The Republic Of Uganda

NAMAYINGO DISTRICT LOCAL GOVERNMENT

NAMAYINGO DISTRICT FAMILY PLANNING - COSTED IMPLEMENTATION PLAN 2017 – 2022

This District Family Planning Costed Implementation Plan for 2017-2022 has been developed with support from FOC REV and Faith to Action through Namayingo District Health Office and Rosette Nsonga as the lead consultant

SEPTEMBER 2017

FOREWORD

Massage from the District Chairman:

Namayingo District Family Planning Costed Implementation Plan 2017- 2022 focuses on ensuring that women and men raise manageable families. The District Local Council is resolved to work with all key stakeholders to ensure that, "All Promote Manageable Health Families" as a matter of priority.

I want to acknowledge the role of Faith Based Organizations, cultural leaders and Men in supporting the uptake of family planning and mobilization of communities for health families.

The District CIP provides a logical approach to Family Planning services by highlighting strengths, weaknesses, opportunities and threats. This plan is consistent with the Ministry of Health National FP Costed Implementation Plan, Vision 2040 and the FP2020 commitments.

This Plan is premised on six thematic areas;

- ✓ Demand Creation
- ✓ Service delivery and access
- ✓ Contraceptive Security
- ✓ Financing
- ✓ Policy and enabling environment
- ✓ Stewardship, Management and Accountability

I believe that with the New leadership ushered in, we will work together to address the Reproductive Health needs of women and men across all categories to reduce the un met need for family planning. The District Council pledges to augment all Development and Implementing Partners to work with us to support and implement the District CIP to ensure the success of the national FP programme. This is primarily intended to improve the quality of life and well-being of our people.

I have the pleasure to present to you this vital district FP CIP that sets a blue print in our attempt to improve access to accurate information about family planning, improved access to high quality family planning services and in general to strengthen and scale of provision of integrated family planning services by multi-stakeholders in the district. The District FP CIP will be a working document to advocate for family planning services.

For God and My Country

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Sanya Ronald
Chairman / Namayingo District

ACKNOWLEDGMENT

Massage from the Chief Administrative Officer

This District FP CIP 2017- 2022 is a result of the hard work, cooperation and collaboration by several individuals and stakeholder organizations over a considerable period of time. Development and finalization of this document involved consultative processes at various levels. Different stakeholders contributed to the successful process of writing the Plan.

Namayingo Local Government wishes to acknowledge all those individuals and Development Partners at all levels that participated in the in consultative meetings and review process at various stages of the development of this plan. Special appreciation goes to Faith to Action, FOC REV and Population Action International for their financial support during the process of writing out the District FP CIP. Reproductive Health Uganda, Deutsche StiftungWeltseveekerung (DSW), Family Planning Consortium Uganda, PACE, GOAL,TASO, Uganda Health Marketing Group are recognised for their consistent efforts towards improved health status of our local populaces.

I therefore call upon my technical team and all stakeholders to implement the Plan as we aim at Accelerating universal access to family planning services in the district through coordinated multi sectoral approach including public and private initiatives in order to increase the modern contraceptive prevalence rate amongst married women and women in union to 60 percent by 2022.

……..
Esau Ekachelan
Chief Administrative Officer / Namayingo District Local Government.

ACRONYMS

ANC	Antenatal Care
BeMOC	Basic Emergency Maternal and Obstetric Care
CAO	Chief Administrative Officer
CeMOC	Comprehensive Maternal and Obstetric Care
CH	Child Health
CS	Contraceptive Security
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DHO	District Health Office
DHS	Demographic Health Survey
DHT	District Health Team
DQA	Data Quality Assurance
DSW	Deutsche StiftungWeltseveekerung
DTPC	District Technical Planning Committee
FOWODE	Forum for Women in Democracy
FP	Family Planning
FP CIP	Family Planning Costed Implementation Plan
FY	Financial Year
HC	Health Centre
HMIS	Health Management Information System
LLG	Lower Local Government
MARPS	Most At Risk Populations
MoH	Ministry of Health
NGOs	Non Governmental Organizations
NMS	National Medical Stores
OPD	Out Patient Department
PNFP	Private Not For Profit
RDC	Resident District Commissioner
RH	Reproductive Health
RHU	Reproductive Health Uganda
SBCC	Social and Behavioral Change Communications
SWOT	Strength Weaknesses Opportunities and Threats
TC	Town Council
TOT	Training of Trainers
FOC REV	**Friends of Christ Revival Ministries**
UDHS	Uganda Demographic Health Survey
UHMG	Uganda Health Marketing Group
VHT	Village Health Team

Contents

1.0 EXECUTIVE SUMMARY

The government of Uganda is committed to reducing unmet need for family planning (FP) to 10 percent and increasing the modern contraceptive prevalence rate to 50 percent by 2020.The Namayingo District Family Planning- Costed Implementation Plan complements the Government of Uganda Costed Implementation Plan. In partnership with Central Government, the District Costed Implementation Plan (2017 – 2021), will enable Uganda reach her FP goals, as well as support the strategic direction of the district in regard to Family Planning. Similar to the National FP Costed Implementation Plan 2017-2020, this district FP CIP is driven by the strategic priorities – listed below- that will reduce current gaps in family planning in Uganda as a whole

1.1Priorities:

1) Increase age-appropriate information, access, and use of family planning amongst young people, ages 10–24 years

2) Promote and nurture change in social and individual behavior to address myths, misconceptions, and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies
3) Implement task sharing to increase access, especially for rural and underserved populations
4) Mainstream implementation of family planning policy, interventions, and delivery of services in multisectoral domains to facilitate a holistic contribution to social and economic transformation
5) Improve forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors

1.2Thematic areas

The National CIP has six thematic areas for family planning which are driven by the above strategic areas. Namayingo District thus adapts its FP-CIP form the National FP-CIP.

Below are the 6 national thematic areas:

1. Demand creation
2. Service delivery and access
3. Contraceptive security
4. Policy and enabling environment
5. Financing
6. Stewardship, management, and accountability

This CIP will also be used as a tool by the District and its partners to mobilise resources for implementation of the plan. The CIP will also act as a monitoring tool for District and her partners

2.0 INTRODUCTION

Namayingo District is a district in Eastern Uganda. The district is named after its 'chief town', Namayingo, where the district headquarters are located.

The district has eight rural sub-counties and one Town Council, 45 parishes and 250 villages with a total of 31,859 estimated number of households with a total population of 282,478 people (males – 46.2% and females - 53.8% respectively) as projected by the District Planning Unit). Namayingo district health care system has a number of health facilities that include both public and private not for profit (PNFP) facilities. The district has no General Hospital, has one health centre IV, seven health centre IIIs (4 public and 3 PNFP) and twenty four centre II's (20 public and 4 PNFPs).

2.1 Economic Activities

The Namayingo District Family Planning- Costed Implementation Plan (2017 – 2021) builds on Uganda government political commitment towards increased financing of family planning at the London Summit 2012. Implementing her strategic commitment, Uganda developed the Uganda Family Planning Costed Implementation Plan- FP -CIP, 2015- 2020. The FP –CIP reflects a "common" plan for all stakeholders involved in implementing family planning activities towards a consultative, coordinated, a streamlined management and accountability structure involving local government and District Multi-sectoral stakeholders. In order to foster this mandate, Namayingo District Local Government in collaboration with FOC REV and Faith to Action initiated through a participatory and consultative process the development of this District Family Planning Costed Implementation Plan in alignment of the national FP-CIP (2015 – 2020).

Below is a brief description of Namayingo District profile with specific reference to location, demographic data, health facility staffing, health facilities and socio-economic activities, district SWOT and process of developing the district FP-CIP.

2.2 District Location

Namayingo District was carved out of Bugiri District in 2010.Namayingo is bordered by Bugiri District its mother District to the west, Busia to the north the republic of Kenya to the East and the republic of Tanzania to the South .It hosts 9 habitable islands including the famous Migingo Island and these are: Siguluisland, Lolwe, Bukana , Buduma, Haama, Wayasi, Yebe, Golfa, Kandege Islands. The district headquarter is located in Namayingo Town Council.

2.3 Socio Economic Activities

Agriculture forms the back bone of the economy in the district with over 70% characterized as subsistence production. Bordering Kenya and Tanzania has also promoted cross border trade in the District.The presence of Lake Victoria has promoted fishing in the district.

The district is endowed with a range of social amenities and social services (schools, water, health, electricity, and telecommunication services). The social services and social amenities have attracted small and medium size business entities.

2.4 Road Network

Namayingo District is proud to have good feeder road network of and community access roads. This therefore makes easy movement from one area to another to access social services, produce, fish and other commercial goods to markets including Gold mining.

Namayingo District Population structure

Table 1: Broad Age Groups by Sub County for the Total Population

Sub County	Under 1	Under 5	Under 18	All Adults (18 above)
Namayingo T/C	744	3493	5,360	11,928
Banda S/C	2,159	10,142	15,565	34,642
Buyinja S/C	1,593	7,483	11,483	25,561
Sigulu S/C	1,139	5,351	8,211	18,276
Lolwe S/C	855	4,013	6,159	13,706
Bukana S/C	285	1,338	2,053	4,568
Buswale S/C	1,682	7,900	12,123	26,983
Buhemba S/C	1,243	5,838	8,959	19,939
Mutumba	2,204	10,353	15,889	35,363

Source: Namaying District National Population and Housing Census

2.6 Fertility Rate in the district–Major heading

According to Namayingo District Development Plan (2015 – 2020), Namayingo District has a high fertility rate hence, rapidly growing population (estimated total population: 276768). The total fertility rate estimated at 7.8%. It is estimated that there are 2214 women of child bearing age (15 -49 years)

with number of pregnancies at 8,200 per year; expected births of 12058 Peryear. Namayingo has an estimate of 11092 Children less than 1 year, with a contraceptive prevalence rate of 23% and an unmet need for family planning at 77%, compared to the national of 34%. In reference to the UDHS (2011) observations were made that childbearing begins early with 24% of women aged 15-19 already mothers or pregnant with their first child. Further the Survey concluded that teenage pregnancy and motherhood are a major social and health concern as it's associated with higher morbidity and mortality of both mother and the baby.

Table 2: Selected Demographic Health Indicators

Demographic Variables	**Result**
Total Population	278768
District HIV Prevalence Rate	5.8%
Estimated no of women of child bearing age (15- 49)	166,072
Expected Number of Pregnancies per year	56,312
Number of Expected birth per year	56,312
Infants below one year	11,988
District Maternal Mortality Rate	1/100,000
Contraceptive Prevalence Rate (2014/2015)	23%
Unmet need for family planning	77%

Source: National Population and Housing Census (2014) & District HMIS 2015

2.7 District Human Resources for Health

According to Ministry of Health staffing norms, Namayingo District should be having a total of 316 health workers. However, by the close of December 2016, there were **only 186** health workers. The staffing level in the district stands at 60.06 per cent including the administration staff as reflected in the table 3 below;-

2.8 Table 3 Human Resource for Health approved staff structure and staffing level as at June 1, 2017

No	**Job Title**	**Scale**	**Approved**	**Filled**	**Vacant/ Excess**	**% Filled**
1	District Health Officer	UISE	1	0	1	0%
2	ADHO (Environmental Health)	U2Sc	1	1	0	100%
3	ADHO (MCH)	U2Sc	1	0	1	0%
4	Stenographer Secretary	U5L	1	0	1	0%
5	Cold Chain Technician	U6L	1	0	1	0%
6	Senior Environmental Health Officer / Principal Health Inspector	U3U	1	0	1	0%
7	Senior Health Educator	U3Sc	1	0	1	100%
8	Biostatistician	U4Sc	1	1	1	100%
9	Senior Medical Officer	U3Sc	1	1	0	100%
10	Medical Officer	U4Sc	1	3	-2	300%
11	Senior Medical Clinical Officer	U4Sc	4	5	-1	125%
12	Medical Clinical Officer	U5Sc	6	13	-7	216.70%
13	Dispenser	U5Sc	1	1	0	100%

14	Anaesthetic Officer	U5Sc	1	1	0	100.00%
15	Nursing Officer - Psychiatry	U5Sc	1	1	0	100.00%
16	Nursing Officer- Nursing	U5Sc	5	5	0	100.00%
17	Nursing Officer- midwifery	U5Sc	1	4	-3	400%
18	Medical Laboratory Technologist	U5Sc	0	1	-1	
19	Medical Laboratory Technician	U5Sc	5	5	0	0.00%
20	Public Health Dental Officer	U5Sc	1	2	-1	200.00%
21	Health Inspector	U5Sc	2	2	0	100.00%
22	Theatre Assistant	U6U	2	1	1	50.00%
23	Ass. Entomological Officer (med)	U5Sc	1	2	-1	200.00%
24	Ophthalmic Clinical Officer	U5Sc	1	0	1	0.00%
25	Senior Nursing Officer	U4Sc	1	1	0	100.00%
26	Assistant Health Educator	U5Sc	1	0	1	0.00%
27	Anaesthetic Assistant	U7U	2	0	2	0.00%
28	Office typist	U7U	1	0	1	0.00%
29	Cold Chain Assistant	U7U	1	0	1	0.00%
30	Medical Laboratory Assistant	U7U	5	12	-7	240.00%
31	Enrolled Nurse	U7U	35	52	-17	148.57%
32	Enrolled Psychiatric Nurse	U7U	1	5	-4	500.00%
33	Enrolled Midwife	U7U	31	24	7	77.40%
34	Health Information Assistant	U7U	5	6	-1	120.00%
35	Health Assistant	U7U	25	10	15	40.00%
36	Accounts Assistant	U7U	2	2	0	100.00%
37	Stores Assistant	U7U	1	1	0	100.00%
38	Nursing Assistant	U8U	57	14	43	24.50%
39	Car Driver	U8U	2	1	0	50.00%
40	Askari	U8U	51	0	51	0.00%
41	Porter	U8L	51	10	3	76.90%
	Total		**316**	**186**		**60.06%**

Source: Namayingo District Human Resources for Health Plan 2016/17

The shortfalls in health sector staffing have several implications for service delivery. Some key health workers required at some levels of health care are missing. In reference to family planning services, some health centers are not able to offer particular methods especially the long term methods due the fact that the required professionals are not retained. Health facilities at the border with other districts and countries serve wide catchment population resulting into increased work load for available staff, stock-out of some drugs and other related pharmaceutical supplies and long lines for patients as reported by DSW (2014).

2.9 Table 4 Health Facility Total PHC Allocation 2017/18

Name of Health Facility	Total PHC Allocation 2017/18	Sub-County	Parish
1. Namayingo DHO's Office	27,368,959.0	Namayingo TC	Nambugu
2. Buyinja HC IV	23,020,963.1	Namayingo TC	Namayingo Central
3. Banda HC III	6,167,339.20	Banda	Lutolo
4. Bumooli H C III	5,672,384.6	Buswale	Nansuma
5. Mutumba HC III	5,774,699.20	Mutumba	Mutumba
6. Sigulu HC III	4,754,555.20	Sigulu	Manga
7. Buchumba HC II	2,395,638.90	Banda	Buchumba
8. Bugali HC II	2,722,881.30	Mutumba	Lubira
9. Bugana HC II	2,446,903.80	Bugana	Bukana
10. Bujwanga HC II	2,505,100.90	Banda	Bujwanga
11. Bukimbi HC II	3,514,472.40	Buhemba	Buwongo
12. Bumalenge HC II	2,213,607.00	Sigulu	Bumalenge
13. Buyombo HC II	2,582,047.60	Banda	Buwoya
14. Dohwe HC II	2,590,180.00	Buhemba	Dohwe
15. Haama HC II	2,323,083.10	Lolwe	Haama
16. Isinde HC II	2,271,197.10	Buhemba	Sinde
17. Kifuyo HC II	2,370,973.60	Buyinja	Kifuyo
18. Lolwe HC II	2,545,833.30	Lolwe	Lolwe west
19. Lugala HC II	2,400,298.10	Banda	Lugala
20. Mulombi HC II	4,021,600.60	Mutumba	Mwema
21. Namavundu HC II	2,480,845.10	Buyinja	Nsoono
22. Namayuge HC II	1,823,302.0	Buswaale	Namayuge
23. Rabach HC II	2,511,369.60	Sigulu	Labachi
24. Singila HC II	2,148,167.00	Lolwe	Lolwe East
25. Siro HC II	1,983,086.60	Lolwe	Haama
26. Syanyonja HC II	3, 393,136.60	Buyinja	Syanyonja
NGO – PNFP Health Facilities			
27. Busiro COG HC III	5,198,416.20	Banda	Bujwanga
28. Buswale St. Matia HC III	7,643,754.40	Buswale	Buswale
Total	**136,844,795.5**		

3.0 Health Facilities in the District

As already indicated in table above, health service provision is by both public, private not profit and private sector. The district has 25 Health Centre IIs, 8 health centre IIIs and 1 Health Centre IV.

The average distance from one health centre to another is about 8kms. According to the DSW 2014 report, the distance to Health centers contributes to why some people don't use family planning. The Health Centre IV and IIIs are able to offer a range of family planning services including the

permanent methods. For HCII, the community is able to receive ANC and short term family planning methods.

3.1 Table 5 Health Service providers in Namayngo District

Service outlet	Government owned	Private not for profit	Private	Total	Services
Hospitals	0	0	0	0	
Health Center IV	1	0	0	1	All
Health Center III	04	02	02	8	All offered by HC IIIs
Health Center II	20	0	05	25	All offered by HC IIs
Total	25	02	07	34	

3.2 Table: 6 Development Partners in the District as at the end of 2016

Namayingo district has several partners within the health sector supporting different areas. Below is table 5 capturing the different partners and their form of support to the district.

Name of Partner	Intervention Area	Duration of project	Coverage
RHITE-EC	Comprehensive	5 Years	All Sub counties
Intra-Health	PM	5 Years	All Sub counties
UDHA	HTS	5 years	6 Sub counties
UHMG	FP	4 Years	Busiro HC III and Dembe HC II
Maria Stopes	MCH	4 Years	5 HFs
GOAL	Sanitation and Hygiene	5	All sub counties
PACE	HIV/AIDS, MALARIA	5	All sub counties

4.0 SWOT Analysis for Family Planning Services

The SWOT analysis for the District examined the Strengths, Weaknesses, Opportunities, Threats for the family planning services in Namayingo district.

SWOT Analysis

Strength	Weakness
• Enabling environment for partners • Committed Human Resource • Budget improvement by Partners • Good number of ICT materials • Good leadership and governance with commitment to serving the people • Existence of regulatory framework and laws	• 9 Habitable Islands yet with poor transport system • Myths attached to family planning • Male negative influence in decision making in FP • Less periodization of resources for FP • Majority of HCs are HC 11s yet with less skilled staff • "Half baked" staff in midwifery • Lack of skilled managers to design properly FP programs
Opportunities	**Threats**
• Wide Stakeholder involvement and engagement in the health sector planning • Existence of enabling policies, laws and regulations supporting family planning in Uganda • Existence of Implementing Partners and PNFP in the Health Sector (PPP) • Demonstrated Commitment by Government of Uganda • Availability & willingness of Community volunteers and VHTs • Presence of Family Planning Faith based Champions in the District	• Interventional designs targeting women and yet men have an upper hand in decision making as far as FP is concerned • Contradictory policy approach-Health vis-à-vis Politics • Community held misconceptions against family planning by potential FP services users • Sexual and Gender Based Violence • Some religious & Cultural leaders continue to condemn family planning as its felt to promote immorality • Lack of partner support to FP • Pressure & Competition to give birth especially in polygamous families • Unwillingness by some development partners to declare their budgets Uncontrollable inter-district migration

5.0 Process of developing the District CIP

The process of developing the District Family Planning Costed Implementation Plan started with a comprehensive desk review to analytically understanding the conceptual issues around family planning in general and specifically in Namayingo District. The process entailed wider involvement and consultation of key stakeholders playing key roles in the district. At district level, stakeholders were drawn from District Council, District Health Team (DHT), District Technical Planning Committee (DTPC), Family Planning Development Partners, Cultural& Religious leaders, Private Sectors, Community Volunteers and Civil Society Organizations (CSOs). All Lower Local Governments were represented in the District Technical Planning Committee (DTPC) for their inputs. Data for District FP CIP was informed by both secondary and primary data that were collected through (a) Desk reviews, (b) Meetings with technical staff (c) District level key informant interviews, (d) LLGs consultative meetings, and community and health facility visits.

Insert a photograph taken during some of the district consultative meetings

6.0 Namayingo District FP Costed Implementation Plan

This section presents a detailed analysis and literal review of key issues that influence contraceptive prevalence rate. As detailed in the Uganda National FP CIP 2015-2020, the review and analysis is categorised along the following main themes;-

I. Awareness of family planning services
II. Service Delivery and access
III. Contraceptive Security
IV. Policy and Enabling Environment
V. Financing
VI. Stewardship, Management and Accountability

6.1 Awareness of Family Planning services

The UDHS (2011) reported that awareness of at-least one method of contraception in Uganda is universal. However, in Namayingo district, there are fears of side effects mixed with misconceptions about family planning services and some local people harbour feelings that contraceptives promote promiscuity, immorality and prostitution (DSW 2014). Additionally, the same report revealed that:

- Many women in the district are battling with ignorance about the efficacy and side effects of different family planning methods.
- Some Youths are ignorant or don't know that family planning services are free of charge in public health facilities
- Some health workers do not give appropriate information to the local people on family planning methods preferred
- Limited support from men, while most males think that family planning is only for women since the men have less option

The above scenario suggests that within the district, there are inadequacies in the knowledge levels about family planning. In few sub counties, mass education about the benefits of family planning through community based meetings are conducted by Faith based leaders and CSOs and other community volunteers. For the few local people who turn to health workers for technical advice and guidance, the health workers are themselves constrained with heavy work load, coupled by the fact

that sometimes one may lack capacity inform of skills, equipment and commodities to fully deliver contraceptives services. Additionally, there is no age specific sensitive information that targets groups of persons such as youths, adolescents and the elderly.

In the Family Planning district stakeholders' meeting held on the 20th January 2017at Namayingo District Headquarters hall with support from FOC REV, the key stakeholders unanimously agreed that within the district, there is no clear behaviour change communication framework and consistent messaging about family planning. Generally, there is low involvement of religious and local leaders in mobilising the community and advocating for family planning services. However, there is growing recognition by some key religious leaders who have been enrolled as a family planning Champions by FOC REV With the Bible and Quran being rich in their prescriptions in support of family planning, religious leaders have greater potentials to mobilise the local masses and support family planning as they have a wider followership

Fortunately, the district has development partners involved in the promotion of some family planning services such as PACE, Marie Stopes Uganda, RHITE-EC, UHMG. The development partners have attempted to socially market some contraceptive commodities. One of the challenges associated with the presence of development partners is that they have pre determined agenda which they simply 'must' implement without the input of the district authorities.

7.0 Service Delivery and Access

7.1 Namayingo District Family planning uptake

Comparative to the FY 2014/15, FY 2015/16, there was lower uptake of family planning services across the district of Namayingo. FY 2014/15 had the highest coverage of 28%, but in 2015/16 it declined to 23% (Namayingo District HMIS year). Table below provides an overview of FP service uptake across the district service providers.

7.2 **Table 7 FY 2014/15 and FY 2015/16 comparative analysis of FP services uptake among service providers in Namayingo District.**

	Name of Health Facility	**Total new FP users 2015/16**	**Coverage to the total Users FY 2015/16**
1.	Buyinja HC IV	156	2%
2	Hukeseho HC III	309	22%
3.	Banda HC III	130	4%
4.	Bumooli H C III	172	6.2%
5.	Mutumba HC III	176	3%
6.	Sigulu HC III	456	35%
7.	Buchumba HC II	100	41%
8.	Bugali HC II	51	28%
9.	Mwema DORUDO HC II	12	44%
10.	Bugana HC II	502	54%
9.	Bujwanga HC II	94	26%
10.	Bukimbi HC II	147	33%
11.	Bumalenge HC II	304	73%

12.	Buyombo HC II	134	49%
13.	Dohwe HC II	220	52.8%
14.	Haama HC II	467	60%
15.	Isinde HC II	38	18%
16.	Kifuyo HC II	148	39%
17.	Lolwe HC II	540	62.4%
18.	Lugala HC II	63	9%
19.	Mulombi HC II	610	66%
20.	Namavundu HC II	107	44.7%
21.	Namayuge HC II	39	34%
22.	Rabach HC II	94	12%
23.	Singila HC II	256	20%
24.	Siro HC II	23	5%
25.	Syanyonja HC II	90	13%
26.	Busiro COG HC III	941	62%
27.	Buswale St. Matia HC III	57	1%
	URHC HC II	0	0%
	Taoky Medical Clinic HC II	115	12%
	Santa Medical Clinic HC II	0	0
	Lico HC II	0	0
	Total	**16,960**	**23%**

7.3 Table 8 Family planning users and contraceptives dispensed per FY for Namayingo District

Financial Year	Family Planning Users	Contraceptives dispensed
2014/15	16,301	430,201
2015/16	16,960	431,621

Source: DHIS2 NAMAYINGO

The contraceptives considered in the table above include: Female Condoms, IUDs, Injectables Male Condoms, Natural, Oral : Ovrette or Another POP, Oral: Lo-Feminal, Oral: Microgynon ,Female Sterilization (Tube Ligation) Implant New Users Male Sterilization (Vasectomy), however Male condoms were the most common contraceptive used. DSW (2014) district analysis of family planning services shows that pills were preferred by females because of less side effects

7.4 Unmet need for Family Planning

Namayingo District targeted between July 2015 to June 2016 to reach 30% Family planning users, but reached only 23% (Namayingo HMIS 2016). This implies that almost half of the targeted population is not reached with intended FP services. There are several reasons for this scenario. Health Communications Partnership (2009) reported that there were many contradictory arguments from political and religious leaders about the role of family planning in socio economic development. In the same report, observation was made that, political leaders encourage large families to spur economic growth making full implementation of family planning policies very challenging

It is not clear, whether or not, such uptake is informed by national priorities in FP. What is clear though is the wisdom for Namayingo District to harmonize national costed implementation plan with the district priorities.

UDHS (2011) observed that only 16% (national) of women that gave birth in health facilities were counselled before discharge. This could even be lower for Namayingo district than the national average. However in Namayingo there is health education provided to mothers at ANC and OPD, as well as community outreaches by selected government facilities. Community Family Planning dialogues supported by technical people and faith based champions offer an opportunity to discuss family planning activities in the district, but there is a still widely low male involvement in FP services; men believe that wives should take responsibility to use family planning (DSW,2014) since methods also available for men are very limited (UDHS, 2011).

Other key challenges in service delivery and access within Namayingo District include:

- Shortage of Human Resources for Health or poor ratio of client to health workers
- Fear of the long queues at the HC
- Poor attitude of some health workers.
- Some religions do not support family planning
- Negative cultural believes
- Lack of performance incentives
- The lack of privacy and targeted FP interventions at health centres
- Multiple hardships for accessing services at Island health facilities

7.5 Contraceptive Security

According to Uganda Demographic and Health Survey (2011), Government of Uganda remains the major provider of contraceptive method; this stands at 47% free supply of contraceptives. This guarantees freedom of choice by family planning users. Indeed this attracts many users leading to long queues along the supply chain. Through this chain, Government operates both a push and pull system. The Push system is not client centred and does not guarantee and promote free choices in contraceptive use. With the pull system, the health centre IVs are able to requisition according to the needs of communities.

As shown in **Table 7** above Namayingo has one health centre IV and 4 public health centre IIIs; this compared to the number of health centres II reflects Namayingo District over reliance on the push system. Additionally, the turn up in HC III and HC IV is usually higher, an aspect that sometimes accounts for the regular stock outs of some family planning commodities in the district.

According to the District Health Office (2016), the district strives to maintain an adequate supply of family planning commodities but is constrained by

a) Dilapidated district and health unit stores,

b) Expiry of some family planning commodities in the lower health facilities and

c) Inadequacies in records management resulting into poor quantification and forecasting.

7.6 Policy and Enabling Environment

According to the National FP Costed Implementation Plan (2015 – 2020), the current policy environment is conducive for strengthened implementation of the FP programme in Uganda. Family planning is recognised as a key strategy to promote social, economic, and environmentally sustainable

development, to realize sexual and reproductive health and reproductive rights, and to improve the health of women and their children by preventing unintended pregnancies and improving child spacing, thus reducing maternal and neonatal morbidity and mortality.

Uganda government has developed a host of national policies and plans such as Uganda Population Policy, National Gender Policy, National Development Plan, National Health Policy, Health Sector Strategic and Investment Plan, National Family Planning Advocacy Strategy etc but what remains is popularising these policies among key district stakeholders. The health service providers, religious, cultural and the district local leaders are not substantially aware of the key policy provisions and attendant implications for the development of the country.

In accordance with the Constitution of Uganda and the Local Government Act 1997 (as amended) and decentralisation policy, Namayingo district has put up spirited efforts to recruit and retain the critical health workers to offer high quality health care services. However, the attrition rate is worrisomely high in the district for critical some health cadres.

7.7 Financing

A review of Namayingo District Health Budget for the last five financial years 2012 – 2016, indicates extremely low provision for family planning activities but caters for some reproductive health activities. This is further confirmed by DSW observation that family planning activities were not captured in the annual health sector work plan. In conclusion, there is no direct funding to the family planning services. From the key informant interviews conducted, it's apparently clear that family planning is integrated into HIV services or Ante natal care services

8.0 Table 8 Health, Reproductive Health and Family Planning Budget ratios in Namayingo District

	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Health Percentage share of District Budget	0.001%	0.001%	0.001%	0.001%	0.001%
Reproductive Health %ge share of District health budget	20%	20%	20%	20%	20%
FP share of District reproductive health budget	40%	40%	40%	40%	40%

Source: Adopted from the District budget

According to Namayingo District Development Plan (2017), Family Planning is highly prioritized, but a budget analysis as reflected in the table 8, above suggests low allocation of financial resourcing for Family Planning in Namayingo. According to Namayingo District Health office there is no direct funding by government to Family Planning services. This however does not disregard the financial contribution of various non-governmental stakeholders towards family planning services in Namayingo. DSW (2014), however, notes that such activities and their financial contribution towards family planning services are hardly captured in district plans

8.1Stewardship, Management and Accountability

District Leadership

The district leadership is highly pro poor growth as reflected in their vision and mission statements and commitment to serve the people of Namayingo district. In the district council, the Chairperson of Health Sectoral Committee directed that CIP be developed and consistently her committee has spear headed a number

of innovations in the sector. The District Health Officer and his entire District Health Team has been praised by development partners for good coordination and direction of the health sector. In specific terms, the district leaders are aware of their mandates and responsibilities and have ensured coordination among actors in the district.

8.2 Family Planning Partnerships

The DHT has initiated the family planning partnership with the PNFP and the Private sector to promote contraceptive use in the district. There are efforts to formulate Namayingo District FP Consortium for linkage and coordination. Additionally, the district has never developed any specific annual work-plan for family planning services.

8.3 Data Collection, analysis and use

The data is collected using the Health Management Information Systems (HMIS) tools from health centers and forwarded to the District Bio Statistician for onward routine reporting to Ministry of Health through the DHIS2. At each health centre in the district, there is designated staff in charge of medical records. Within the PNFP and the Private sector, attempts are made to collect and submit data to the district and Ministry of Health using standard HMIS tools. However, there are challenges with timeliness of reporting, some health centers both public and private have consistently failed to report in time. What is very challenging is that some HMIS focal persons at health facilities lack the technical capacity in effective management of data.

The collected data is stored at both the health centre and district in both electronic and hard copies. The major challenge is that some areas have very poor network connectivity and therefore electronic transmission of data is delayed. Data is always easily consolidated and analyzed at the health facility and district levels. The significant challenge is the dissemination and use of data for key decisions making. Additionally, the data is rarely shared with the implementers and other district relevant stakeholders.

9.0 DISTRICT STRATEGIC PRIORITIES

This section provides an outline of the strategic priorities for family planning in Namayingo District. The section is structured to rhythm with the priorities highlighted in the National FP Costed Implementation Plan 2015 -2020. It follows a format that aligns national strategic outcomes with district local priorities. It builds on the District Vision, Mission, Core Values and Goal.

9.3 Vision of the District FP Costed Plan

This District FP-CIP builds upon the vision of National Family Planning Costed Implementation Plan 2015-2020 and this is "Universal access to family planning to help Uganda attain the middle income country status by 2040."

9.3.1 Goal

In line with the national operational goals of reducing the unmet need for family planning to 10 percent and increase modern contraceptive prevalence rate amongst married and women in union to 50 percent by 2020, the goal of the district is:

"Increased access to family planning services in the district through coordinated multisectoral approach including public and private initiatives in order to increase the modern contraceptive prevalence rate amongst people of 15-49 years to 60 percent by 2021."

9.4 District strategic priorities in FP

The National FP CIP is well aligned to the Health Sector Strategic Plan III 2010/11-20114/15 and related strategic plans of HIV/AIDS, reproductive health commodity security, reduction of maternal and neonatal and adolescent policies (Uganda FP CIP 2015- 2020). In the process of writing the district FP CIP, due attention was made to the national strategic priorities which represent key areas for financial resource allocations and implementation performance.

9.4.1 The five national strategic priorities are;-

Priority 1: Increase age appropriate information, access and use of family planning amongst young people ages 10- 24 years

Priority 2: Promote and nurture change in social and individual behavior to address myths, misconceptions and side effects and improve acceptance and continued use of family planning to prevent unintended pregnancies

Priority 3: Implement task sharing to increase access, especially for rural and underserved populations

Priority 4: Mainstream implementation of FP policy, interventions and delivery of services in multispectral domains to facilitate a holistic contribution to social and economic transformation.

Priority 5: Improve forecasting, procurement and distribution and ensure full financing for commodity security in the public and private sectors.

In order to ensure that the limited resources are directed to areas that have the highest potential to reduce the unmet need for family planning and also achieve the district's stated goal, the activities are structured around six thematic areas namely;

i) Demand Creation
ii) Service Delivery and Access
iii) Contraceptive Security

iv) Policy and Enabling
v) Financing
vi) Stewardship, Management and Accountability.

9.5.1 Demand creation

While behavioral change communication campaigns do exist in Namayingo District, there is need to localize the national costed implementation plan strategy in the design of social and behavior change communication (SBCC) campaigns. Efforts shall be taken by the district authorities and other stakeholders to increase on target market segmentation with clear messaging on family planning. As prescribed in the National Costed Implementation Plan, Namayingo District shall focus efforts on SBCC with clear messaging to target current non-users of contraception who have high motivation to adopt, as this population will then be best positioned to become FP champions to address myths and misconceptions to their non-user peers, which is deemed as important and critical to lowering the percentage of unmet need. As a culturally diverse district, there is need to package messages in languages that serve different tribal segments so as to tackle myths and fears of both users and non – users of contraception. Integrating a gender in family planning approaches is also critical to improving male involvement in interventions on family planning. As informed by the District HMIS data, gender analysis shall be integrated in the district family planning approach so as to gauge male involvement. Overall, demand creation approach in family planning in Namayingo District will be people centered coupled with innovative outlets such as mobile health advocacy campaigns and use of information communication technologies.

9.5.2 Increase demand for FP services in Namayingo District.

Namayingo District will strive to increase the percent of women in reproductive age group (15–49 years) demanding for family planning services using a communications strategy that makes use of the available local media- including community radios in trading centers. Drama, music and debates will be organized at village levels at various fora such as faith based group meetings in the mosques and Church of Uganda, fathers union meetings, Malwa& sports gatherings among others. Special groups segments of the population will be targeted, most specifically the youths, men, Most At Risk Persons (MARPS) including Sex Workers Accessible radio stations including Open gate FM, Step FM, Jogo FM,Mambo FM and Eastern Voice FM among others will continue to run spot messages (demand driven) on FP in local languages.

It is further planned that through the Interfaith Committee, religious leaders will use their various platforms to mobilize and educate their followers on the benefits and importance of family planning at individual and community levels. Equally, traditional leaders will first be trained and later on through a cascading plan, use their structures to advocate for family planning services. To galvanize the interagency collaboration, a family planning desk will be established at the district and health facility level.

9.5.2.1 Results

a) Men support the use of modern contraceptive for themselves and their partners.

Namayingo District will aim at increasing numbers of men that support the use of modern contraception for themselves and their partners. Given the high numbers of young men engaged in the transport industry (Boda Boda riders) and fishing within the district Vs their unique sexual and reproductive health needs, increased involvement through dialogue and service provision will be critical. Deliberate efforts will be taken to use any available opportunities to advance the cause of

family planning among men with age specific messages. At all health facilities, male friendly services will be established.

b) Young people, 10–24 years old, are knowledgeable about family planning and are empowered to use FP services.

As enjoined in the national FP Costed Implementation Plan, NamayingoDistrict will aim to increase knowledge and empowerment of young people and empower adults to help youth avoid teenage pregnancy. Crucially, health service providers including the Village Health Teams (VHT) will be re-educated to change their attitudes towards young persons with reproductive health needs. This will move along social marketing of free products that the young people access including free condoms distribution.

c) Social Marketing of free Products

The district will continue to support the social marketing of free family planning commodities services by the PNFP actors.

9.5.3 Table 9 Summary costs for Demand Creation

	2017/18	2018/19	2019/20	2020/2021	2021/22
UGX-MILLIONS	120	135	115	115	125

9.6 Service Delivery and Access

Similar to the National Costed Implementation Plan prescription, Namayingo District will adopt a rights- based approach that includes informed choice, free and informed consent, respect to privacy and confidentiality, equality and non-discrimination, equity, quality, client-cantered care, participation and accountability; it also responds to community factors that impede access. Namayingo District health department and Development Partners will strive to train health workers – including VHTs on rights based programming to FP. Namyingo District will enhance to utilisation of community based approaches (mobile clinics and distribution points) to complement services provided at Namayingo HCIV and other health centres.

Deliberate efforts will be taken to guarantee privacy and confidentiality for effective family planning service delivery.

9.6.1Results

a. Access to FP services is increased.

Community based service/ distribution points will be increased to serve the very rural communities and Islands such as in Sub Counties such as Sigulu, Lolwe, Bugana, Mutumba, Banda, Buhemba, Buswale, Buyinja.

b. Referral services are strengthened.

NamayingoDistrict will aim to create a referral directory for FP. The District Health Officer and Assistant District Health Officer will ensure appropriate referral tools are used in the referral systems and that all clients referred receive appropriate services.

c. **Motivation for FP health care workers is increased.**

In a bid to increase health workers' motivation, staff participation in decision making in FP will be enhanced. Staff continued capacity development will also be part of the implementation plan. The

district with support of its development partners will arrange transport means to facilitate outreaches especially in the hard to reach areas. Through the District Rewards and Sanctions' Committee; the district will introduce performance incentives for its staff.

d. Family planning services are integrated into other health services.

As enjoined in the national FP Costed Implementation Plan, in Namayingo District, FP services will be integrated into cervical cancer screening, postnatal care, postpartum care, prevention and treatment of sexually transmitted infections, including HIV prevention, care, and treatment and malnutrition programmes. Namayingo district will roll out national health management protocols and all relevant stakeholders trained.

e. Family planning services are accessible by people with disabilities.

Namayingo District will ensure access of people with disabilities to FP services; with the availability of FP clinical service delivery guidelines, the district health office will ensure all relevant FP service providers are trained on use.

f. Family planning side effects are managed.

Namayingo District will utilize counselling guidelines for family planning to manage and mitigate side effects, alongside utilization of appropriate reporting tools. The New Medical Eligibility criteria will be adhered to enable health workers guide the clients on the choices of Family planning.

g. In-service FP training

Regular Continuous Professional Development (CPD) will be organised by the District either at facility or district level to improve on the knowledge levels of the health workers. Throughout the CPD, standard manuals issued by MoH will be used.

a. Family planning in the VHT system is strengthened.

Coverage of VHTs in Namayingo District will be enhanced coupled with continuous capacity building and provision of necessary FP commodities through a well organised and coordinated system, all VHTs in the district will be supervised and monitored.

h. Youth-friendly services are provided in health facilities.

To increase the availability of youth-friendly services, youth-friendly corners will be established, and health workers will be trained on youth-friendly services. In addition, FP service delivery hours will be increased to include outside school hours to accommodate youth.

9.6.2 Table 10 Summary cost for Service Delivery and Access

	2017/18	2018/19	2019/20	2020/2021	2021/22
UGX-MILLIONS	250	260	220	220	255

10.0 Contraceptive security

In order to guarantee availability of family planning commodities, Namayingo District will work closely with Central Government through Ministry of Health and specifically National Medical Stores

(NMS)and other non-government stakeholders to ensure supply of contraceptive commodities and relevant consumables in the District.

Namayingo District will make available contraceptive commodities and other consumables to meet client needs. Specific activities will be undertaken to ensure that contraceptives are received as forecasted from NMS to the health facilities to ensure reproductive health commodity security throughout the district. Efforts will be taken to securely and safely store the family planning commodities in the district.

10.1 Results

I. District staff is able to quantify and forecast FP commodities.

Namayingo District staff will forecast FP commodities more accurately as possible. Efforts will be taken by the District Health Office in ensuring timely submission of requisitions to NMS and or development partners. This shall ensure that facilities are stocked more efficiently to meet FP needs of the district clients.

II. VHTs and community-based distributors have commodities.

As enjoined in the national FP CIP, VHTs and community- based distributors will be utilized to ensure timely delivery of FP commodities to the local communities within the District. As such, the Health Sub Districts will play a proactive role in maintaining the desirable stock levels of family planning commodities.

III. **Commodity distribution to private not-for-profits increased**.

The District will work closely with private not for profit stakeholders already in existent in the district to increase FP services in the district. As part of the district implementation plan, the contribution of other stakeholders will be firmly tracked within the HMIS to help coordinate FP activities execution.

10.2Table 10 Summary Costs for Contraceptive Security

	2017/18	2018/19	2019/20	2020/2021	2021/22
UGX-MILLIONS	120	135	115	115	125

11.0 Policy and enabling environment

Under this priority area, the District will align all FP activities implementation with the national costed implementation plan. To improve the policy environment for family planning, government policies and strategies will be disseminated to all relevant district stakeholders. Specific advocacy will also be conducted to ensure that policies and guidelines for family planning promote access to FP services rather than hamper access for often-marginalized groups such as the rural population and youth and to ensure the provision of FP services in accordance with human rights and quality of care standards.

11.1 Results

1. Legal framework and knowledge of policies for family planning are improved.

The legal framework that promotes family planning will become popularised through dissemination of the revised public acts and sensitisation of district health teams (DHTs), and health providers. A

simplified District Family planning handbook with standard information shall be developed and widely disseminated.

2. **Local, cultural, and religious leaders are supportive of family planning**.

The District will aim to use local, cultural leaders, FP coalitions and religious leaders as advocates for FP. Young celebrities within the district will be targeted to act as role models but also champion the advocacy platform in FP service delivery.

11.2 Table 11 Summary costs for Policy and Enabling Environment

	2017/18	2018/19	2019/20	2020/2021	2021/22
UGX - MILLIONS	45	35	30	30	35

12.0 Financing

FP will be highly integrated in the District's budget framework paper to ensure adequate recognition and consideration of the need for FP services delivery. Other non-governmental organizations and donors will be lobbied for increased support to complement support from government. Strategically, the district will aim at the following outcomes:

12.1 Results

i. **Family planning is mainstreamed in district planning and budgeting processes**.

Advocacy for the creation of budget lines for family planning at the district level will support the prioritisation and integration of family planning into district planning and budgeting processes. At-least not less than one percentage of the total local revenue shall be allocated to the health sector and in particular to family planning.

ii. Financial investment in human resources development for health is increased.

Advocacy for increased funding for training and support for midwives and nurses at lower-level health facilities will help increase the national financial investment for human resources development for health.

12.2Table 12 Summary costs for Financing

	2017/18	2018/19	2019/20	2020/2021	2021/22
UGX - MILLIONS	90	110	130	140	160

13.0 Stewardship, Management & Accountability

As reaffirmed in the National CIP, strong monitoring, management, leadership and accountability are necessary and essential ingredients in the Operationalization of the plan. At the district level, the DHO will lead the technical level supported by the DHT to effectively monitor, coordinate, lead and ensure good governance of family planning activities at all levels in the district. The DHT will be trained to effectively coordinate and manage family planning services. All activities of family planning (by both government and PNFP) will be tracked by DHO's office through MoH designed tools and electronic data base. The District HMIS focal person will ensure timely and quality data management and analysis to inform planning and decision making by the relevant stakeholders. Consequently, mentorship and supervision of the lower level HMIS focal persons and other health workers is crucial.

As a requirement in the Local Government Act (1997), the Resident District Commissioner (RDC), District Chairperson, Secretary for Health, Health Sectoral Committee and the entire Council will play an oversight function to ensure that all services are delivered to all people in Namayingo District. All lower local political leaders will be oriented to offer oversight roles to ensure high levels of accountability.

13.1Results

1) **Capacity at the District to effectively lead, manage, and coordinate the FP programme is Strengthened.**

The DHT will be trained; reporting mechanism strengthened, and shall develop an annual work-plan. The district will hold quarterly review meetings with the different stakeholders in the district. Further, the district shall commit resources to efficiently and timely monitor and supervise the family planning activities.

2) **The District effectively tracks and monitors the FP-CIP and provides support to Implementing Partners to report activities and funding and identify gaps**

The district will track activities including financial data outputs. The District will coordinate quarterly data sharing with the implementing partners and other relevant stakeholders. The identified performance gaps will form a basis for refresher training.

3) **Reporting of Family Planning Indicators is strengthened**

Through training and sharing of reporting tools health workers will improve their reporting on family planning indicators

4) **District efforts to collect, analyze and use data to track progress is strengthened**

The district capacity collect, analyse and use data will improve through well tailored trainings and hands on experience.

5) **The FP CIP is assessed at midterm and end of plan to inform FP activities and programming**

A midterm review and final evaluation of the CIP will be executed by the district to determine progress, success and inform future FP strategy development and programming. Multi stakeholders will be engaged during the evaluation process to fairly reflect the community held opinions.

13.2 Table 13 Summary costs for Stewardship, Management & Accountability

	2017/18	2018/19	2019/20	2020/2021	2021/22
UGX - MILLIONS	190	195	210	200	240

14.0 Table 14 Costing of the plan

The costing of the strategic activities is premised on the assumption that the limited resources are committed to areas with the greatest potential to achieve the stated district goal. It is also important to note that Contraceptive Commodities are not costed as it is assumed that NMS will procure, supply and distribute the commodities to and within the district. Additionally, a sustainability mechanism is in built and it's for this reason why for some thematic areas, the costs reduce in the last years.

District Priority	Results	FP Costs per year in Ug X millions				
		2017/18	2018/19	2019/20	2020/21	2021/22
Demand creation	Increased demand for FP services	40	50	35	35	45
	Men support the Use of for themselves and their partners	30	35	30	30	30
	Young people 10-24 years old are knowledgeable about FP	30	35	30	30	30
	Social Marketing of Free products	20	15	20	20	20
		120	135	115	115	125
Service delivery and access	Access to FP is increased	35	35	35	35	35
	Referral services are strengthened	20	20	20	20	20
	Motivation for FP health workers is increased	25	25	25	25	25
	Family Planning services integrated into other health services	25	25	25	25	25
	Family Planning services are accessible by PWD	30	30	20	20	30
	Family planning side effects are effectively managed	30	30	20	20	30
	In service training is improved to handle family planning service	25	25	15	15	25
	Family planning in the VHT system is strengthened	30	40	30	30	30
	Youth friendly services are available in health facilities	35	35	35	35	30
		250	260	220	220	255
Contraceptive Security	District staff are able to forecast and quantify	5	5	5	5	5
	VHTs and	20	20	20	20	25

	Community based distributors have commodities					
	LMIS & HMIS improved	5	5	5	5	5
	Commodity distribution to PNFP increased	30	35	20	20	20
		60	65	50	50	55
Policy and enabling environment	Legal framework and knowledge of FP are improved	10	10	5	5	5
	Local, cultural, and religious leaders are supportive of FP	15	15	10	10	15
	Knowledge of FP policies amongst stakeholders and health workers improved	10	10	10	10	10
	FP health workers are retained	10	5	5	5	5
		45	35	30	30	35
Financing	District funding to FP is increased	30	40	50	60	70
	Donor funding for FP is increased	30	40	50	60	70
	Family planning is mainstreamed in district planning and budgeting process	30	30	30	20	20
		90	110	130	140	160
Stewardship, Management and Accountability	District capacity to effectively lead, manage and coordinate FP is strengthened	65	65	65	55	60
	District effectively tracks and monitors the FPCIP and provides support to implementing partners to report activities and funding and identify gaps	50	55	55	55	60
	Reporting of FP indicators is	10	10	10	10	20

	strengthened					
	District efforts to collect, analyse and use data to track FP progress is strengthened	40	40	50	50	55
	District is assessed at midterm and end of plan to inform future FP activities and programming	25	25	30	30	35
		190	195	210	200	240

14.1 Table 15 Summary costs per thematic area per Financial Year (Millions Ug X)

Priority/FY	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2020/22**	**Total**
Demand Creation	120	135	115	115	125	610
Service Delivery & Access	250	260	220	220	255	1,205
Policy & Enabling Environment	45	35	30	30	35	175
Contraceptive Security	60	65	50	50	55	280
Financing	90	110	130	140	160	630
Stewardship, Management & Accountability	190	195	210	200	240	1,035
Total	**755**	**800**	**755**	**755**	**870**	**3,935**

From the table 15 above, its projected that demand creation will consume 610 million, Service delivery and access will cost 1,205 million policy and enabling environment will cost 175 million,Contraceptive security will cost 280 Financing will cost 630 and Stewardship, Management and Accountability is likely to cost 630 totaling to 3,935 million shillings over a period of five years.

15.0 DISTRICT INSTITUTIONAL ARRANGEMENTS FORIMPLIMNETATION OF THE PLAN

Namayingo District FP Costed Implementation Plan will be implemented in line with the national health framework and within the decentralization realm. Working closely with central government-whose leadership and governance responsibility is prescribed in the National Health Policy-Namayingo District Health Office, along with the District Health Team, and the District Council Chairperson (LC 5) will engage various stakeholders to create opportunities for coordination and management of the national FP effort. In tandem with the National FP-CIP, Namayingo District will follow management, coordination and accountability structures, as outlined below.

15.1 Management, Coordination, and Accountability Structure

Namayingo District FP-CIP recognizes that the Ministry of Health (MOH) takes stewardship and spearheads the planning, financing, implementation and performance monitoring of the District FP Costed Implementation Plan, to feed into the National FP-CIP within the local government structures. This District FP-CIP will be implemented by District Health Office and supported by community based organizations, women groups, faith based organizations, civil society organizations especially FOC REV

15.2 Roles and Responsibilities of Key Actors (District Level)

Chief Administrative Office

Consistent with the national FP-CIP coordination structure, this district FP-CIP will through the office of the Chief Administrative Officer (CAO) enforce proper coordination, planning, resource allocation, implementation, monitoring and evaluation for FP services in Namayingo District.

District Health Officer (DHO)

Given the administrative stewardship of health services in Namayingo District, the DHO will oversee the implementation of the district FP-CIP. Consistent with the national FP-CIP, the DHO will work closely with the CAO to plan and allocate financial resources for FP within the district health budget. DHO and the Assistant DHO will mobilize partner efforts towards FP in Namayingo, as well as offer technical support to implementing partners, institutional based health workers and Village Health Teams at village level.

Civil society and nongovernmental organizations

Namayingo District has a multiplicity of civil society organizations such as FOC REV, private sector-drug shop owners, media- , amongst others. This district FP-CIP will, through the CAO and DHO engage these actors to ensure provision of financial resources towards FP and delivery of FP services, but also advocacy for improved demand, quality service provision.

15.3 Coordination Framework

District level

In Namayingo District, coordination of this District FP-CIP will be led by the CAO and DHO through organized multispectral stakeholders' approach. This will include the district FP steering committee, chaired by the Local Council V (LC 5) and a district FP technical working group, chaired by the District Health Officer. At the technical level, it is proposed that quarterly review meetings will be held with the DHT members and later on shared with the relevant key stakeholders.

15.4 Resource Mobilization Framework

Through concerted efforts, Namayingo District will commit a percentage of its local revenue towards FP and continue lobbying and advocating for increased donor support. The District Budget Framework paper will reflect a commitment towards increased financing of FP over the 5 year period. Informed by the district funding gaps, Namayingo District Planner and the Chief Finance Officer will forecast and project resource implications for FP financing.

15.5 Performance Monitoring and Accountability

Measuring Namayingo District performance against the national FP-CIP targets will be critical and crucial during the implementation period. As expounded under the monitoring and evaluation section in this district FP-CIP, routine monitoring will occur through the DHMIS, with reporting on performance executed to MOH through the coordination mechanism as prescribed by the national FP-CIP. Key performance targets will hinge on the strategic priorities as informed by the national FP-CIP. It is anticipated that district performance towards the national FP-CIP will be shared in MOH review/ strategic planning meetings. Below is a list of indicators as adapted from the national FP-CIP (2015 -2020)

16.0 Table 16 Illustrative list of national indicators to inform the District FP-CIP

Category	**Illustrative Indicators**		**Data Source**
Demographic Indicators	• mCPR • Percent distribution of users by modern method • Number of additional FP users • Percent of women with an unmet need for modern contraception • Percent of women whose demand is satisfied with a modern method • CYP • Unmet need • Teenage pregnancy rate		Track20, PMA2020, and the UDHS
Service statistics	• Number of women receiving counseling or services in family planning—new acceptors and continuing clients • Number of women receiving FP services, by method • Number of products dispensed, by method • Number of youth receiving counseling or services in family planning—new acceptors and continuing clients • Number of HIV-positive clients using family planning		HMIS
Process indicators	Demand creation	• Percent of non-users who intend to adopt a certain practice in the future • Number of radio and TV spots aired • Percent of audience who recall hearing or seeing a specific message • Availability of accessible, relevant, and accurate information about sexual and reproductive health tailored to young men	• Activity reports • Programme surveys • DHS • FP-CIP progress

			monitoring database
	Service delivery and access	• Number of providers trained on family planning by district • Number of mobile clinic events organized, and number of people reached by district • Number of youth-friendly service clinics established • Availability of accessible, relevant, and accurate information about sexual and reproductive health tailored to young men	DHO
	Contraceptive security	• Contraceptive stock-outs • Actual annual contraceptive delivered for the public sector • Percent of facilities that experienced a stock-out at any point during a given time period	HMIS
	Policy and enabling environment	• Evidence of FP programmes incorporated into national strategic and development plans • Evidence of documented improvement in the enabling environment for family planning, using a validated instrument (e.g., the Family Planning Programme Effort Index and Contraceptive Security Index) • Evidence of targeted public and private sector officials, faith-based organizations, or community leaders publicly demonstrating a new or increased commitment to family planning • Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or sub national FP policy	
	Financing	• Annual expenditure on family planning from local revenue budget • Evidence of new financing mechanisms for family planning identified and tested • Evidence of private for-profit sector participation in family planning • Share of contraceptive procurement for the public sector financed by the government	

Source: Adopted from National FP-CIP (2015-2020)

16.1 Routine Data Collection

Family planning services data will be collected through the normal HMIS system. As a requirement, each health facility and associated volunteers will compile data using the standard tools from Ministry of Health and later on forwarded to the district Biostatician for onward submission to Ministry of

Health. The primary consumption data at all health facilities (both government and PNFP) will be captured in hard copies and where possible, electronic (HMIS) data base will be maintained.

16.2 Data Management

Data Quality Assurance Mechanism

The District Biostatistician will play a lead role in ensuring Data Quality Assurance (DQA) collection, transfer, compilation, analysis and storage. This will be executed through a series of technical review meetings with the HMIS staff and health facility assessment checks. As such routine support supervision will be undertaken on a quarterly basis and technical support will be offered in areas of need to health centres both for government and the private not for profit. Due care will be taken to identify any inconsistencies in data by comparing the submitted data records with the original data sources

M&E Coordination

Once data has been collected at each facility, submission will be made to the district and finally to Ministry of Health as required.

Capacity Building

It is envisaged that HMIS staff and other health workers will be oriented and trained in data collection, assurance, and analysis. The training in will be on job and where necessary, offsite training will be arranged by the office of DHO. This will ensure that data tools are completed accurately.

Information Dissemination and Use

It is planned that during the quarterly stakeholders' review meetings, the consolidated and analysed data will always be presented to inform decision making. Deliberate efforts will be taken to disseminate performance levels with the relevant stakeholders.

17.0 Table 17 DISTRICT IMPLEMENTATION FRAMEWORK WITH FULL ACTIVITY DETAIL

AREA #1: Demand Creation (DC)						
Strategic Outcomes	**Expected Results**	**Activity**	**Sub Activities**	**Inputs**	**Output indicators**	**Timeline**
DC1 : Demand for FP services is increased	Women ages 15-49 years with demand for family planning (met demand and unmet demand)	Align NamayingoDistrict communication strategy with national strategy with evidence based messaging	Disseminate strategy	- Dissemination meetings (1 day)	- District specific Communication strategy disseminated to relevant stakeholders	2017
		Implement a mass media campaign on FP based on the district communications strategy	Purchase media space for FP messaging (radio and TV)	- Buy 30 min spots to play 3 times a week - Buy time and host quarterly discussions on TV	- Number of radio spots purchased and aired per week - Number of quarterly discussions held on TV	2017 2018 2019 2020 2021
		Mobilize cultural leaders and community leaders working on HIV, PMTCT,GBV, Maternal health to participate in sensitization to include family planning in their work	Engage cultural and community leaders in workshops to orient them in FP messaging	- Cultural leaders participate in FP workshops	- Number of Namayingo District cultural leaders sensitized on FP messaging	2017
DC2: Men support the use of modern contraceptive for themselves and partners	Number of men who support the use of modern contraception for themselves or their partners in Namayingo District	Conduct monthly community outreach events to engage men in family planning	Conduct men special days	- Hold community outreach event for men in Namayingo District - Purchase radio announcement: 30 seconds for 3 -4 days - Distribute advertising posters - Distribute promotional - materials (T-shirts)	- Number of men reached in Namayingo District through special days	Quarterly Scale- up
			Conduct FP outreach events	-	- Number of community outreach events held	2017 2018 2019 2020 2021
DC3: Young People, 10-24 years old are knowledgeable about family planning	Young people in Namayingo, 10 -24 years are knowledge about FP and accessing FP services	Engage peers in Namayingo to educate young people about family planning services	Participate in regional youth camp for peer educators	- Youth selected for participation in camp	- Number of youth camps held in region in which Namayingo lies.	2017 2018 2019 2020 2021
			Participate in the development of youth plans for Namayingo and supervised by	- Youth selected to participate in youth plans	- Number of Namayingo district youth plans supervised	2017 2018 2019 2020

			MOH	development and supervised by MOH	by MOH	2021 Quarterly
		Disseminate educational yearly youth magazine that describes youth FP activities, programmes and services	Disseminate youth magazine in Namayingo	- Youth magazines distributed to youth corners, peer educations and CAO	- Youth Magazine disseminated annually in Namayingo.	2017 2018 2019 2020 2021
		Empower parents, caregivers and teachers to help their children to avoid teen pregnancy, including parent- child communication on sexual issues	Participate in workshops with teachers and parents to orient them on how best to talk to youth about family planning	- parents, caregivers and teachers participate in dialogues and workshops on FP	- Number of parents, caregivers and teachers participating in dialogues and workshops - Number of dialogues and workshops conducted	2017 2018 2019 2020 2021
		Hold " edutainment" community events like dances , music concerts and sports competitions to provide opportunity for knowledge exchange amongst young people			- Number of events held in Namayingo District	
DC4: Social marketing of free products and commercial sector increases FP	Project to brand free, public-sector condoms initiated and evaluated	Roll out pilot project to brand free, public sector condoms to see if overall uptake increases in Namayingo	Distribute branded free public sector condoms		- Number of condoms distributed in Namaying	2017-2021
AREA #2: Service Delivery (SD)						
Strategic Outcomes	**Expected Results**	**Activity**	**Sub Activities**	**Inputs**	**Output indicators**	**Timeline**
SD1: Access to FP services increased	Family planning service delivery points increased in rural communities	Conduct mobile clinics in Namayingorural communities	Engage in conducting out mobile clinics		Number of mobile clinics established in Namayingo	2017 2018 2019 2020 2021
	FP services are expanded through public- private partnerships	Organizations participate in sensitization on the importance of promoting and using FP services	Participate in workshops to sensitize private organizations	Private organization participants	Number of people from private organizations oriented on provisions of FP services	2017 2019
SD2: Referral services are strengthened	A uniform FP referral is created in Namayingo	Disseminate and train on FP referral forms	DHO and ADHO participate in training on new referral forms to	DHO and ADHO trained	Number of participants trained on referral forms	2017

			take to health workers			
SD4: Family Planning services are integrated in other health services	FP services integrated into - Cervical cancer screening - Post natal care - Postpartum care - STI - Malnutrition programmes	Disseminate FP integration protocols	Host meetings with professional associations to develop	Providers trained in FP service integration	Number of providers in Namayingo trained in FP service integration	2017
SD5: Family Planning services are accessible by people with disability	FP service delivery guidelines developed for people with disabilities	Develop guidelines for provision of FP services to people with disabilities	Train health workers on providing services to FP clients with disabilities	Service providers participate in training	Number of providers trained on disability service provision in Namayngo	2017
		Participate in sponsored courses for service provision to learn sign language	Train in sign language	Namayingo HC IV and 111s have one person that understands sign language	Number of service providers in Namayingo trained in sign language	2017
SD6: Family Planning side effects are managed	Counselling guidelines for family planning is re-assessed	Participate in training on FP side effects counselling	Engage in training	District Health worker	Number of district health workers trained on side effects counselling	2017
SD8: Family Planning in the VHT system is strengthened	Standardized FP training for VHTs is scaled up	Participate in training of VHTs on FP methods	Participate in TOT for VHT	TOT participate in training	Number of trainers trained in Namayingo	2017 2018 2019 2020 2021
SD9: Youth – friendly services are provided in clinics	Youth – friendly corners are established in clinics	Establish youth – friendly corners in clinics currently without any in Namayingo	Map current clinics without youth corners	Clinics identified, mapped and established	Number of clinics mapped for youth-friendly centres	2017
	Health workers trained on how to provide youth-friendly services	Participate in TOT on youth –friendly services	Health workers participate in training on youth –friendly services	5 participants from Namayingo	- Number of health workers trained on youth – friendly services	2017
AREA #3: Contraceptive Security (CS)						
Strategic Outcomes	**Expected Results**	**Activity**	**Sub Activities**	**Inputs**	**Output indicators**	**Timeline**
CS2: District staff are able to quantify and forecast FP commodities	Staff are sensitized on forecasting and quantifying of FP methods	Integrate forecasting and quantification within routine facility and Namayingodistrict activities	Participate in assessments to review capacity of staff to quantify FP methods	Health workers and Staff	Number of visits by MOH to Namayingo to review staff ability to quantify FP methods	2017 2018 2019 2020 2021
CS3: VHTs and community-based istributors have commodities	Community- based distributors are distributing FP commodities	Ensure supply chain system provides accurate and timely re-stocking	Health centre logistics manager trained on how to quantify and distribute commodities to	Health centre managers participate in trained	Number of logistics manager trained	2017

			community based distributors			
CS9: Commodity distribution to private not-for- profits increased	JMS includes FP commodities in procurement	Advocate for JMS to include FP commodities in procurement	Participate in assessment of the unmet need for FP in the faith- based sector service delivery points in Namayingo	Service delivery points assessed	Number of faith-based sector service delivery points assessed for unmet need in Namayingo	2017
AREA #4: Policy and Enabling Environment (PEE)						
Strategic Outcomes	**Expected Results**	**Activity**	**Sub Activities**	**Inputs**	**Output indicators**	**Timeline**
Legal framework and knowledge of policies for family planning improved	The legal framework that promotes FP is better known	Sensitize different members of society on FP rights, and correct any misconceptions	Participate in sensitization of DHTs to understand FP rights and correct misconceptions	DHT members participants	Number of DHT members trained on FP rights	2017
Parliament, local, cultural, and religious leaders are supportive of family planning	A national coalition of advocates/ champions to support family planning is established and supported	Scale up FP advocacy through FP advocates and champions in Namayingo District	Share best practices in advocacy and lessons learned	Advocates and champions participate in meetings	Number of advocates and champions from Namayingo participating in meetings	2017
			Provide technical support to prominent FP champions in Namayingo	Advocates and champions participate in receive technical assistance	Number of advocates and champions provided with technical assistance	2017 2018 2019 2020 2021
AREA #5: Financing (F)						
Strategic Outcomes	**Expected Results**	**Activity**	**Sub Activities**	**Inputs**	**Output indicators**	**Timeline**
F4. Family planning is mainstreamed in district planning and budgeting processes	Family planning is prioritized and integrated in district budgeting processes	Create a budget line for family planning at district level	Participate in district outreach visits by MOH	FP components integrated in district plan	Number of visits conducted by MOH held in Namayingo during district planning	2017 2018 2019 2020 2021
F5: Financial investment in human resources development for health is increased	Budget for training and support for midwives and nurses in the health sector is increased.	Advocate for increased funding for training and support for midwives and nurses at lower – level health facilities	Receive document explaining the commitments that were made at meetings	None	Documented evidence of progress or decisions made on coverage of FP in health insurance scheme	2017 2018 2019 2020 2021
AREA #6: Stewardship, Management and Accountability (SMA)						
Strategic Outcomes	**Expected Results**	**Activity**	**Sub Activities**	**Inputs**	**Output indicators**	**Timeline**
SMA3: The capacity of districts to effectively manage their FP programmes is strengthened	DHTs effectively plan for, monitor , and report on FP services	Conduct annual review meetings of Namayingodistrict plan	Hold meetings with DHTs	DHT participants	Work plan review meetings held	2017 2018 2019 2020 2021
	FP stakeholder coordination and performance monitoring at district level is increased	Improve FP stakeholder coordination and performance monitoring at district level	Participate in workshop to orient district management committees and DHTs	DHT participants and management committees	Number of DHT and committee members trained on stakeholder coordination and performance monitoring	2017 2018 2019 2020 2021
SMA 4: Reporting of	Health care workers report on	FP reporting tools are widely distributed to	Distribute reporting tools	FP reporting tools	Number of FP reporting tools	2017

FP indicators is strengthened	FP indicators	health care workers in Namayingo			disseminated	2018 2019 2020 2021

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