20	2014	51.2	47.9	ND	ND	ND
Number of health workers (all reported cadres) national/subnational	Task-sharing	Ministry of Health (MoH) Uganda human resource for heath dashboard	2024					
Medical officer				1803				
Dental surgeon				67				
Pharmacists				226				
Laboratory technicians				3898				
Enrolled nurse				10811				
Enrolled midwife				7125				
Registered nurse				158				
Registered midwife				150				
Nursing officer				4054				
Nursing officer – Midwifery				524				
Assistant nursing officer				1671				
Assistant nursing officer - Midwifery				316				
Chairside Assistant				5				
Nursing Assistant				4819				
Nursing Assistant – Aides				22				
Midwifery Educators				4				
Assistant Midwifery Educators				4				
Community Health Workers				103				
Doctors per 1000 population	Task-sharing	World Bank microdata catalog	2020	0.2				

Nurses (plus midwives) per 1000 population	Task-sharing	World Bank microdata catalog	2020	1.7				
CHWs per 1000 population	Task-sharing	World Bank microdata catalog	2005	0.2				
% of workforce that are CHW	Task-sharing	MoH Human Resource for Health (HRH) dashboard	2024	0.2				
Ratio of unfilled posts to total number of posts, by cadre	Task-sharing	Ministry of Health (MoH) Uganda human resource for heath dashboard	2024					
Medical officer				0.4				
Dental surgeon				0.5				
Pharmacists				0.3				
Laboratory technicians				0.1				
Enrolled nurse				0.2				
Enrolled midwife				0.1				
Registered nurse				0				
Registered midwife				0				
Nursing officer				0.2				
Nursing officer – Midwifery				0				
Assistant nursing officer				0.4				
Assistant nursing officer - Midwifery				0				
Chairside Assistant				0.2				
Nursing Assistant				0.5				
Nursing Assistant – Aides				0				

Midwifery Educators				0				
Assistant Midwifery Educators				0				
Community Health Workers				0				

Table 11: Data review for SBCC

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Data source**	**Year**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS	2022	29.8	ND	ND	9.4	ND
		DHS	2016	27.3	26.1	30.5	9.4	32.7
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS	2022	ND	ND	ND	ND	ND
		DHS	2016	7.7	7.6	8.2	1.1	9.7
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	PMA	2022	13.0	13.9	11.0	4.5	15.3
		DHS	2016	25.6	26.3	23.9	10.6	26.8
% of women with unmet need for FP	All	DHS	2022	18.5	20.2	15.1	12.2	ND
		PMA	2022	15.3	17.2	10.9	9.8	16.7
		DHS	2016	28.4	30.1	22.8	30.4	28.2
% of women knowing at least 3 modern methods	**All**	PMA	2022	98.3	98.1	98.6	93.2	99.6
		DHS	2016	96.7	96.5	97.4	88.7	99.1
% of FP users with full method information index (informed of side effects, told what to do if experience side effects, informed of other methods of FP)	**SBCC**	PMA	2022	50.3	52.3	46.1	37.7	51.6
		DHS	2016	48.0	48.0	47.0	42.8	48.7
% of women intending to use FP in the future (or next 12 months)	**SBCC**	PMA	2022	24.4	25.9	20.5	12.4	29.8
		DHS	2016	60.6	59.9	62.7	63.4	59.4
% of women practicing covert FP use	**SBCC**	PMA	2022	15.6	16.9	12.7	7.5	16.4

		DHS	2016	ND	ND	ND	ND	ND
% of women not using FP due to health concerns or fears of side effects	**SBCC**	PMA	2022	11.2	11.6	10.2	10.5	11.5
		DHS	2016	15.7	15.4	16.8	13.8	15.9
% of female non-users intending to use FP in the future	**SBCC**	PMA	2022	24.4	26.0	20.6	12.4	29.8
		DHS	2016	63.9	62.8	68.1	74.1	62.8
% of women FP users making decisions about FP on their own or jointly with their husband	**SBCC**	PMA	2022	90.0	89.4	90.9	86.7	90.2
		DHS	2016	92.6	92.3	93.5	87.2	92.9
% of women FP non-users making decisions about FP on their own or jointly with their husband	**SBCC**	PMA	2022	ND	ND	ND	ND	ND
		DHS	2016	84.4	83.7	87.4	78.3	85.0
% of FP clients involved in decisions about their care during FP consultations	**SBCC**	DHS SPA FP exit	2022	ND	ND	ND	ND	ND
		DHS SPA FP exit	2016	ND	ND	ND	ND	ND
% of women exposed to different FP messages (via different channels: radio/TV, newspapers, mobile phone)	**SBCC**	PMA	2022	79.3	75.7	87.3	71.2	81.4
		DHS	2016	68.7	65.7	76.8	61.5	70.8
% of facilities with available visual aids for FP (flip charts, leaflets)	**SBCC**	SDP/ SPA FP exit Inventory						
No. or % of districts with active health promotion teams	**SBCC**	HMIS (?)						
No. or % of health facilities with community outreach for RMNCH	**SBCC**	HMIS (?)						

8.3. Findings from the KII survey

A total of 25, 23, and 30 purposively selected policymakers, programme managers, health workers and researchers were interviewed for PPFP, SBCC, and task sharing, respectively, to identify bottlenecks of the scaling up of the three EBPs. Respondents' scores (from 1: fully agree to 5: fully disagree) were averaged, and an overall mean was computed to generate the mean score for each bottleneck. Results on respondents' background characteristics and mean scores per bottleneck are presented in Table 12 below. The overall mean scores were then grouped into four categories.

- **Mean score of 4.0-5: Dark red (very important bottleneck).**
- **Mean score of 3.0-3.99: Light red (important bottleneck).**
- **Mean score of 2.0-2.99: Light green (minor bottleneck).**
- **Mean score of 0.1-1.99: Dark green (not a bottleneck).**

PPFP was the worst-performing EBP with highest number of indicators that were either very important/important bottlenecks (15/35) or ranked as minor bottlenecks (18/35). SBCC followed this with 21/35 non-bottlenecks, 12/35 minor bottlenecks and task sharing, which had 21/35 non-bottlenecks and 13/35 minor bottlenecks. There was a total of 3 important bottlenecks across all EBPs, with Finance/Spending allocation cutting across, implying that government expenditure on EBPs does not match the allocated budget, Information/Client SBC/IEC on PPFP, implying that SBC/IEC materials are not available for use in maternal and newborn health facilities, and Governance/Regulation of SBCC implying that there isn't adequate regulation to ensure effective SBCC for FP.

Finance/insurance, which speaks to national health insurance schemes covering access to contraceptives within post-partum and post-abortion care under PPFP, and through community health workers under task sharing, together with finance/equity, which speaks to the availability of equitable allocation of budget for implementation and scale-up of SBCC for FP nationally according to population or other health and demographic criteria under SBCC, and had borderline score (2.9) to being important bottlenecks.

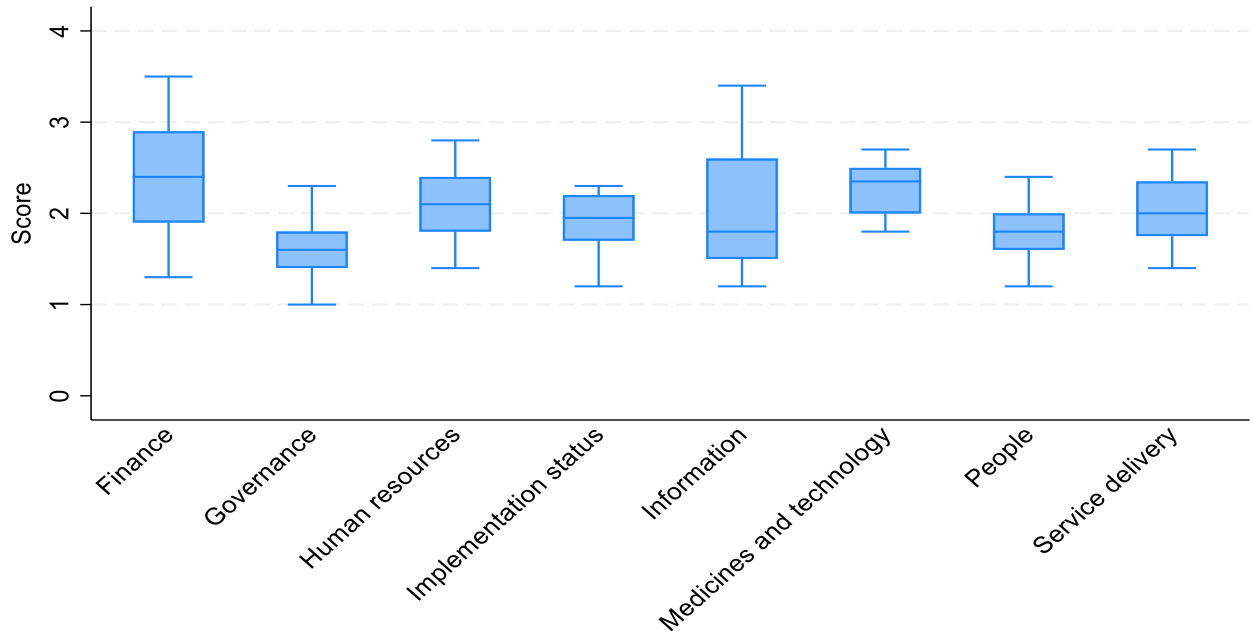
Table 12: Summary of background characteristics and Bottleneck Mean Scores Sper EBP.

	PPFP	**SBCC**	**Task sharing**
Background characteristics	**n = 25**	**n = 23**	**n = 30**
Type of organization			
Government	14	9	22
Professional association	2	8	1
NGO/Civilian society	9	6	7
Role in the organization			
Policy	1	2	1
Programme management	8	5	5

Researcher/ M&E	–	–	1
Clinician/ health worker	16	16	23
Level of support provision			
National	7	8	6
Regional	11	4	5
District	13	6	9
Community	12	11	20
Static clinic	–	1	–
Duration of working/supporting FP programmes			
< 1 year	1	0	0
1 - 3 years	1	7	7
3 - 10 years	14	10	17
> 10 years	9	6	6
Bottleneck	**Mean rate scores**		
Implementation status	1.9	1.7	1.6
Governance			
Governance/Leadership and commitment	1.6	1.4	1.8
Governance/Accountability	1.7	1.7	1.8
Governance/Regulation	1.7	3.4	2.3
Governance/Guidance formulation	1.6	1.5	2.1
Finance			
Finance/Budgeting	2.3	2.5	2.5
Finance/Donors	1.8	2.0	2.1
Finance/Insurance	2.9	1.6	2.9
Finance/Spending allocation	3.5	3.6	3.7
Finance/Planning	2.4	1.9	2.2
Finance/Equity	2.2	2.9	1.9
People			
People/Communication, knowledge and awareness	1.9	2.3	2.0
People/Acceptability	1.5	1.8	1.8
People/Consultation	2.0	2.3	2.1
People/Coordination	1.8	1.8	1.8
People/Networks	1.6	1.8	1.8
People/Community engagement	2.0	1.8	1.7
Information			
Information/Reporting	1.6	1.9	1.8
Information/Data and HMIS	1.8	1.8	1.8
Information/Guidelines and tools	2.7	1.7	2.0
Information/Client SBC/IEC	3.0	2.0	2.0
Information/Health promotion	2.1	1.8	1.9
Medicine and Technology			
Medicines and technology/Infrastructure	2.6	1.9	2.5
Medicines and technology/Supplies	2.2	2.4	2.2

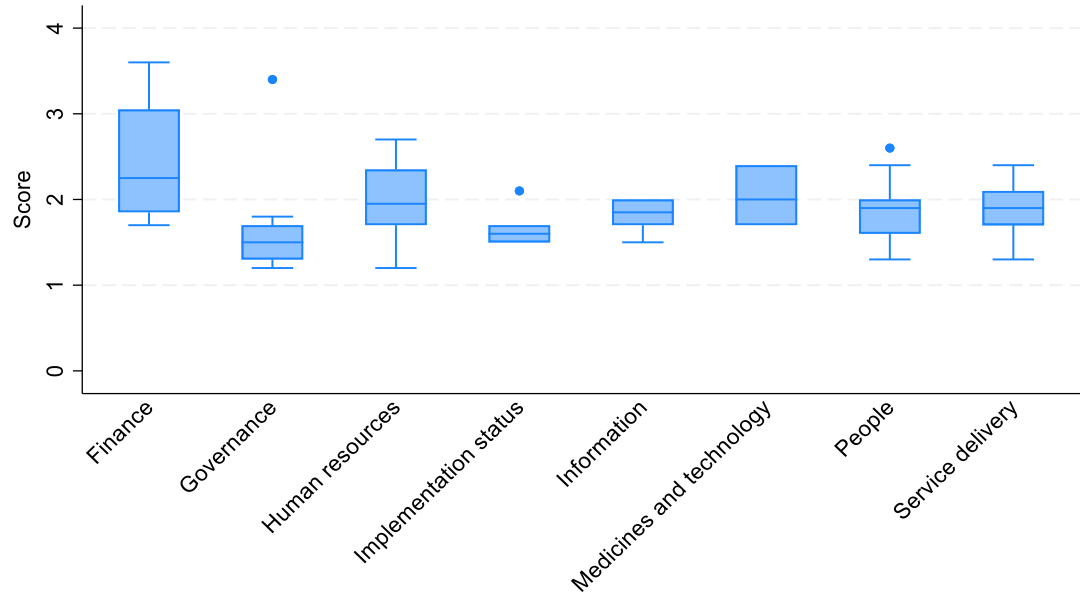
Medicines and technology/Innovation	2.3	*NA*	*NA*
Service delivery			
Service delivery/Management	2.1	2.0	1.9
Service delivery/Supervision	*NA*	1.7	1.9
Service delivery/Teamwork and coordination	1.6	1.3	1.6
Service delivery/Service organization and scheduling	1.9	2.0	1.7
Service delivery/Referral systems	2.4	1.7	1.4
Service delivery/Fees	1.8	1.7	1.6
Human resources			
Human resources/Training and education	2.2	2.2	1.7
Human resources/Capacity	2.4	2.1	1.7
Human resources/Roles	2.6	1.5	2.2
Human resources/Skills and competences	2.0	1.9	1.5
Human resources/Motivation	2.1	2.3	1.9

Figure 3: Median rating scores for PPFP bottleneck by themes.



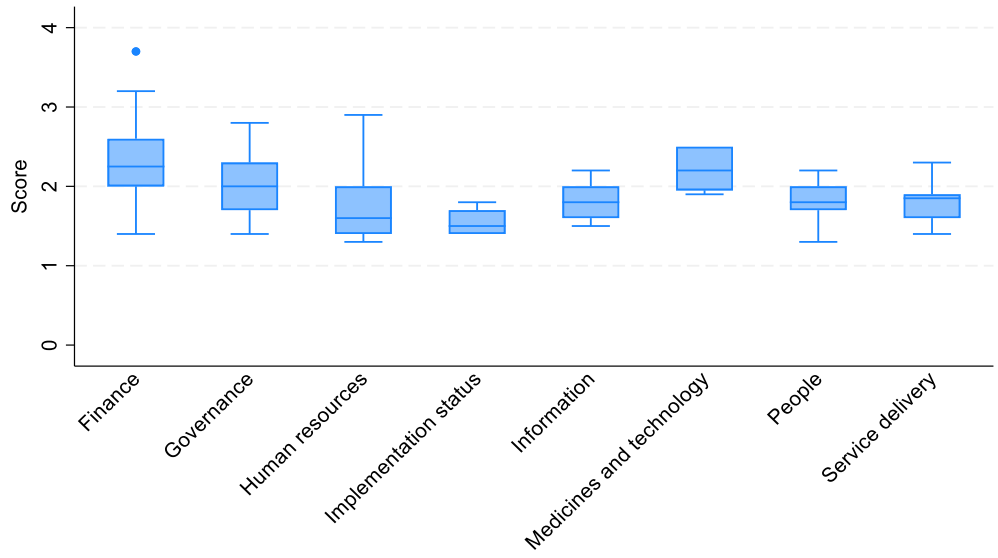
Only 4 of the PPFP themes were classified as "not a bottleneck", i.e. mean score<2. **Governance and People** have the **lowest median (least bottlenecks**), while **Finance, Medicine, & Technology** have the **highest median scores (very important bottleneck**), which need the most/urgent attention.

Figure 4: Median scores for SBCC bottleneck by themes.



Six of the SBCC themes were largely classified as "not a" bottleneck", i.e. mean .score<2. ***Governance*** *and* ***Implementation*** *have the lowest median (****least bottleneck****), while* ***Finance and Medicine & Technology*** *have the highest median scores (****very important bottleneck****).*

Figure 5: Median scores for Task sharing by themes



Six of the Task Sharing Themes were largely classified as "not a" bottleneck" i.e. mean score<2. ***Human Resources*** *and* ***Implementation*** *status* ***"not a"*** *bottleneck, while* ***Finance and medicines & technology*** *had the* ***"minor"*** *bottlenecks.*

Table 13 below shows the bottlenecks inhibiting the scale-up of PPFP as per the desk review, case studies and KII survey across the 7-health system building blocks of Governance, Financing, People, Information, Medicines and Technology, Service delivery and Human resources.

Table 13: Bottlenecks inhibiting the scale-up of PPFP as per the Desk review, Case studies and KII survey.

Bottlenecks inhibiting the scale-up of PPFP as per the Desk review, Case studies and KII survey						
Governance	**Financing**	**People**	**Information**	**Medicines & Technology**	**Service delivery**	**Human resources**
-Lack of systematic collection of data disaggregated and missing data. - Poor planning and budgeting warranting data utilization to ascertain usage of various FP methods at the district level. -Not involving other stakeholders beyond health (Political, religious and cultural leaders). -Lack of bottom-up approach to planning.	-Limited funding to motivate the health providers.	-Low male involvement. -Cultural/ religious beliefs, Myths and misconceptions about FP methods, especially postpartum IUDs. -Partner opposition to the use of contraception.	-Ignorance/knowledge-use gap. -Lack of enough sensitization in the community. -Inadequate dissemination of information. -Lack of IEC materials for both the workers and the clients.	-Side effects of FP methods. -Lack of space. -Lack of commodities and supplies, especially for IPPFP-IUD.	-low uptake, -Traditional birth attendants mislead mothers. -Negative attitude of the midwives. -Poor quality of care -FP information not integrated into ANC for mothers to embrace IPPFP/PPFP (most of the deliveries come as referrals). -Long distances to health facilities. -Low integration of FP in other services e.g. FP-HIV and FP-Immunization.	-Insufficient skills, especially for the LARCs. - Midwives and healthcare providers weren't trained to insert postpartum IUDs. -Have the knowledge, but their competence. - There are also no Standard Operating Procedures about the Postpartum IUD provided to health providers. -Some CHWs are unaware of the existence of postpartum IUDs. -understaffing.

Table 14: Enablers, Achievements, Lessons Learnt, and Recommendations for Scaling up PPFP as per the Desk review, Case Studies, and KII survey.

Enablers	Achievements	Lessons Learnt	Recommendations
1. On-site support; Sharing and learning. 2. Stakeholder and community engagement. 3. Donor support to get services, especially to the hard-to-reach areas. 4. Clients trust the FP services provided at the facilities. 5. A complete method mix. 6. Outreaches with LARCs. 7. Fulfilling the donor interests of transparency and accountability 8. Incorporating IPPF and emphasizing. it right from ANC to PNC. 9. Incorporating consent forms to be signed by mothers prior to receiving the IPPFP methods.	1. Complete method mix, including LARCS in facilities. 2. trained staff for the provision of LARCs. 3. Government facilities improved LARCs provision, specifically implant insertion.	1. On-site support; Sharing and learning. 2. Stakeholder and community engagement. 3. Training and equipping staff with skills to provide services, especially LARCs. 4. Conditional cash transfers like vouchers for the rural-poor mothers. 5. keeping PPFP services client-centred and rights-based. 6. PPFP information needs to be provided during ANC. 7. Partner involvement and support, starting from ANC.	1. The implementation of protocols to manage the side effects of contraceptives effectively. 2. Ensure effective coordination, system management. 3. Strengthening joint government donor collaboration and coordination. 4. Establish a system that measures accountability and performance at all levels. 5. In-school and in-service Training should include FP provision, including the LARCs 6. Provide public access to information about health budgets.

Table 15: Bottlenecks inhibiting the scale-up of SBCC as per the Desk review, Case studies and KII survey.

Table 15 below shows the bottlenecks inhibiting the scale-up of SBCC, as per the desk review, case studies, and KII survey, across the seven-health system building blocks of Governance, Financing, People, Information, Medicines and Technology, Service delivery, and Human resources.

Bottlenecks inhibiting the scale-up of SBCC as per the Desk review, Case studies and KII survey.						
Governance	**Financing**	**People**	**Information**	**Medicines & Technology**	**Service delivery**	**Human resources**
- Lack of systematic collection of disaggregated data or no data at all (Poor documentation of FP uptake. - Lack of guidelines for the service provider.	- Not having enough resources (money). -Underfunding or little budget for translated IEC materials.	- Language barrier to technical issues. - Stigma in the community - unrealistic expectations, like handouts. - Relapses in community attitudes and behaviour when funding runs out. - Low male involvement: It is hard getting men to commit time to sit and listen about FP. - Adolescents fear accessing contraceptives from certain health facilities.	- Failure to harness cultural/traditional and religious values: (Modern FP not appreciated by PNFPs). - Ignorance, myths and misconceptions about FP methods among clients.	- Inadequate Infrastructure (space & equipment). - No commodities, equipment or supplies in health facilities.	- Knowledge gap about SBCC among the health workers in the community. - lack of integration of FP with other healthcare services. - Negative attitudes of healthcare providers towards providing some methods, e.g. postpartum IUD. - Natural disasters: Floods in Buliisa displacing populations. - Poor road infrastructure: Impassable roads to health facilities.	- Staff shortage and/or Insufficient skills. - Limited training of health care workers, especially in modern methods.

Table 16: Enablers, Achievements, Lessons Learnt, and Recommendations for Scaling up SBCC as per the Desk review, Case Studies, and KII survey.

Enablers	Achievements	Lessons Learnt	Recommendations
1. Adequate staffing of health workers with the right skills mix. 2. Community engagement. 3. Service delivery emphasizing evidence-based, high-impact interventions. 4. Having language-specific women champions of FP 5. Involving cultural leaders in promoting FP. 6. Using champions for campaigns for men (like in Vasectomy). 7. Using community members to implement projects and facilitate their movements. 8. Giving enough information about FP.	1. Implementing culturally rich SBCC programmes that embrace many dialects. 2. Involving cultural leaders in promoting family planning. 3. A lot of behaviours change in terms of support from the elders first to the women to go and access family planning services. 4. Male involvement programmes have increased the uptake of FP services by both women and men and men supporting their spouses.	1. You need time to pass on the information and to see behaviour change. 2. You need to give as much information as possible to the community. 3. Passing through cultural structures is key to programming progress and success. 4. Having enough resources and good planning are crucial. 5. Men still play a big role in decision-making regarding family planning uptake, so they should be involved very well. 6. Men should be segmented according to age and use different approaches and different kinds of communication information.	1. Ensure effective coordination, system management. 2. Strengthening joint government donor collaboration and coordination. 3. Establish a system that measures accountability and performance at all levels, especially for inclusive health governance. 4. Provide public access to information about health budgets. 5. There's a need to strengthen individual and community ownership of health communication interventions and improve resilience to vulnerabilities. 6. Repositioning health facilities as a one-stop centre for reliable health information and services.

Table 17 below shows the bottlenecks inhibiting the scale-up of PPFP as per the desk review, case studies and KII survey across the seven health system building blocks of Governance, Financing, People, Information, Medicines and Technology, Service delivery and Human resources.

Table 17: Bottlenecks inhibiting the scale-up of Task Sharing as per the Desk review, Case studies and KII survey.

Bottlenecks inhibiting the scale-up of Task Sharing as per the Desk review, Case studies and KII survey						
Governance	**Financing**	**People**	**Information**	**Medicines & Technology**	**Service delivery**	**Human resources**
-Lack of a clear policy and guiding framework for task sharing. **-** Lack of certification of trained Community Officers.	**-** Limited earmarked financing mechanism for supporting CHWs, - usually phased out after donors. - Low or no remuneration of CHWs, including the absence of guidance on their remuneration. - Lack of enough resources to train.	-Parents don't want their adolescents to use FP because of myths and misconceptions. -Male involvement is still very lo - Cultures don't promote family planning. - Community-Low levels of education have also hindered the FP practices. -language barrier between the clients and healthcare providers.	**-** Lack of sensitization in the communities	**-** Inadequate infrastructure & equipment. - Lack of commodities, supplies and equipment at health facilities.	- Quality and competence concerns. - Side effects of the FP. - Women have a tendency of home delivery. - Long distances to the hard-to-reach communities.	- Heavy workload, especially at lower-level facilities. - Limited knowledge and capacity for the use of available tools, especially the revised HMIS tools. - Staffing is low.

Table 18: Enablers, Achievements, Lessons Learnt, and Recommendations for Scaling up Task Sharing as per the Desk review, Case Studies, and KII survey.

Enablers	Achievements	Lessons Learnt	Recommendations
1. Inadequate number of doctors. 2. Successfully demonstrated pilot task-sharing projects. 3. Employable at low cost. 4. Strong support from other stakeholders. 5. Existence of CHW governance structures at national and sub-national levels. 6. Readily available & committed CHWs. 7. CHWs can relate to the community 8. Selection of the right trainers.	1. Training clinical officers to offer LARCs and permanent methods, which is not part of their school training. 2. Through VHTs, there is an increased uptake, even among adolescents.	1. Not task shifting; we call it task sharing. 2. Determination to learn, NOT Prior experience and training 3. Recognition/appreciation/ remuneration for the extra skill. 4. Partner involvement and support are key. 5. FP services should be expanded to lower level/community facilities.	1. Strengthening coordination, supervision and monitoring. 2. Make SOPs and guidelines for task-sharing for the different cadres. 3. Build the capacity of CHW in microplanning, data use, community feedback, and reporting. 4. Equip CHW with digital tools. 5. Strengthening the capacity of health facilities, districts, and national levels to use community-level logistics data for planning and decision-making. 6. Improve staffing and remuneration. 7. Mobilizing resources required for effective task-sharing.

8.3. Findings from the BNA Workshop

Theme 1: Governance and Financing

Governance and Financing consisted of the sub-themes below.

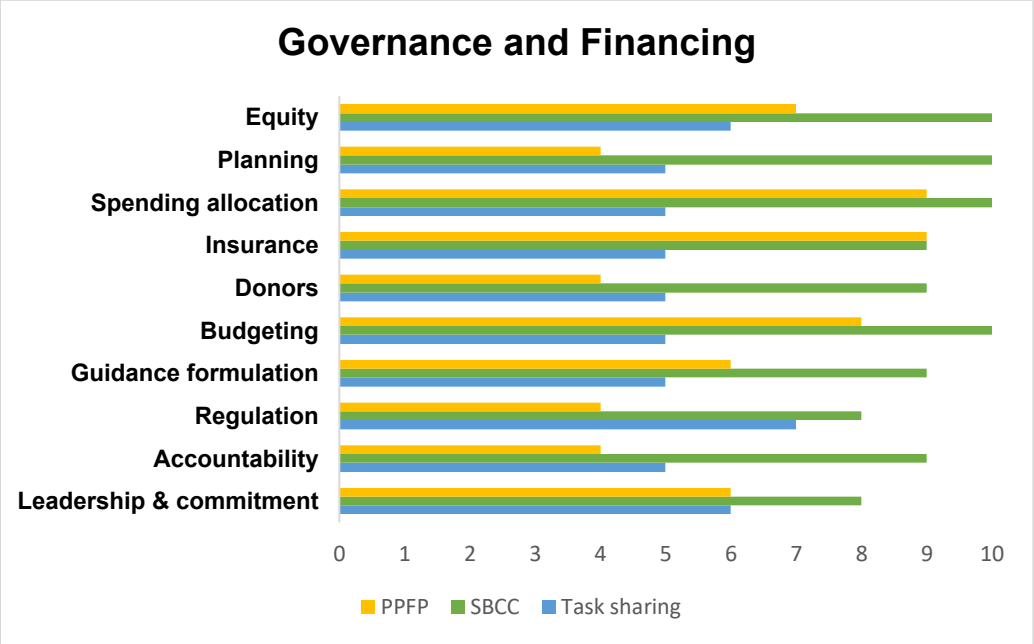
1. **Leadership:** There is strong leadership and commitment to support the scale-up of the EBP.
2. **Accountability:** There is strong accountability for EBP across institutional structures and among policymakers and programme managers.
3. **Regulation:** There are strong regulations to ensure access to the EBP.
4. **Guidance Formulation:** There is sufficient guidance (including policies, guidelines, and tools) to support the scale-up of the EBP.
5. **Budgeting:** There is an adequate budget available at all levels to support the EBP scale-up.
6. **Donors:** Donors sufficiently contribute to financing the scale-up of the EBP.
7. **Insurance:** National health insurance schemes cover access to contraceptives within the EBP.
8. **Spending Allocation**: Government expenditure on the EBP matches the allocated budget.
9. **Planning:** There is a coherent national plan for the EBP scale-up.
10. **Equity:** There are financing mechanisms and policy actions in place to ensure equitable scale-up to EBP.

Rating: *10 is the most important bottleneck, 1 is the least important. The most important bottlenecks require the most urgent attention and were scored 7-10; somehow important were scored 4-6 and the least important were scored 1-3.

Table 19: Average Group Rating for Governance & Financing for the 3 EBPs.

Governance & Financing	Task sharing Average group rating	SBCC Average group rating	PPFP Average group rating
Leadership & commitment	**6**	8	**6**
Accountability	5	9	4
Regulation	**7**	8	4
Guidance formulation	5	9	**6**
Budgeting	5	10	**8**
Donors	5	9	4
Insurance	5	9	**9**
Spending allocation	5	10	**9**
Planning	5	10	4
Equity	**6**	10	**7**

Figure 6: Average Group Rating for Governance & Financing for the 3 EBPs



For SBCC, the most important bottlenecks with the highest rating (7 and above) were in Equity, spending allocation, and budgeting. For PPFP, the most important bottlenecks were in spending allocation, insurance, and budgeting. For task sharing, many of the components were rated as either somehow important or least important (5 and below), and the most important bottlenecks were regulation, equity, and leadership and commitment.

Theme 2: Medicines and Technology/Service delivery/Human resources

Medicines and Technology/Service delivery/Human resources consisted of the sub-themes below.

1. **Infrastructure**: There is adequate health infrastructure to deliver the EBP for FP.
2. **Supplies:** Health facilities and community health programmes have commodities, equipment, and other supplies required to deliver task-sharing.
3. **Management:** There is effective health management to support the EBP.
4. **Supervision:** There is adequate clinical supervision to quality assure the EBP.
5. **Teamwork & coordination:** Different teams involved in the EBP work together to ensure its delivery.
6. **Service organization & scheduling:** The organization of services makes the EBP feasible (e.g., which providers are allocated to which rooms/departments, etc.).
7. **Referral systems:** Referral systems support the EBP.

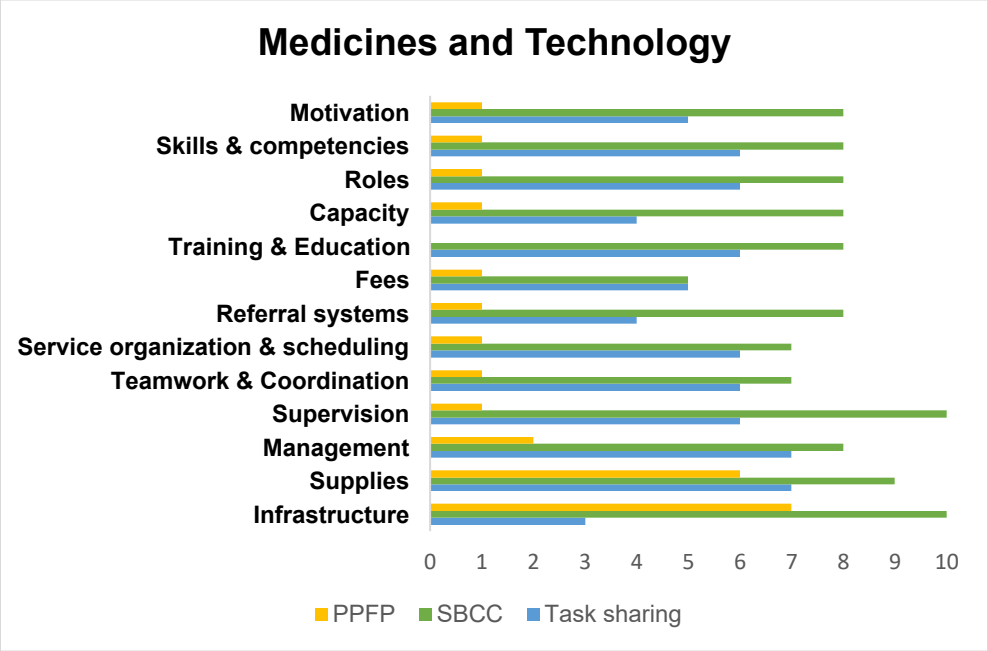
8. **Fees:** FP services through the EBP are free or there are no additional fees when FP methods are shared to lower cadre providers (i.e. for injectables when delivered by CHWs, and implants when delivered by auxiliary nurses).
9. **Education & Training:** EBP is integrated adequately into pre-and-in-service training of health workers.
10. **Capacity:** Health Facilities/Health workers in MNH services have the capacity to deliver the EBP.
11. **Roles:** The relevant FP method provision is included in job descriptions of staff who are assuming new FP provision.
12. **Skills and Competencies:** Competency assessments take account of the EBP and additional support needs.
13. **Motivation:** Providers involved in the EBP have positive attitudes towards the policy.

Rating: *10 is the most important bottleneck, 1 is the least important. The most important bottlenecks require the most urgent attention and were scored 7-10; somehow important were scored 4-6 and the least important were scored 1-3.

Table 20: Average Group Rating for Medicines & Technology/Service delivery/Human resources for the 3 EBPs.

Medicines and Technology	**Task sharing Average group rating**	**SBCC Average group rating**	**PPFP Average group rating**
Infrastructure	3	**10**	**7**
Supplies	**7**	**9**	6
Management	**7**	8	2
Supervision	6	**10**	1
Teamwork & Coordination	6	7	1
Service organization & scheduling	6	7	1
Referral systems	4	8	1
Fees	5	5	1
Training & Education	6	8	0
Capacity	4	8	1
Roles	6	8	1
Skills & competencies	6	8	1
Motivation	5	8	1

Figure 7: Average Group Rating for Medicines & Technology/Service delivery/Human resources for the 3 EBPs.



Under Medicines and Technology/Service delivery/Human resources, SBCC had the most important bottlenecks, with all components having a rating above 7. These included infrastructure, management, supervision, supplies, referral systems, training and education, roles, motivation, capacity and skills and competencies. For PPFP, the most important bottlenecks were infrastructure and supplies, while for task sharing, the most important bottlenecks were management, supplies, training and education, roles, skills and competencies.

Theme 3: People and Information

People and Information consisted of the sub-themes below.

1. **Knowledge & awareness:** There is adequate knowledge and awareness of recommended EBP policies and practices.
2. **Acceptability:** There is acceptance of the recommended EBP policies and practices at all levels.
3. **Consultation:** Key stakeholders have been adequately consulted about the EBP recommended approaches (or guidance, if it exists).
4. **Coordination:** There is adequate coordination between different stakeholders to ensure effective scale-up of the EBP for FP.
5. **Network:** There are effective professional networks supporting the scale-up of the EBP for FP.
6. **Community Engagement:** There is adequate community engagement for FP.

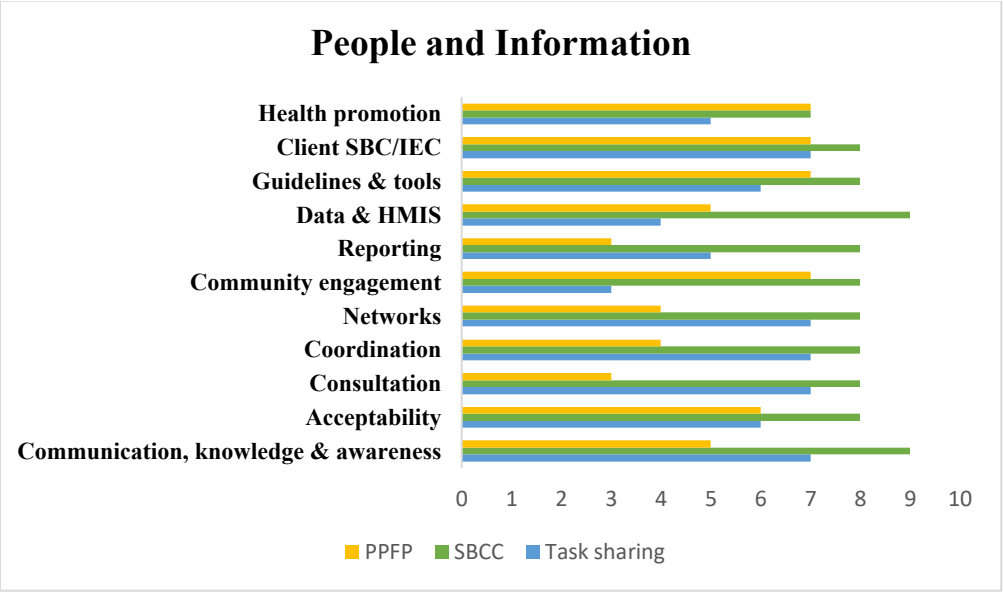
7. **Reporting:** There is adequate reporting on the uptake of FP through the EBP or the EBP activities.
8. **Data &HMIS:** There is an effective HMIS to support data collection on the EBP activities and/or referrals, and data is used regularly for performance management.
9. **Guidelines and Tools**: Updated guidance on the EBP for FP is available and used.
10. **Client IEC:** Information, education, and communication (IEC) materials exist to support the EBP for FP.
11. **Health promotion:** Adequate intervention to promote PPFP or Communication on FP is integrated with health promotion activities.

Rating: *10 is the most important bottleneck, 1 is the least important. The most important bottlenecks require the most urgent attention and were scored 7-10; somehow important were scored 4-6 and the least important were scored 1-3.

Table 21: Average Group Rating for People and Information for the 3 EBPs.

People and Information	Task sharing Average group rating	SBCC Average group rating	PPFP Average group rating
Communication, knowledge & awareness	**7**	**9**	5
Acceptability	6	8	6
Consultation	**7**	8	3
Coordination	**7**	8	4
Networks	**7**	8	4
Community engagement	3	8	**7**
Reporting	5	8	3
Data & HMIS	4	**9**	5
Guidelines & tools	6	8	**7**
Client SBC/IEC	**7**	8	**7**
Health promotion	5	7	**7**

Figure 8: Average Group Rating for People and Information for the 3 EBPs



Under people and information, almost all SBCC components, apart from health promotion, were important bottlenecks as they scored 8 and above. Communication, knowledge and awareness, data and HMIS had the highest ranking. For PPFP, the most important bottlenecks were health promotion, client/SBC/IEC, guidelines and tools, and community engagement. The most important bottlenecks for task sharing were client/SBC/IEC, networks, coordination, consultation, and communication and knowledge.

Table 22: Solutions proposed by the workshop participants to the Major Bottlenecks.

Proposed solution	Which bottleneck does it address?	Check: How feasible is this solution?	Check: How impactful will this solution be?	Which organizations can support this solution?
PPFP				
1. Need for training, mentorship and dissemination of policies on PPFP. - Zoom networking.	Communication, Knowledge and awareness.	Very feasible	Increased uptake of PPFP.	MOH, Districts, IPs, CSOs, CBOs and NGOs
2. Manage side-effects	Acceptability	Very feasible	Increased uptake of PPFP.	MOH, Districts, IPs, CSOs, CBOs and NGOs
3 Donor collaboration & coordination.	Equity	Very feasible	Increased uptake of PPFP.	MOH, Districts, IPs, NGOs and donors
4. Manage shortages of methods, staff, and equipment.	Equity, supplies & infrastructure	Very feasible	Increased uptake of PPFP.	MOH, Districts, IPs, CSOs, CBOs and NGOs

SBCC				
2. Capture and utilize SBCC indicators in the HMIS.	Poor reporting of SBCC data on the HMIS	Very feasible by revision of tools, training of providers	Realize the scale-up & data sharing	MOH, IPs, development partners, Districts, local governments
3. Standardize referral for SBCC.	Irregular referral systems, which are IP-based	Very feasible	Access and tracking of the number of referrals	MOH, Implementing partners, Development partners, districts, local governments
Task Sharing				
4. Ensure policies and commitments are honored and implemented at all levels.	Leadership and commitment	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations
5. There is a need for established, strengthened and functional structures for coordination and accountability at regional levels.	Accountability	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations
6. Establish regulatory frameworks for task-sharing.	Regulation	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations
7. Develop an integrated policy framework on task sharing.	Guidance formulation	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations
8. There is a need to develop an all-inclusive budget catering for all levels of care.	Budgeting	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations
9. We need an earmarked budget targeting task-sharing.	Donors	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations
10. There is a need for a national insurance scheme.	Insurance	Very feasible	Service Delivery	IPs, NGOs, local governments, development partners, Civil Society Organizations

Table 23: The SBCC components in which the stakeholders are involved.

#	COMPONENT	Details
1.	Information	Routinely address people on FP practices through the dissemination of health messages.
2.	Response	Listen and respond to partners' queries on the FP approach.
3.	Interpersonal communication	Strategic communication to stakeholders on FP.
4.	Community dialogues	Host interfaith dialogue & Use of group dialogue/structure.
5.	Mass media	Show on family health.

		Involving young people and other stakeholders in radio talk shows.
6.	Print media	Writing newspaper articles. Young talk paper, straight talk paper, parent talk, teacher talk.
7.	Others (Specify)	Research & collaborate with other practitioners to establish baseline data on a couple of health challenges.

Table 24: Summary of the very important bottlenecks (rated =>7) for each EBP across the health system building blocks.

Health System Block	**SBCC**	**PPFP**	**Task sharing**
Governance & Financing	**Equity**, Planning, **Spending & allocation**, Insurance, Budgeting, Donors, Guidance formulation, Regulation Accountability, **Leadership &commitment.**	**Equity**, **Spending & allocation,** Insurance, and Budgeting.	**Equity**, Regulation, **Leadership & commitment.**
Medicines and Technology/Service delivery/Human resources	Motivation, Skills &competencies, Roles, Capacity, Training & Education, Fees, Referral Systems, Service organization & scheduling, Teamwork & coordination, supervision, **management**, **supplies & infrastructure.**	**Infrastructure and supplies.**	Skills &competencies, motivation, roles, training &education, **management, supplies,** supervision & Teamwork &coordination.
People and Information	Health promotion, **client SBC/IEC,** Guidelines & tools, Data& HMIS, Reporting, Community engagement, Networks, Coordination, Consultation, Acceptability, **Communication, Knowledge and awareness.**	Health promotion, **client/SBC/IEC**, guidelines and tools, and community engagement.	**Client/SBC/IEC,** networks, coordination, consultation, communication **and knowledge and awareness.**

Discussion

This study assessed the health system bottlenecks inhibiting the scale-up of EBPs, including SBCC, task sharing and PPFP. By and large, the assessment shows bottlenecks inhibiting each of the EBPs across the health system building blocks of governance and financing, medicines and technologies, services delivery, human resources, people and information. These bottlenecks indicate inequities in FP service provision that contribute to poor FP outcomes and derail the achievement of the national FP targets.

The most important bottlenecks for task sharing were a lack of financing mechanisms and policy actions that ensure equitable scale-up, a lack of a strong regulation mechanism to ensure access through task sharing, and a lack of strong leadership and commitment to supporting its scale-up. There was also a lack of an effective management system to support task sharing, and health facilities and community workers did not have enough commodities, equipment and other supplies for task sharing. There was also no teamwork and coordination among the stakeholders regarding task sharing, inadequate supervision, a lack of skilled and competent providers, unmotivated providers, unmentioned roles in the job descriptions, and not integrating the EBP into pre-and-in-service training of health workers. Furthermore, there was low knowledge and awareness of the recommended practices, key stakeholders have not been consulted for effective professional support of the EBP, and there are no IEC materials to support task sharing.
The desk review and key informant interviews revealed a lack of a national policy, regulatory framework, financing mechanism, and data on some indicators for task sharing in Uganda, pointing to the dire need for clear directions and guidance.

For PPFP, the most important bottlenecks were a lack of financing mechanisms and policy actions that ensure equitable scale-up, government expenditure on PPFP not matching the allocated budget, absence of a national health insurance scheme to cover access to PPFP, and a lack of an adequate budget available at all levels to support PPFP scale-up. There was no adequate health infrastructure to deliver PPFP, nor were there commodities, equipment, and supplies at the health facilities and for community health workers. Additionally, there were no adequate interventions to promote PPFP or communication on FP integrated with health promotion activities like ANC. There was a lack of adequate updated guidance, tools, and IEC materials to support PPFP and inadequate community engagement. The MoH and its partners need to evaluate the distribution of implementing partners and streamline the financing mechanisms and budgets for PPFP and FP broadly. These inputs significantly affect the service delivery processes at the health facilities and community level, contributing to inequities in access to FP [29-30].

For SBCC, nearly all components across the health system building blocks were significant bottlenecks. However, the country possesses a robust SBCC framework with numerous FP implementing partners engaged in this area. This indicates the need to re-evaluate the scale: *where it is being done and if the guidelines have been scaled up to all levels of delivery*; reach *the sub-groups of those who are being reached to assess if those in need of SBCC interventions are equitably reached*; and the structural and service delivery quality of the SBCC. This will guide the targeted redesign of SBCC programmes to address bottlenecks and ensure that the

programme improves family planning outcomes in the country. This will guide the targeted redesign of SBCC strategies and interventions to address bottlenecks and ensure that the programme improves FP outcomes.

Conclusion

There are bottlenecks inhibiting the scale-up of Task sharing, PPFP and SBCC across all the health system building blocks, which need to be addressed by the MoH and FP implementing partners to improve FP outcomes in the country. Across all the health system building blocks, bottlenecks regarding equity, spending and allocation, leadership and commitment, management, infrastructure and supplies, client/SBC/IEC materials, and knowledge and awareness were cross-cuttings for all the 3 EBPs.

Limitations:

The 2022 UDHS indicators are limited to those available in the main report, and datasets were unavailable for extra secondary analysis. However, the PMA platform provided estimates for indicators unavailable from the UDHS 2022 report. Data on the percentage of women accessing private-for-profit and not-for-profit facilities was unavailable because the ownership/managing authority of private facilities was not captured during DHS data collection. Decision-making on FP among non-users could not be estimated using the PMA dataset, as the question is only addressed to current users. In addition, indicators estimated from the DHS SPA FP exit dataset, such as the percentage of FP clients involved in decisions about their care during FP consultations, were not established because the survey was last conducted in 2007.

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10.0 Workplan, Budget and Sources of Funding

The WHO funds the consultancy component of this work, and the UNFPA funds the data collection component.

Work Plan for the Activities.

WHO-BNA Work Schedule-Assessment Timelines

NO	ACTIVITY	September				October				November				December			
		WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4
01	**Step 1: Preparation**																
1.1	Review and adaptation of the modules of each EBP																
1.2	Review and adaptation of the data collection tools																
1.3	Engagement with the WHO country team on adapted protocol, modules and tools																
1.4	Addressing feedback from the WHO country team on adapted protocol, modules and tools																
1.5	Scoping visits to health facilities to inform adaptation of the tools																
1.6	Proposal submission to the Institutional and national ethical boards																
02	**Step 2: Data collection**																
2.1	Conduct a desk review.																
2.1.1	Policy and guideline alignment assessment																
2.1.2	National data review																
2.1.3	Case studies assessment																

2.2	KII questionnaire adaptation and pretesting																
2.	Key Informant Interview Survey																
2.4	Data Analysis																
03	**Step 3: Bottlenecks Assessment Workshop**																
3.	Workshop Preparation																
3.	BNA Workshop																
04	**Dissemination and progress monitoring**																
4.	Report writing																
4.	Dissemination to the FP-TWG																
4.2	Dissemination to other national and sub-national stakeholders																
4.	Submission of the Final Report																

Appendix 1: List of Documents Reviewed for Policy and Guidelines Alignment for Task Sharing.

#	Document Title	Author and Date of Publication	Document Type
1.	National Family Planning Costed Implementation Plan 2020/21- 2024/25.	Ministry of Health, 2021	Policy Document
2.	NATIONAL COMMUNITY HEALTH STRATEGY	Ministry of Health, April 2022	Policy Document
3.	USAID/UGANDA FAMILY PLANNING ACTIVITY QUARTERLY REPORT, FY21Q1(October-December 2020).	USAID, 2021.	Case Report.
4.	THE NATIONAL IMMUNISATION STRATEGY (NIS) 2024-2028.	Ministry of Health, July 2024	Policy Document
5.	National Family Planning Advocacy strategy and costed implementation Plan 2020/21- 2024/25.	Ministry of Health, June 2021	Policy Document
6.	Quality of care implementation guide for reproductive maternal, newborn, child, adolescent health and nutrition service.	Uganda Ministry of Health. 2023	Policy Document
7.	Uganda Clinical Guidelines 2023.	Ministry of Health, 2023	Clinical Guideline Document.
8.	Ugandan Government FP 2030 Commitments.	MoH, 2021	Policy Document
9.	Supporting Couples to Make Active, Joint Decisions About Childbearing.	IntraHealth, May 2021.	Case Report
10.	UGANDA NUTRITION ACTION PLAN II 2020/21-2024/25.	UNICEF/UN0412376/Kabuye, 2020	Policy Document
11.	Essential Maternal and Newborn Clinical Care Guidelines for Uganda.	Ministry of Health, May 2022.	Clinical Guidelines.
12.	Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging. Sharpened Plan for Uganda 2022/23–2027/28.	Ministry of Health 2022	Policy Document
13.	The National Total Market Approach (TMA) Strategy 2020-2025.	Ministry of Health, Dec 2020	Policy Document
14.	Ministry of Health Strategic Plan 2020/21 - 2024/25.	Ministry of Health,2021	Policy Document
15.	Comprehensive Health Service Standards Manual.	Ministry of Health, Jul 2021	Clinical Guidelines.

Appendix 2: List of Documents Reviewed for Policy and Guidelines Alignment for PPFP

#	Document Title	Author and Date of Publication	Document Type
1.	THE SECOND NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2020/21 - 2024/25 (FP-CIP II).	Ministry of Health 2021	Policy Document
2.	NATIONAL COMMUNITY HEALTH STRATEGY.	Ministry of Health, April 2022	Policy Document
3.	USAID/UGANDA FAMILY PLANNING ACTIVITY QUARTERLY REPORT, FY21Q1(October-December 2020).	USAID, January 2021.	Case Report.
4.	THE NATIONAL IMMUNIZATION STRATEGY (NIS) 2024-2028.	Ministry of Health July 2024	Policy document
5.	National family planning advocacy strategy and Costed implementation Plan 2020/21- 2024/25.	Ministry of Health June 2021	Policy Document
6.	Ugandan Government FP 2030 Commitments.	Ministry of Health, 2021	Policy document
7.	Quality of care implementation guide for reproductive maternal, newborn, child, adolescent health and nutrition service.	Uganda Ministry of Health. 2023	Policy Document
8.	Uganda Clinical Guidelines 2023.	Ministry of Health, 2023	Clinical Guideline.
9.	Supporting Couples to Make Active, Joint Decisions About Childbearing.	IntraHealth, May 2021.	Case Report.
10.	UGANDA NUTRITION ACTION PLAN II 2020/21-2024/25.	UNICEF/UN0412376/Kabuye, 2020	Policy Document
11.	Essential Maternal and Newborn Clinical Care Guidelines for Uganda.	Ministry of Health, May 2022.	clinical Guidelines.
12.	Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging. Sharpened Plan for Uganda 2022/23–2027/28	Ministry Of Health 2022	Policy Document
13.	The National Total Market Approach (TMA) Strategy 2020-2025.	Ministry of Health, Dec 2020	Policy Document
14.	Ministry of Health Strategic Plan 2020/21 - 2024/25.	Ministry of Health,2020	Policy Document
15.	Comprehensive Health Service Standards Manual.	MOH, Jul 2021	Clinical Guidelines.

Appendix 3: List of Documents Reviewed for Policy and Guidelines Alignment for SBCC

#	Document Title	Author and Date of Publication	Document Type
1.	USAID/UGANDA FAMILY PLANNING ACTIVITY QUARTERLY REPORT, FY21Q1(October-December 2020).	USAID, 2021.	Case Report.
2.	Ugandan Government FP 2030 Commitments.	Ministry of Health, 2021	Policy document
3.	THE NATIONAL IMMUNIZATION STRATEGY (NIS) 2024- 2028.	Ministry of Health, July 2024	Policy Document
4.	National Family Planning Advocacy Strategy and Costed implementation plan 2020/21- 2024/25.	Ministry of Health, June 2021.	Policy Document
5.	Quality of Care Implementation Guide for Reproductive Maternal newborn, child, Adolescent health and nutrition service.	Uganda Ministry of Health 2023	Document Policy
6.	Uganda Clinical Guidelines 2023.	Ministry of Health, 2023	Clinical Guideline.
7.	NATIONAL COMMUNITY HEALTH STRATEGY	Ministry of Health, April 2022	Policy Document
8.	The second National Family Planning Costed Implementation Plan 2020/21 - 2024/25.	Ministry of Health, June 2021	Policy document
9.	Supporting Couples to Make Active, Joint Decisions About Childbearing.	IntraHealth, May 2021.	Case report
10.	Essential Maternal and Newborn Clinical Care Guidelines for Uganda.	Ministry of Health, May 2022.	clinical Guidelines.
11.	Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging. Sharpened Plan for Uganda 2022/23–2027/28.	Ministry Of Health 2022	Policy Document
12.	The National Total Market Approach (TMA) Strategy 2020-2025.	Ministry of Health, Dec 2020	Policy Document
13.	Ministry of Health Strategic Plan 2020/21 - 2024/25.	Ministry of Health, 2021	Policy Document
14.	Integrated SBCC Programmes.	USAID, 2021	Case Study
15.	Comprehensive Health Service Standards Manual.	Ministry of Health, Jul 2021	Clinical Guidelines.