



**GLOBAL PROGRAMME FOR  
REPRODUCTIVE HEALTH  
COMMODITIES SECURITY  
(GPRHCS)**



**FACILITY ASSESSMENT FOR  
REPRODUCTIVE HEALTH  
COMMODITIES AND SERVICES-  
UGANDA**

**SURVEY REPORT - 2014**

**SUBMITTED BY**



## Foreward

Availability of Reproductive, Maternal, New born and Child health (RMNCH) commodities and services at service delivery points is key to ensuring that we reach every woman, girl, man and boy who needs services to enable us achieve Millennium Development Goals (MDGs) 1, 3, 4, 5 and 6.

While some commodities have been reported to be overstocked at central level, access to them at facility level has still remained a challenge mainly due to supply chain challenges and inadequate technical and functional capacities at service delivery level.

The Ministry of Health has continued to build capacity towards achieving real-time monitoring of commodity stock status and service delivery standards at facility level. In the meantime, supervision reports and surveys have remained vital sources of information from service delivery points.

This annual facility assessment for reproductive health commodities and services in Uganda is one of the initiatives from the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS) and is conducted across 46 countries worldwide. This report will not only guide the Global Programme, but also many stakeholders and implementing partners in Uganda, to better focus their resources in ensuring RMNCH commodity security by addressing both the supply and demand sides of commodities.

I am confident that this document will not only provide guidance to stakeholders and individuals to increase commodity security, but will also serve as a baseline for future monitoring and evaluation of projects and programs working to increase RMNCH commodity security.

I therefore urge all stakeholders to use the information in this report to guide our investment in improving availability of services and commodities for RMNCH.

  
Dr. Asuman Lukwago  
Permanent Secretary

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Prof. Anthony K. Mbonye  
**Director Health Services, Clinical and Community**

## Acronyms

ANC	:	Antenatal Care
CBO	:	Community Based Organisation
DHO	:	District Health Officer
EMHSLU	:	Essential Medicines and Health Supplies list of Uganda
EmOC	:	Emergency Obstetric Care
FP	:	Family Planning
GH	:	General Hospitals
GPRHCS	:	Global Programme for Reproductive Health Securities Commodities
GPS	:	Global Positioning System
HC	:	Health Centre
HMIS	:	Health management information
HSSIP	:	Health Sector Strategic and investment Plan
HSSIP	:	Health Sector Strategic Investment Plan
ICT	:	Information Communication Technology
JMS	:	Joint Medical Stores
MMR	:	Maternal Mortality Rate
MoH	:	Ministry of Health
MSU	:	Marie Stopes Uganda
NDA	:	National drug Authority
NGO	:	None Governmental Organisation
NMS	:	National Medical Stores
NRH	:	National Referral Hospital
PACE	:	Program for Access and Community Education
PNFP	:	Private-Not-for-Profit
RH	:	Reproductive Health
RHCS	:	Reproductive Health Commodities Security
RHU	:	Reproductive Health Uganda
RRH	:	Regional Referral Hospital
SDP	:	Service Delivery Points
SPSS	:	Statistical Package for the Social Sciences
SRH	:	Sexual Reproductive Health
TOR	:	Terms of Reference
UCG	:	Uganda Clinical Guidelines
UCMB	:	Uganda Catholic Medical Bureau
UDHS	:	Uganda Demographic and Health Survey
UHMG	:	Uganda Health Marketing Group
UMMB	:	Uganda Muslim Medical Bureau
UNFPA	:	United Nations Populations Fund
UNMHCP	:	Uganda National Minimum Health Care Package
UOMB	:	Uganda Orthodox Medical Bureau
UPMA	:	Uganda Private Midwives Association
UPMB	:	Uganda Protestant Medical Bureau
VHT	:	Village Health Team

## Table of Contents

### Contents

Foreward.....	i
Acknowledgement.....	ii
Acronyms.....	iii
Table of Contents.....	iv
List of Tables.....	vi
Executive Summary.....	viii
Introduction:.....	viii
<b>1 INTRODUCTION.....</b>	<b>1</b>
1.1 Background.....	1
1.2 Rationale and Objectives of the study.....	2
1.3 Survey Organisation and Management.....	2
1.4 Methodology.....	3
1.5 Sample design.....	3
1.6 Data collection tools.....	7
1.7 Data Analysis.....	7
1.8 Challenges during field work.....	7
1.9 Outline of the report.....	8
<b>2 NATIONAL GUIDELINES, PROTOCOLS AND LAWS.....</b>	<b>9</b>
2.1 Summary of guidelines, protocols and laws for provision of modern contraceptives.....	9
2.2 Summary of guidelines, protocols and laws for provision of maternal/RH medicines.....	11
<b>3 SURVEY FINDINGS FOR AVAILABILITY OF COMMODITIES AND SERVICES.....</b>	<b>13</b>
3.1 Geographic distribution of facilities.....	13
3.2 Distance of SDPs from the source of supplies.....	13
3.3 Modern contraceptives offered by facilities.....	15
3.4 Availability of maternal and RH medicines.....	19

3.5	Incidence of No Stock-Outs of modern Contraceptives .....	22
3.6	Supply Chain, including cold chain.....	24
3.7	Staff Training and Supervision .....	35
3.8	Availability of guidelines, Checklists and Job aids .....	44
3.9	Use of Information Communication and Technology and Waste disposal.....	46
3.10	Charges for User fees .....	52
3.11	Availability of Maama Kits .....	55
<b>4</b>	<b>RESULTS OF THE EXIT INTERVIEW .....</b>	<b>60</b>
4.1	Background Characteristics of clients for exit interviews.....	60
4.2	Client’s Perception of family Planning Service provision .....	64
4.3	Client appraisal of Cost of family Planning Services .....	68
<b>5</b>	<b>CONCLUSIONS AND RECOMMENDATIONS .....</b>	<b>79</b>
5.1	Availability of Modern Contraceptive methods.....	79
5.2	Not all staff trained on insertion and removal of implants were providing FP services: .....	79
5.3	Lack of Guidelines and job aids for FP: .....	79
5.4	Charging of user fees for family planning services:.....	79
5.5	High transportation costs for FP clients:.....	79
5.6	Long waiting time for FP services by clients in Karamoja: .....	79
5.7	High levels of satisfaction with services by FP clients:.....	80
5.8	Un-availability of essential lifesaving maternal and RH medicines:.....	80
5.9	Support supervision had some gaps: .....	80
5.10	Stock-outs of Maama kits:.....	80
5.11	Long time taken between ordering and receiving of supplies: .....	80
5.12	Waste disposal methods: .....	80
5.13	Recommendations: .....	81
<b>6.</b>	<b>REFERENCES.....</b>	<b>86</b>

## List of Tables

Table 1: Relative Proportion of Categories of SDPs in Uganda.....	4
Table 2: SDPs Surveyed by region and category.....	5
Table 3: Shows the number of family planning clients by region.....	6
Table 4: Table on General Characteristics .....	13
Table 5: Distance from source of supply by SDP type .....	14
Table 6: Distance from source of supply by administrative Unit.....	14
Table 7: Distance from source of supply by Location.....	14
Table 8: Primary SDPs offering at least three types of contraceptives.....	15
Table 9: Secondary and Tertiary SDPs offering at least five types of contraceptives.....	16
Table 10: Reasons for not offering certain contraceptives .....	18
Table 11: Percentage distribution of service delivery points with seven (Including 2 essential) lifesaving maternal/reproductive health medicines.....	20
Table 12: Reasons for not offering certain lifesaving maternal and RH medicines.....	21
Table 13: Percentage distribution of service delivery points with “no stock-out” of modern contraceptive method in the last six months by type of facility .....	22
Table 14: Percentage distribution of SDPs with persons responsible for ordering medical supplies by type of SDPs.....	25
Table 15: How resupply is quantified .....	26
Table 16: Availability of logistical forms for ordering supplies.....	27
Table 17: Responsibility for transportation of supplies .....	29
Table 18: Estimated Length of time between order and receiving of supplies.....	31
Table 19: Frequency of resupply by type of SDPs.....	32
Table 20: Availability of cold chain by type of SDP .....	33
Table 21: Source of power for Fridges used for cold chain by type of SDP.....	34
Table 22: Percentage of SDPs with staff trained to provide FP services including insertion and removal of Implants .....	36
Table 23: Trained staff in FP who are actually providing services.....	37
Table 24: Percentage distribution of the last time the facility was supervised in the past 12 months with respect to RH including family Planning.....	39
Table 25: Frequency of supervisory visits.....	41
Table 26: Issues included in the supervision of staff for reproductive health including FP.....	42
Table 27: Percentage of SDPs with guidelines, check-lists and job aids .....	44
Table 28 Percentage of SDPs with types of ICT tools available .....	46
Table 29: Percentage of SDPs by how ICT was acquired at the SDP .....	47

Table 30: Main purpose of ICT per type of SDP, region and management of SDP .....	49
Table 31: Main method used by the SDP to dispose of health waste .....	51
Table 32: Percentage distribution of SDPs by issues for which user fee is charged.....	52
Table 33: Percentage distribution of SDPs by issues for which user fee is charged.....	53
Table 34: Percentage distribution of SDPs by issues for which user fee is charged for services provided by a qualified health care provider .....	55
Table 35: Percentage of facilities offering Maama kits .....	56
Table 36: Availability of maama kits by the time of the survey .....	57
Table 37: Reasons for not offering maama kits when SDP has a mandate to offer them .....	59
Table 38: Showing Sex distribution of FP clients.....	60
Table 39: Age distribution of FP clients.....	61
Table 40: Marital Status of FP Clients.....	62
Table 41: Percentage distribution of clients by educational level.....	63
Table 42: Percent Distribution of clients by frequency of visit to the SDP for FP services .....	64
Table 43: Percentage distribution of client’s perception of FP service provider’s adherence to technical issues.....	65
Table 44: Percentage distribution of client’s perceptive of FP service organizational aspect .....	66
Table 45: Percentage distribution of clients’ perspective of FP service inter-personal aspects.....	67
Table 46: Percentage distribution of clients perceptive of FP service outcome aspect .....	68
Table 47: Client appraisal of cost of Family Planning methods.....	70
Table 48: Percentage distribution of clients by mode of transportation, distance travelled and cost of transportation.....	71
Table 49: Average time spent by client for FP service .....	73
Table 50: Percentage distribution of clients by activities they would have engaged in during the time spent receiving FP services.....	74
Table 51: Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were away receiving FP services and the estimated payment.....	75
Table 52: Average amount paid to persons who performed activities on behalf of clients by activities while client was away receiving FP services .....	76
Table 53: Percentage distribution of clients by source of funds used to pay for FP services .....	77
Table 54: Average amount paid from each source by background characteristics of client .....	78



## Executive Summary

### Introduction:

In 2009, Uganda received support from the Global Program for Reproductive Health Commodity Security (GPRHCS) to assist the Ministry of Health in developing a national strategy. The strategy focused on logistics management to improve the functionality of the national and district Reproductive Health commodities Security (RHCS) coordination mechanisms. Uganda is among the 46 countries under the GPRHCS that has conducted these annual surveys to track RHCS indicators. The survey was designed to go beyond the availability of RH commodities to cover significant aspects of service delivery facilities that shore up good RH programmes. In addition to assessing the availability and stock-out of RH commodities, the survey looked at supply chain (including cold chain) systems; staff training and supervision; availability of guidelines and protocols, Information Communication Technology, method of waste disposal and user fees. The survey also obtained the views of clients about the quality and cost of services through exit interviews.

The survey was conducted in Health facilities which were grouped into three categories of Service Delivery Points (SDPs); Primary (Health centre IIs & IIIs), Secondary (Health Centre IVs and General Hospitals), and Tertiary (Regional referrals Hospitals [RRHs] and National Referral Hospitals [NRHs]). A total of 734 health facilities were surveyed and this included 617 at primary level, 104 at secondary level, and 13 at tertiary level. Out of the 734 facilities surveyed; 491 were Government owned, 148 were privately owned, 90 were NGO owned and 5 were owned by others including CBOs.

**Modern contraceptives offered by facilities;** the survey findings revealed that at primary service delivery points, 83% of the facilities offered at least three modern contraceptive methods<sup>1</sup> while 17% did not offer at least three.

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<sup>1</sup> The modern contraceptive methods assessed for included; Male condoms, Female condoms, Oral contraception, injectables, emergency contraception,

At secondary and tertiary level, 75% offered at least five modern contraceptive methods while 25% did not. At secondary level alone, 73% offered up to five modern methods while 85% of the tertiary SDPs offered up to five modern methods. The main reasons given by health facilities for not offering certain contraceptive methods were; the delay by the suppliers/source institution to supply contraceptives, the lack of trained staff to provide certain methods such as insertion and removal of IUDs, implants, and female and male sterilization and low client demand for some methods such as female condoms.

**Availability of Maternal and RH medicines;** the survey team assessed the availability of the Seven (including the 2 essential) lifesaving maternal/reproductive health medicines<sup>2</sup> It was established that overall 62% of the SDPs had available (by the time of the survey) all the seven including the two essential lifesaving maternal and RH drugs while 38% did not have them available. On average, the main reason given for not having these medicines was the delay on the part of the supplier/warehouse to deliver the medicines.

**Incidence of No stock-out of the modern contraceptive methods;** a facility that had a 'stock-out' was determined as one that had one or more of the contraceptive methods being out of stock on a given day of the last six months before the survey. The findings show that 79% of the SDPs had a stock-out of one or more methods in the six months preceding the survey, while only 21% had not had a stock-out. In terms of management, the NGO managed SDPs had the highest stock-out of 83%, followed by government owned SDPs (81%) and the privately owned SDPs(72%).

**Supply chain including Cold chain;** the main source of supplies for contraceptives was the

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IUDs, implants, sterilization for females, and sterilization for male.

<sup>2</sup> The Seven including two essential lifesaving drugs included Ampicillin, Azithromycin, Benzathine, Benzylpenicilin Betamethasone, Calcium gluconate, Cefixime, Gentamicin, Hydralazine, and magnesium sulfate.

Central Medical Stores (51%), followed by the private source (20%), the regional/district warehouse (17%), and the local medical store on site (6%), NGO (4%), and donors (2%). In terms of residence, 60% of the facilities in the rural area used the central medical stores compared to 35% of the urban facilities. In terms of management, 67% of government owned used the central medical stores while 72% of the privately owned 37% of NGO owned used the private sources as the main source of supply. The main establishment handling transportation of supplies is the National/central government (42%) through the National Medical Store, followed by Local/district administration (27%), the facilities themselves (27%) and the others at 4%.

The estimated average time between ordering and receiving of supplies was mainly less than 2 weeks for 28% of the SDPs, more than 1 month but not up to 4 months for 24% of SDPs, more than six months for 17% of SDPs, and more than 2 weeks but not up to 1 month for 15% of SDPs. The frequency of resupply was mainly once every year (59%) of SDPs mainly government owned, and once every two weeks for 12% of the SDPs mainly privately owned.

Of all the SDPs surveyed, only 27% did not have cold chain facilities. The SDPs with no cold chain included 30% at primary, 8% at Secondary, while all of the tertiary SDPs had cold chain facilities. The main cold chain equipment was the refrigerator and the main source of power was gas (45%) followed by electricity from the national grid (32%).

#### **Staff training and supervision**

Four out of five SDPs that offered FP had staff trained to provide family planning services and 70% had staff trained for the insertion and removal of implants. Only 56% of the staff trained to provide FP services were actually providing FP services. Some of the reasons for not providing the services included lack of equipment, materials and consumables, and low client demand for some methods.

Out of all the SDPs surveyed, 70% had received support supervision. Important to note is that about two of every five SDPs had not been supervised in the last 12 months by their respective supervisory authority. Overall, the

SDPs received the direct supervisory visits from the authorities mainly every two to three months (42%).

**Availability of Guidelines, checklists and job aids;** The survey findings indicated that; family planning guidelines (National or WHO), family planning check-lists, Maternal health (including PNC and ANC) guidelines, and/or job-aids, national waste disposal guidelines, national waste disposal check-lists and/or job-aids were on a whole available at most of the SDPs across the region and irrespective of residence and management of facility. The relatively low availability of guidelines at the Primary level is a cause of concern. It was determined that only three in five SDPs had FP guidelines, and only 51% had FP checklists and job aids at primary level.

#### **Use of information Communication technology (ICT) and waste disposal;**

About 72% of SDPs had Mobile phones - basic handsets, 39 % had computers and 15% had Mobile phones - Smart phones. Tablets, LAN and internet Wi-Fi were least available at SDPs. Most of the staff were using personal gadgets like phones, tablets and lap tops for SDP work. Majority of ICT are used for communication, patient registration and facility record keeping. In terms of waste disposal, majority of SDPs dispose health wastes by burning (66%) in all regions followed by central collection by specific agency for disposal away from SDP (13%) and by use of incinerator (13%).

**Charges for user fees;** User fees were charged for consultation on care of sick children (53% of SDPs), delivery and new born services (46%), and 41% on antenatal services. About 49% of all SDPs charged user fee on HIV medication, 43% on child health medicines, 28% on maternal health medicines and 20% on FP commodities. There were no user charges for HIV medicines at tertiary SDPs. Results show that majority of SDPs charge user fees for services provided by a qualified health care provider for Family Planning services, antenatal care services, delivery services, postnatal care services, newborn care services, HIV care, and caesarean section. Most of these fees are charged at primary and secondary SDPs.

**Availability of Maama kits;** Four in Five SDPs were supposed to provide maama kits as a matter of policy. Out of the SPDs that were supposed to provide Maama kits, 73% had maama kits available on the day of the survey while 27% did not have maama kits available. In terms of availability of maama kits by level, all tertiary level SDPs (100%), 75% of secondary level and 71% of primary level had maama kits. The main reason advanced for not having maama kits was the delay on the part of the main source institution to supply maama kits on time (58%).

**Client's perception of family planning service provision;** Clients were generally satisfied with the quality of services from FP providers. Close to 95% of the clients reported to have been treated with courtesy while 94% were satisfied with the attitude of health care providers. Most clients (96%) were satisfied with the services received and expressed willingness to return to the SDP in future. Also about 98% reported that they would refer relatives to the SDP.

**Client's appraisal of cost of family planning services;** results show that nearly 12% of the clients paid for FP services. In terms of management, 63% of Clients who paid for FP were from the private SDPs. On average, FP services were generally more expensive in urban areas compared to rural areas. Those that reported to have paid for FP services, paid on average UGX 4,200 in government facilities, UGX 5, 400 in private facilities and UGX 6,000 in NGO managed facilities. Most FP clients (61%) walked to the SDP for services covering on average 3.2Km. The average travel cost was UGX 3,600 with Karamoja region registering the highest cost of transport of UGX 7,000.

### **Recommendations**

The Ministry of health together with its partners and NMS should review the supply chain management process and ensure that supplies do not take long to get to the facilities. A business process re-engineering of the supply chain management system is recommended to ensure delays and unnecessary process are eliminated to reduce time it takes to supply from when orders are placed.

Continuous training and mentoring for the insertion and removal of implants is encouraged to cater for the gap of lack of trained service providers, a major reason for the stock-out of two methods including Implants (33%) and IUDs (8%).

Sensitization at the community level using VHTs is recommended to increase the demand for some contraceptives like the female condom which was mainly out of stock due to lack of demand. Government and its partners should further sensitize on the use of condoms (male and female) in particular regions like Karamoja and northern Uganda where demand was low.

It is strongly recommended that staff who make supply orders, are trained, mentored and supervised in supply chain and stock management including the filling in of order forms in the respective formats. Also important is to ensure that more than one staff has the ability to make the orders to cater for periods when another staff is either on leave, sick or when they leave the facility. The Facility in-charges especially at the primary level facilities have to manage exquisitely the supplies unit and to continually monitor its performance to ensure internal processes do not lead to drug stock-outs.

It is recommended that the MoH and its partners intensify the distribution and use of the guidelines and job aids in the different facilities where they were missing. The MoH and its partners should ensure that all SDPs at all levels have the necessary job-aids in all departments that deliver FP services, and in a form that is easily usable as reference material by health workers.

Regarding payment for FP services, it is recommended that further investigation be done on the issue of user fees payment in facilities where FP services are supposed to be provided for free. Government should provide guidance to private wings in tertiary level health facilities where user-fees are permitted to differentiate between chargeable and non-chargeable services. Government should further intensify the sensitization drive to the public in regards to FP services being free.

Regarding transport costs hindering access to FP services in Karamoja, it is recommended that government and its partners consider taking FP services closer to the people in Karamoja through the use of VHTs, or incentivize transportation on particular days to cater for those that cannot afford the cost of transport to attend FP.

Regarding the long waiting times for FP services in Karamoja region and Northern Uganda, it is recommended that further efforts to have more health workers in these regions be considered through staff motivation, incentives and better pay, for as long as it brings medical services to these regions up to standard.

Regarding the glaring gap in availability of essential life-saving maternal and RH medicines, the recommendation to improve supply chain management has already been made and cannot be exaggerated. In particular, since most facilities (especially the government facilities) cited that the gap was

on the side of the suppliers, it is important that the recurrent problem of central stores constraining service delivery be dealt with through persistent leadership actions targeting these stores. This recommendation is also pertinent to the finding that about one in six health facilities (one in five government health facilities) receive their supplies on average six months from the time they are ordered.

Regarding support supervision, Ministry of Health in collaboration with the District Health Office and implementing partners should design a schedule for support supervision for SDPs to ensure continued quality RH services including family planning.

Regarding availability of mama kits, It is recommended as already stated that supplies systems be reviewed to eliminate the irregularities and delays, but also importantly provision of maama kits by private providers should be promoted where such public-private partnerships are possible.

## 1 INTRODUCTION

### 1.1 Background

#### Country Background

The reduction in Uganda's Maternal Mortality Ratio (MMR) has progressed slowly and currently stands at 438 deaths per 100,000 live births (UDHS 2011). On the other hand, Contraceptive Prevalence Rate increased from 14% in 2001, to 18% in 2006 and was at 26% in 2011 (UDHS 2011). Total fertility rate also slightly reduced from 6.9 in 2001, to 6.7 in 2006 and stood at 6.2 in 2011 according to the UDHS 2011 report. Although the unmet need for family planning fell from 41% in 2006 to 34% in 2011, it is undoubtedly still very high.

Uganda government through the Ministry of Health and development partners are implementing interventions in the areas of emergency obstetric care (EmOC), skilled attendance at birth, family planning, and antenatal care (ANC) to meet its international and national obligations on maternal health. Government acknowledges that insufficient supplies and commodities is one of the key challenges facing effective delivery and utilisation of effective maternal health services. According to the Reproductive Health Commodity Security Strategic Plan (2009/10-2013/14), the key objectives are; to increase the contraceptive prevalence rate from 26% to 50% and reduce the unmet need for contraceptives from 41% to 5% by 2015 and to increase the proportion of health facilities with no stock-outs of selected Reproductive Health (RH) commodities to 80% by 2015. However, successive reports have indicated varied performance of the indicator on proportion of facilities without stock-out of essential medicines, including reproductive health commodities.

#### Reproductive Health Commodity Security

Reproductive Health Commodity Security is achieved when all individuals can obtain and use affordable, quality reproductive health commodities (GPRHCS Report 2009). This is a UNFPA Global Programme to Enhance Reproductive Health Commodity Security launched in 2007 to address the urgent and ongoing need for a reliable supply of contraceptives, condoms, medicines and equipment. The Global Programme is already yielding measurable results through a framework for assisting countries in planning for their own needs, with a focus on commodities as well as capacity development to strengthen health systems. The GPRHCS provides a structure for moving beyond ad-hoc responses to stock-outs towards more predictable, planned and sustainable country-driven approaches for securing essential supplies and ensuring their use. In 2010, funding for the GPRHCS reached nearly \$100 million.

Each year, more countries are establishing reproductive health commodity security (RHCS) as an integral and permanent component of the overall health sector plan and a key strategy in reducing maternal and newborn death and preventing the spread of HIV.

In 2009, Uganda received support from the GPRHCS to assist the Ministry of Health in developing a national strategy. The strategy focused on logistics management to improve the functionality of the national and district RHCS coordination mechanisms. As part of this effort, six district Medicine and Therapeutic Committees (MTCs) were established. Their members received training in logistics management, and then carried out supervisory visits to health facilities at the sub-district level.

## **1.2 Rationale and Objectives of the study**

Uganda is one of the 46 countries under the Global Program for Reproductive Health Commodity Security (RHCS) that has conducted the annual surveys to track RHCS indicators. The survey was designed to go beyond the availability of RH commodities to cover salient aspects of service delivery facilities that underpin good RH programmes. In addition to assessing the availability and stock-out of RH commodities, the survey addresses supply chain (including cold chain) systems; staff training and supervision; availability of guidelines and protocols, Information Communication Technology, method of waste disposal and user fees. The survey also obtained the views of clients about the quality and cost of services through exit interviews.

### **Objectives of the Survey**

The main objectives of this survey were to:

- i. To generate information on the availability and stock-out of RH commodities in the sampled health facilities;
- ii. To assess the family planning services as well as cost borne by clients to access services;
- iii. Make key recommendations for RH commodities and services.

The survey obtained baseline information on a set of RHCS programmatic and managerial issues as set in the National Guidelines. The survey results will enable the Ministry of Health (MOH) and partners to develop milestones and targets for a set of agreed upon indicators in the framework in line with existing national policy frameworks, strategies and plans. In addition the survey data will be used in the preparation of the Annual Health Sector Performance Report and the Global Program report on RHCS.

## **1.3 Survey Organisation and Management**

The Survey was carried out by Eficon Consulting Ltd, under the direct coordination and supervision of UNFPA in collaboration with the Ministry of Health. A survey committee was constituted comprising of the FP/RHCS team. The Assistant Commissioner Reproductive Health chaired the Survey Committee and had the powers to invite the members of the FP/RHCS committee to be members of the Survey Committee. The RHCS Coordinator at the MOH was the Secretary to the Survey Committee.

**The Survey committee's roles included the following:**

- Overall guidance for the national facility assessment of the RH commodities and services
- Coordination of the survey processes
- Organizing meetings to review progress on the planned activity schedule
- Offering technical advice to enable the consultants to execute the designated tasks
- Monitor implementation of the survey activity plan
- Reporting progress to the MCH Cluster.
- Coordinating the process of consolidating, formatting and editing the survey report
- Coordinating the validation and peer review process of the report
- Organizing fora for the dissemination of the final report

#### **1.4 Methodology**

The methodology used followed standardised methods, tools and procedures to enable global comparison in all the 46 Countries implementing the GPRHCS programme. The methodology was implemented along the four main stages including: Inception, Field work, Data analysis and reporting stages. During the inception stage, the consultant and the survey committee discussed in detail the survey methodology, the sampling methods and the work plan. The survey committee approved the inception report and the team of consultants proceeded to collect data in the different regions of the country. The details of data collection are discussed in a separate sub section below. After data collection, data was cleaned and entered into EpiData 3.02 software and analysed in STATA 10 and SPSS 17.

#### **1.5 Sample design**

The survey considered the following broad categories of Service Delivery Points (SDPs)/domains that provide modern methods of contraceptives and maternal/RH services as stratum:

- a) Primary Level Care SDPs/facilities (i.e Health Centre IIs and IIIs)
- b) Secondary level care SDPs (i.e Health Centre IVs and General Hospitals)
- c) Tertiary level care SDPs (i.e Regional referrals Hospitals (RRHs) and National Referral Hospitals (NRHs<sup>3</sup>))

The Ugandan health System has four major categories (i.e. Hospitals, HCIV, HCIII, HCII) as pointed out in the MOH Master Health Facilities Inventory July 2012. The Hospitals are further broken down into General Hospitals, Regional Referral Hospitals and National Referral Hospitals. These categories were grouped to form the three survey categories of primary level, secondary level, and tertiary level.

Following the standardised methodology, the country was divided into 10 regions based on UBOS statistical regions used during Demographic and Health Surveys.<sup>4</sup>

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<sup>3</sup> RRH and NRH, are tertiary level SDPs, but have been given special attention due to their vital role in the Ugandan Health System in health care provision, training and supervision.

<sup>4</sup> UDHS 2011

These regions included, *Kampala, Central 1, Central 2, East Central, Eastern, Karamoja, North, West Nile, Western, and South Western*. The ten regions served as the administrative units, referred to in the standardised methodology.

**Sample size determination**

The sample size was computed using this standard formula (Leslie Kish, 1965) given below:

$$n = \frac{z^2 p(1 - p)}{d^2}$$

**Where by**

**n**= expected sample size

**z**= score that corresponds to a confidence interval = 1.96 at 5% level.

**p**=the proportion of the attribute (type of SDP) expressed in decimal

**d**= level of permissible error =0.05.

The formula provides the minimum sample size that can be drawn at the specified level of precision from the SDPs under the assumptions of normal distribution.

Using the Master Health Facilities Inventory 2012 from Ministry of Health (MoH), the above formula was used to obtain the total sample for the survey which was distributed among the different categories according to the relative share of each category in the total number as shown in table 1 below.

**Table 1: Relative Proportion of Categories of SDPs in Uganda**

	Hospital	HC IV	HC II	HCII	Total
Number of SDPs	152	193	1279	3605	5229
Relative Proportion	0.029	0.037	0.245	0.689	1.00

These proportions were further proportionately distributed within the ten administrative units (regions) based on the proportionate share of each region under each category. A representative probability sample of 711 Service delivery Points was determined using the proportions. A non-response rate of 10% was added, to cater for any forms of non-response, thus bringing the **final sample size** to 782 Service delivery Points in the country.

**Selection of SDPs**

The sampled SDPs were selected using systematic sampling. The complete list of SDPs per region and per domain was obtained from the MoH. The GPRHC guideline (1) for systematic sampling states: For each domain (Health facility Level) the facilities were listed without any order or regard to any characteristics. Based on the above guideline, the SDPs per region and category were each given a unique code in Ms-Excel 2007 and used to calculate a sampling interval. The required number of SDPs in each category was the selected starting with the smallest unique code until the final sample was attained. During the selection, the SDPs whose unique codes were selected using the interval were considered as part of the sample.



A total of 734 Service delivery Points were surveyed in Uganda. Though this number was below the inflated target of 782, it was well above the minimum sample of 711 which indicated a response rate (RR) of 94 percent higher than the initial assumed RR of 90 percent. These included 617 of primary level SDP (HC II and HCIII), 104 of Secondary SDPs (HCIV and General hospitals) and 13 Tertiary level SDPs (Regional and National Referral hospitals). See Table 2 below for the details.

**Table 2: SDPs Surveyed by region and category**

Administrative Unit (Region)	Level of facility/SDP (%)			
	Primary SDP (HCII & HCIII)	Secondary SDP (General Hospital & HCIV)	Tertiary SDP (RRHs & NRHs)	Total (%)
Kampala	117	23	2	142
Central 1	62	11	1	74
Central 2	56	10	0	66
East Central	58	8	1	67
Eastern	83	14	1	98
Karamoja	16	2	1	19
Northern	39	5	2	46
West Nile	38	7	1	46
Western	64	7	2	73
South Western	84	17	2	103
<b>Total (%)</b>	<b>617</b>	<b>104</b>	<b>13</b>	<b>734</b>

#### **Client Exit interviews**

Clients were randomly selected for individual interviews at each surveyed SDP that provided family planning services. These clients were identified with the help of the in-charges and or health workers on duty. The clients were selected after receiving services or if they had ever accessed family planning services from the SDP. The number of exit clients who participated in the exit interviews was also proportionately distributed with level of facility. The highest number was at tertiary level SDPs and lowest at primary level SDPs. A total of 3,365 clients were interviewed during the survey of which most were women as seen in table 3 below.

**Table 3: Shows the number of family planning clients by region.**

<b>Administrative Unit</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
Kampala	45	299	344
Central 1	9	519	528
Central 2	18	305	323
East Central	13	198	211
Eastern	33	556	589
Karamoja	7	16	23
Northern	35	169	204
West Nile	44	314	358
Western	12	214	226
South western	34	525	559
<b>Total</b>	<b>250</b>	<b>3115</b>	<b>3365</b>

## 1.6 Data collection tools

The major objective of the facility assessment was to collect data on availability and stock-out of RH commodities at health facility level. There were two categories of data collected including:

**Commodity availability and Facility resources;** This looked at availability of modern contraceptives, maternal medicines, stock-out rates, supply chains, existence of cold Chains, staff training in FP, ICT, staff supervision for RH, guidelines and job aids, waste disposal and charging of fees. This was collected using a standardised Health facility survey questionnaire provided by GPRHCs. The tool was slightly customised to capture some commodities relevant to the Ugandan situation such as the Maama kit, a package of simple essential utilities provided to mothers to help them receive a clean and safe delivery.

**Client perception and appraisal of FP services;** the study also assessed the conditions of services at the facility. A Clients' perception survey was conducted at each sampled health facility. This was intended to solicit client's opinion about the FP services they receive. A client interview guide was used to collect client perceptions.

**Pre-testing of tools;** The Health facility survey questionnaire and a client interview guide were pre-tested in Wakiso district townships where five facilities were identified and assessed. Pre-testing helped the research teams to better understand the tools and improve their interpretation of questions.

## 1.7 Data Analysis

### Data cleaning

This involved a preliminary review of questionnaires in the field by the regional team leaders on a daily basis in order to ensure that errors are corrected while in the field. This was intended to allow for high quality datasets. Data entry was done using Epi-data 3.02 and exported into SPSS version 17.0 and STATA 12. Data was further cleaned using both visual and computer aided checks, based on summary statistics to identify errors, missing cases, outliers, and extremes, before the final analysis was done.

Data were finally analysed using descriptive statistics frequencies, percentages, means and totals generated in STATA 10 and SPSS 17 in certain cases. Results have been presented in the table formats developed by UNFPA. The analysis was based on the Standardized GPRHCS table formats, including disaggregation by SDP, sub regions, rural and urban and management of SDPs.

## 1.8 Challenges during field work

- i. **Long distances and highly dispersed Health centres;** this was partly as a result of systematic sampling which did not take into consideration access and availability of facilities. The survey teams had to contend with long distances and sometimes health facilities were hard to reach.
- ii. Unavailability of health facility in-charges or facility representatives; some health facilities did not have available the in-charges or the representatives to give time

for interviews; this led to delays and several call backs that delayed the survey teams;

- iii. Unavailability of clients for exit interviews; this was mostly experienced at the Health centre IIs and Health centre IIIs, where clients were hard to find. This increased the waiting time, given that on some days no client would report.
- iv. The rainy season and bad roads; the survey was conducted in the month of October 2014 which is a rainy season in most parts of the country. Given that most roads in the country-side are seasonal, this affected movement as some health facilities were hard to reach.
- v. Slow and unfriendly response from privately owned health facilities; the responses from the privately owned health facilities were not as prompt and timely as we would have wanted. A few cases declined to participate in the interviews and others were hesitant to cooperate until after long negotiations and convincing;
- vi. Location of Health centres IIs was a big problem especially in Kampala as some of them had shifted to different locations. A few of the facilities at HCII level in Kampala had closed and this explains the failure to meet the entire targeted samples.

## 1.9 Outline of the report

**The report is divided into five parts:**

**First part;** gives the introduction to the study where the background, the rationale and objectives of the study, the organisation of the survey, methodology, sampling, data collection methods, data analysis and limitations to the survey are discussed.

**Second part;** discusses and summarises the guidelines, protocols and laws for provision of modern contraceptives and for provision of maternal/RH medicines in Uganda.

**Third part;** discusses the results of the survey on availability of commodities and services. This presents general information about facilities, modern contraceptives offered by facilities, availability of maternal and RH medicines, incidence of NO stock-outs of modern contraceptives, supply chain including cold chain, staff training and supervision, availability of guidelines, check-lists and job aids, use of information communication Technology (ICT) and infection prevention and control waste disposal, and charges for fees (user fees).

**Fourth part** discusses the exit interview findings including background characteristics of clients, client's perception of family planning service provisions, client's appraisal of cost of family planning services provision, and client's appraisal of cost of family planning services.

Lastly **Part five** gives the recommendations and conclusions

## 2 NATIONAL GUIDELINES, PROTOCOLS AND LAWS

### 2.1 Summary of guidelines, protocols and laws for provision of modern contraceptives

#### **The Second National Health Policy 2010**

The Second National Health Policy 2010 provides a structure through which health service including Family planning methods are provided, this includes district health system [Village Health Teams (VHTs) and health facilities including HCII, HCIII, HCIV, General Hospitals (GH), Regional Referral Hospitals (RRH) and National Referral Hospital]. The health care system is further subdivided into public (government) and private health facilities with the latter comprising of Private for Profit (PFP) and Private not for Profit (PNFP). Seventy five percent of the facility-based PNFP organisations exist under four umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB). In some PNFP health facilities UCMB, family planning services are not provide but the facilities are expected to provide information and refer the clients to health facilities providing the required FP services.

#### **Health Sector Strategic and investment Plan (HSSIP) 2010/11-2014/15**

HSSIP provides guidance on provision of family planning services as a priority and a cost effective means to lower maternal mortality rates mainly through i) reduction of the risk of exposure to pregnancy and death; ii) reduction of the incidence of abortion by averting unwanted and unplanned pregnancies; iii) averting of pregnancies that occur too early, too late or too frequently during the woman's reproductive cycle, and those that are inadequately spaced, with ultimate outcome effect of reducing the current total fertility rate of 6.2 (UDHS 2011).

As part of strategic intervention of HSSIP under cluster 4: Maternal and Child Health, the government of Uganda aims at i) reducing mortality and morbidity relating to sexual and reproductive health & rights ii) improving newborn health and survival by increasing coverage of high impact evidence based interventions iii) Scaling up and sustaining high, effective coverage of a priority package of cost-effective child survival interventions in order to reduce under five mortality. In all these interventions, family planning services have cross-cutting role in contributing to the effect of these interventions in the health service delivery structure. Specific targeted interventions include i) developing, printing and disseminating evidence based, gender sensitive IEC (including FP) materials, ii) through VHTs, creating awareness about sexual and reproductive health including pregnancy surveillance, family planning among community members with special focus on men, iii) providing integrated family planning services in all health facilities according to the level of care, iv) designing programmes to engage men in planning services and use, and v) increasing the number of health facilities providing adolescent friendly sexual and reproductive health services.

### **The Ministry of Health National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Right:**

Under this policy document both service guidelines and service standards for sexual and reproductive health in Uganda are explicitly stated. The service policy guidelines spell out the general rules and regulations governing reproductive health services, components of reproductive health services, target and priority groups for services and basic information education and communication (IEC) for the target and priority groups. It also identifies the services, those eligible for services, the service providers, and how in-service training, logistics, supervision and evaluation activities will be planned and implemented. The service standards set out the minimum acceptable level of performance and expectations for each component of reproductive health services, expected functions of service providers and the various levels of service delivery.

This policy also defines Family Planning as the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods. The modern methods are further sub-divided into short-term, long-term and emergency contraception methods. The goal of this policy is to provide information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have. Modern Family Planning Methods provided as per this policy include: a) Combined oral contraceptives (Lo-Feminal), Microgynon, Ovrette), b) Progesterone only pill (POP), c) Injectable contraceptives (Depo-medroxyprogesterone acetate (DMPA)), d) Implants, e) Intra-uterine contraceptive devices (IUCD), f) Barrier Methods (male condoms, female condoms, spermicides and diaphragms), g) Voluntary surgical contraception (Bilateral Tubal ligation and Vasectomy), h) emergency contraceptives. These are provided through existing health structure starting from VHT to the national referral hospitals.

### **Reproductive Health Commodity Security Strategic Plan 2009/10-2013/15**

This plan provides guidance for establishing and strengthening functional and institutionalized mechanisms for coordinated planning, procurement and distribution and review of reproductive health supplies including family planning methods at central, district & facility levels. It also guides how National Medical Store (NMS) supplies Reproductive health commodities including FP methods to public health facilities, Joint medical stores (JMS) to faith based health facilities and Medical Access Ltd provide to private facilities.

Under this plan, the Ministry of Health intends to achieve the following objectives a) increase the contraceptive prevalence rate from 23% to 50% and reduce the unmet need for contraceptives from 40% to 5% by 2015. b) Increase the proportion of health facilities with NO stock-outs of selected RH commodities to 80% by 2015. c) Increase public sector/government budget allocation and expenditure on reproductive health commodities, including contraceptives to 80% by 2015.

**Uganda Alternative Distribution Strategy for Contraceptives and selected Reproductive Health Commodities in Public and Private Sector 2012 -2016.**

Alternative distribution strategy for contraceptives and selected Reproductive Health Commodities was developed to overcome some distribution gap in the private sector when it was realized that Joint Medical Stores (JMS), a recognized channel of access for the private sector does not have Family Planning commodities because of religious principles.

Under this strategy, Uganda Health Marketing Group (UHMG), Reproductive Health Uganda (RHU), Program for Access and Community Education (PACE), Marie Stopes Uganda (MSU) and Uganda Private Midwives Association (UPMA) complement government efforts in distributing contraceptives and selected Reproductive Health Commodities with the objective of:

- i) Increasing uptake of contraceptives and other RH commodities at the public service delivery points by 50% annually and
- ii) Reducing the number of service delivery points experiencing stock-outs of contraceptives and other selected RH commodities in both the public and private sector to less than 30% in five years

Under this strategy, i) integration of Family Planning into Out Patient Department (OPD) will be strengthened, ii) Family Planning days/camps will be conducted at each Health Facility, iii) Family Planning will be integrated into non-health sectors e.g. Environment, education institutions, Information, services and FP commodities will be provided at public places including places of entertainment, Hotels and lodges, salons, public transporters, universities and tertiary institutions.

## **2.2 Summary of guidelines, protocols and laws for provision of maternal/RH medicines**

Maternal and Reproductive Health medicines like any other medicines are controlled under the Uganda national drug Policy issued in 2002. The policy aims at ensuring that all drugs available to the public are of appropriate quality, safety and are efficacious. It also aims at ensuring that the essential medicines are accessible to all who need them by ensuring availability in the country and affordability. Medicinal drugs including maternal and RH medicines in the country are regulated by the National Drug Authority (NDA). The authority also controls the registration of drugs and their inclusion on to the National drugs list. The National drug procurement orders are based on this list.

Most maternal and reproductive health medicines are usually not taxable whether they are destined for the private or the public sector. RH drugs for maternity and delivery are part of the essential drugs list and are therefore funded, forecasted and procured through the pharmacy division of the MoH with NMS acting as procurement agent. The NMS similarly largely manages the distribution system of the entire range of maternal and RH commodities particularly for the public sector. On the other hand, NGOs and private facilities may receive supplies from the NMS; the Joint Medical Stores (JMS) which is a substantially large non-government medical

store managed by the catholic and protestant religious medical bureaus. Private pharmaceutical companies are also permitted to import maternal and RH products and all sectors, private and public may procure from them.

**Placement of orders for maternal and RH medicines**

The management of supplies distribution including that of Medicines for maternal and reproductive health care is based on a dual ‘pull-push’ system since year 2010. The ‘push’ system is preferred for HCIIIs and HCIIIIs while for HCIVs and Hospitals, the ‘pull’ system is adopted. Under the push arrangement, medical kits are prepared at the NMS and pre-packed for delivery to HCIIIs and HCIIIIs. The quantification under the push system is an estimate of requirements based on past usage and the Health management information (HMIS) data that reflects client load. Under the pull system, HCIVs and hospitals raise order forms for their medicine requirements and submit them to the NMS for processing and delivery of the supplies.

The Essential Medicines and Health Supplies list of Uganda (EMHSLU) of 2012 provides a guide on which RH commodities are to be situated at which level of service delivery according to service requirements stipulated for the specific level. Similarly, the Uganda Clinical Guidelines (UCG) of 2012 provides guide for patient management including prescription of medicines to end users.



### 3 SURVEY FINDINGS FOR AVAILABILITY OF COMMODITIES AND SERVICES

#### 3.1 Geographic distribution of facilities

Out of the total 734 SDPs which participated in the survey, 258 (35%) were located in the urban areas while 476 facilities (65%) were in the rural areas. Most SDPs (84%) were primary, followed by secondary level (14%) and the tertiary level (2%). The regions with the highest number of SDPs in the survey were Kampala (19%), South Western (14%), and Eastern (13%) the least was in Karamoja (3%), Northern (6%) and West Nile (6%). In terms of management, 67% were managed by government, 20% were privately managed, 12% were NGO managed and only 1% was managed by others. The “others” include five SDPs that belonged to societies and local based groups not registered as NGOs.

**Table 4: Table on General Characteristics**

Characteristic	Urban		Rural		Total	
	No. of SDPs	%	No. of SDPs	%	No. of SDPs	%
<b>Type of facility</b>						
Primary SDP	192	26.2	425	57.9	617	84.1
Secondary SDP	56	7.6	48	6.5	104	14.2
Tertiary SDP	10	1.4	3	0.4	13	1.8
<b>Total</b>	<b>258</b>	<b>35.2</b>	<b>476</b>	<b>64.9</b>	<b>734</b>	<b>100.0</b>
<b>Administrative Unit (Region)</b>						
Kampala	140	19.1	2	0.3	142	19.4
Central 1	25	3.4	49	6.7	74	10.1
Central 2	21	2.9	45	6.1	66	9.0
East Central	15	2.0	52	7.1	67	9.1
Eastern	18	2.5	80	10.9	98	13.4
Karamoja	2	0.3	17	2.3	19	2.6
Northern	3	0.4	43	5.9	46	6.3
West Nile	5	0.7	41	5.6	46	6.3
Western	13	1.8	60	8.2	73	10.0
South Western	16	2.2	87	11.9	103	14.0
<b>Total</b>	<b>258</b>	<b>35.2</b>	<b>476</b>	<b>64.9</b>	<b>734</b>	<b>100.0</b>
<b>Management of facility</b>						
Government	102	13.9	389	53.0	491	66.9
Private	122	16.6	26	3.5	148	20.2
NGO	32	4.4	58	7.9	90	12.3
Others	2	0.3	3	0.4	5	0.7
<b>Total</b>	<b>258</b>	<b>35.2</b>	<b>476</b>	<b>64.9</b>	<b>734</b>	<b>100.0</b>

#### 3.2 Distance of SDPs from the source of supplies

The distance from the SDPs to the source of supplies is important as it affects the time taken to deliver supplies. Table 5 below shows the average distance in kilometres from the source of supplies per type of SDP.

**Table 5: Distance from source of supply by SDP type**

Type of facility/SDP	Mean (Km)	95% Confidence Interval (CI) for Mean	
		Lower Bound (Km)	Upper Bound (Km)
Primary SDP (HCIIIs & HCIIIs)	59.8	51.0	68.6
Secondary SDP (HCIVs/ General Hospital)	81.3	53.5	109.0
Tertiary SDP (i.e. RRHs & NRHs)	154.5	14.3	294.7
<b>Overall</b>	<b>64.2</b>	<b>55.6</b>	<b>72.8</b>

From the survey, the average distance of the SDPs from the source of supplies was 64km. The primary SDPs on average were 60km from the source of supplies, the secondary SDPs were 81km and the tertiary SDPs were 154.50km on average from the source of supplies (Table 5 above). The long distance for tertiary level SDPs can be explained by the fact that they are distributed in the different regions of the country as regional/ national referrals and their main source is the National Medical Store (NMS) in Kampala. For example, Moroto RRH located in Karamoja region is very far from NMS in Kampala.

**Table 6: Distance from source of supply by administrative Unit**

Administrative Unit (Region)	Mean (km)	95% Confidence Interval (CI) for Mean	
		Lower Bound (Km)	Upper Bound (Km)
Kampala	7.3	1.6	12.9
Central 1	120.7	101.2	140.2
Central 2	62.5	50.5	74.5
East Central	28.6	17.9	39.3
Eastern	95.6	67.1	124.1
Karamoja	61.3	3.3	119.3
Northern	48.3	18.4	78.3
West Nile	102.1	47.5	156.6
Western	121.5	68.2	174.7
South Western	57.5	32.2	82.8
<b>Overall</b>	<b>64.2</b>	<b>55.6</b>	<b>72.8</b>

In terms of administrative units, Western (122km), Central 1 (120.67km), and West Nile (102km) have the highest average distance to the source of supplies. These regions are geographically distant from Kampala where majority of the SDPs get their supplies from the Central medical stores (NMS and JMS). Regions with the lowest distance included Kampala (7km), East Central (29km) and Northern region (48km). The average distance was lowest for SDPs located in Kampala mainly because it is the capital city where majority of the suppliers are located including the NMS and JMS.

**Table 7: Distance from source of supply by Location**

Location	Mean (km)	95% Confidence Interval (CI) for Mean	
		Lower Bound (Km)	Upper Bound (Km)
Urban	40.1	28.8	51.4
Rural	77.1	65.6	88.7
<b>Overall</b>	<b>64.2</b>	<b>55.6</b>	<b>72.8</b>

The SDPs located in the urban areas had an average distance of 40km to the source of supplies, while the rural SDPs on average had 77km. The main explanation is that the urban SDPs mainly get their supplies from the National Medical Stores (NMS) which supplies to mainly government managed health facilities. Other SDPs located in the urban areas also get from private suppliers and Joint Medical Stores (JMS) which mainly supplies privately owned SDPs.

### 3.3 Modern contraceptives offered by facilities

SDPs in Uganda provide modern contraceptives throughout the different levels of health facilities. The range of methods offered depends on the level and capacity of the facilities. The survey sought to establish the type of contraceptives offered at the different levels (primary, secondary and tertiary). The modern FP methods included in the assessment were nine, namely; Male condoms, Female condoms, Oral contraception, injectables, emergency contraception, IUDs, implants, sterilization for females (Bilateral tubal ligation), and sterilization for males (Vasectomy).

The proportion of SDPs offering at least three types of modern contraceptives was assessed. Key findings are presented in the table 8 below:

**Table 8: Primary SDPs offering at least three types of contraceptives**

Characteristic	SDP offers up to Two modern contraceptive methods (%)	SDP offers THREE and more (at least three) modern contraceptive methods (%)	Total (%)	No. of SDPs
<b>Type of Facility</b>				
Primary SDP	17.1	82.9	100	486
<b>Region</b>				
Kampala	27.0	73.0	100	89
Central 1	21.2	78.9	100	52
Central 2	14.7	85.3	100	34
East Central	7.4	92.6	100	54
Eastern	8.6	91.4	100	70
Karamoja	46.1	53.9	100	13
Northern	47.6	52.4	100	21
West Nile	7.4	92.6	100	27
Western	7.3	92.7	100	55
South Western	15.5	84.5	100	71
<b>Residence</b>				
Urban	20.6	79.4	100	146
Rural	15.6	84.4	100	340
<b>Management</b>				
Government	15.6	84.4	100	359
Private	25.9	74.1	100	85
NGO	12.5	87.5	100	40
Others	0.0	100.0	100	2

Characteristic	SDP offers up to Two modern contraceptive methods (%)	SDP offers THREE and more (at least three) modern contraceptive methods (%)	Total (%)	No. of SDPs
<b>Distance from nearest warehouse/source of supplies (in Km).</b>				
≤ 4	19.5	80.5	100	82
5-9	17.9	82.1	100	67
10-14	12.5	87.5	100	40
15-19	10.5	89.5	100	19
10-24	21.7	78.3	100	23
25-29	21.7	78.3	100	23
30-34	20.8	79.2	100	24
35-39	11.1	88.9	100	9
40-44	10.0	90.0	100	10
45-49	8.3	91.7	100	12
≥ 50	19.5	80.5	100	101
<b>Total</b>	<b>17.1</b>	<b>82.9</b>	<b>100</b>	<b>486</b>

The percentage of Primary SDPs offering at least three modern contraceptive methods was 83% while those that did not offer at least three modern methods were 17% as shown in Table 8 above. In terms of regions, 93% of SDPs from Western, West Nile, East central and 91% from Eastern reported to be providing at least three modern methods. The regions with the highest percentages of SDPs not providing at least three modern methods were Northern (48%), Karamoja (46%). In terms of residence, 21% of the urban based SDPs were not providing at least three methods, while only 16% in the rural areas were not offering at least three methods. In terms of ownership, Government owned SDPs that were not offering at least three modern contraceptive methods were 16%. The privately owned were 26% and 13% were NGO managed.

The distance from the nearest warehouse/source of supplies did not have much impact on the offering of up to three modern contraceptives. Table 8 below also shows that the SDPs that were located within four kilometre radius of the from nearest warehouse/source of supplies had 20% of SDPs not offering up to three methods, which is more or less the same with facilities that were located 50km or more from the source (20%).

**Table 9: Secondary and Tertiary SDPs offering at least five types of contraceptives**

Characteristics	SDP offers up to four modern contraceptive methods (%)	SDP offers FIVE and more (at least five) modern contraceptive methods (%)	Total (%)	No. of SDPs
<b>Type of facility</b>				
Secondary SDP	26.5	73.5	100	83
Tertiary SDP	15.4	84.6	100	13
<b>Region</b>				
Kampala	47.4	52.6	100	19
Central 1	16.7	83.3	100	12
Central 2	16.7	83.3	100	6

East Central	25.0	75.0	100	8
Eastern	18.2	81.8	100	11
Karamoja	0.0	100.0	100	2
Northern	50.0	50.0	100	6
West Nile	16.7	83.3	100	6
Western	12.5	87.5	100	8
South Western	16.7	83.3	100	18
<b>Residence</b>				
Urban	20.0	80.0	100	55
Rural	31.7	68.3	100	41
<b>Management</b>				
Government	25.4	74.6	100	71
Private	35.3	64.7	100	17
NGO	0.0	100.0	100	7
Others	0.0	100.0	100	1
<b>Total</b>	<b>25.0</b>	<b>75.0</b>	<b>100</b>	<b>96</b>

The secondary and tertiary SDPs that offered at least five or more modern contraceptive methods were 75% in comparison with 25% that did not offer up to five modern methods as shown in Table 9 above. In terms of secondary SDPs, 74% offered five and more (at least five) modern methods while 85% of the tertiary SDPs offered five and more (at least five) modern contraceptive methods. In terms of regional distribution, the Northern (50%), Kampala (47%) had the highest percentage of SDPs at the secondary and tertiary level that did not offer up to five modern methods. Karamoja (100%), Western (88%) had the highest percentage of SDPs offering at least five or more modern FP methods.

Table 9 above also shows that nearly 32% of the SDPs located in the rural areas offered up to four modern contraceptive methods only, while 20% of the SDPs in the urban areas offered up to four modern contraceptive methods. In terms of management of SDP, the government SDPs that did not offer up to four modern contraceptive methods was 25% as compared to the 35% privately owned SDPs. All the 7 NGO managed SDPs offered at least five or more modern FP methods.

### 3.3.3 Reasons for not offering certain contraceptives

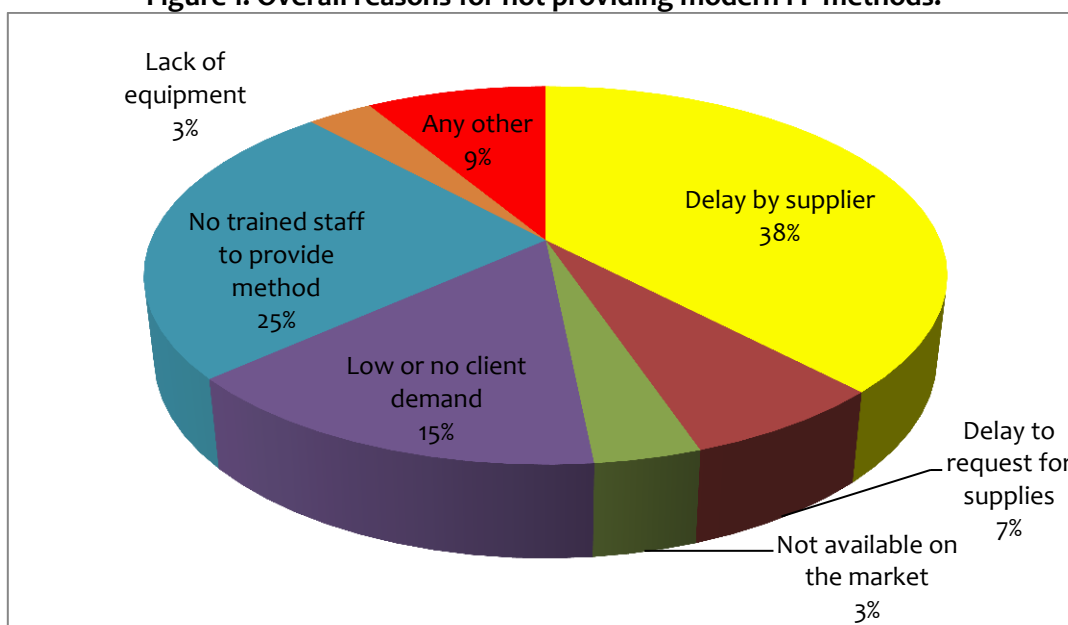
The study examined reasons why some SDPs were not offering certain contraceptives methods while the national guidelines and protocols required them to do so. A range of reasons had been predetermined and respondents were expected to choose which one applied to a specific method, as shown in the table 10 below.

**Table 10: Reasons for not offering certain contraceptives**

Main reason why the health facility does not offer the FP method to clients yet <b>SDP is supposed/ expected to offer it, in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery.</b>	Family Planning method							
	Male Condoms	Female Condoms	Oral Pills	Injectables	IUDs	Implants	Sterilization for Females	Sterilization for Males
1. Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive	75.0	30.2	76.2	64.5	29.9	23.0	2.5	1.2
2. Delays by this SDP to request for supply of the contraceptive	2.8	2.9	9.5	19.4	6.9	7.9	3.8	2.4
3. The contraceptive is not available in the market for the SDP to procure	2.8	1.2	1.2		3.5	5.6	6.3	8.5
4. Low or no client demand for the contraceptive	16.7	53.1	6.0	12.9	7.6	4.0	6.3	13.4
5. No trained staff to provide this contraceptive at the SDP		2.0	1.2		32.6	38.1	64.6	59.8
6. Lack of equipment and/or consumables for the provision of this contraceptive					9.0	8.7	3.8	3.7
7. Other reason specified.	2.8	10.6	6.0	3.2	10.4	12.7	12.7	11.0
<b>Total Number of SDPs (n)</b>	<b>36</b>	<b>245</b>	<b>84</b>	<b>31</b>	<b>144</b>	<b>126</b>	<b>79</b>	<b>82</b>

The main reason given for not providing male condoms was the delay on the part of the main source institution/warehouse to re-supply the SDP with Contraceptives (75%) while 17% reported that there was low or no client demand for the male condoms as shown in table 10 above. Karamoja region had the highest number of SDPs reporting low or no demand for male condoms. Female condoms were not offered mainly because of low demand (53%) and delays on the part of the main source institution/warehouse to re-supply SDPs with this contraceptive (30%). The reasons for not offering Oral pills and injectable were mainly because of the delay on the part of main source institution/warehouse to re-supply SDPs (76% and 66% respectively). In terms of IUDs and Implants, the main reasons given for not offering were the lack of trained staff to provide the service (33% and 38%) respectively, and delays on the part of the main source institution/warehouse to re-supply SDPs (30% and 23%) respectively. In terms of sterilization for men and women, the main reason for not offering this was lack of trained personnel to provide the FP method (65% and 60% respectively).

**Figure 1: Overall reasons for not providing modern FP methods.**



Results shown in figure 1 above, as generated using multiple response analysis technique in SPSS 17, revealed that the overall reasons for not offering certain contraceptives was mainly the delay by the main source institution/warehouse to re-supply SDPs with the contraceptives (38%), the lack of trained staff to provide some methods (25%) like (male and female sterilization), and the low or no client demand (15%) this was common with the female condom. Any other reasons accounted for 9% and this included reason such as religious reasons, lack of sensitization for clients, theatres being non-functional or un-operational to handle some methods.

### 3.4 Availability of maternal and RH medicines

The maternal and RH medicines are important in helping mothers to be safe as well as their babies, to ensure that the indicator on maternal and child mortality are achieved as spelled out by the MoH. The Health facility survey assessed the available maternal and RH medicines in the different SDPs. The medicines assessed were the Seven (including the 2

essential) lifesaving maternal/reproductive health medicines (Ampicilin, Azithromycin, Benzathine, Benzylpenicilin Betamethasone, Calcium gluconate, Cefixime, Gentamicin, Hydralazine, and magnesium sulfate).

### 3.4.1 Maternal and RH medicines available by types of facility

**Table 11: Percentage distribution of service delivery points with seven (Including 2 essential) lifesaving maternal/reproductive health medicines**

Characteristic	Seven (including 2 essential) life-saving maternal/reproductive health medicines available (%)	Seven (including 2 essential) life-saving maternal/reproductive health medicines not available (%)	Total (%)
<b>Type of facility</b>			
Primary SDP	55.8	44.2	100
Secondary SDP	83.7	16.3	100
Tertiary SDP	90.9	9.1	100
<b>Region</b>			
Kampala	32.9	67.1	100
Central 1	67.7	32.3	100
Central 2	70.6	29.4	100
East Central	43.6	56.4	100
Eastern	53.3	46.7	100
Karamoja	52.9	47.1	100
Northern	66.7	33.3	100
West Nile	77.1	22.9	100
Western	88.5	11.5	100
South Western	82.6	17.4	100
<b>Residence</b>			
Urban	54.4	45.6	100
Rural	65.4	34.6	100
<b>Management</b>			
Government	67.3	32.7	100
Private	44.3	55.7	100
NGO	52.2	47.8	100
Others	80.0	20.0	100
<b>Total</b>	<b>61.6</b>	<b>38.4</b>	<b>100</b>

In terms of availability of maternal and RH medicines (including the 2 essential lifesaving drugs maternal/reproductive health medicines, 62% of the facilities offered at least seven including the two essential drugs, while 38% did not offered at least seven including the two essential drugs as shows in Table 11 above. In terms of the level of facility, 90% of Tertiary level SDPs, 84% of secondary and 56% of primary SDPs offered at least seven including the two essential drugs. Most regions had over half of the SDPs offering at least seven including the two essential drugs, for example, western (88%), southwestern (83%), west Nile (77%) and Central 2 (71%), Central (68%), Eastern (53%), and Karamoja (53%). In terms of the rural-urban divide, 54% of SDPs in the urban and 65% of SDPs located in the rural areas offered at least seven including the two lifesaving drugs. In terms of ownership, 67% of government, 52% of NGO and 44% privately owned SDPs offered the seven lifesaving drugs including the two essential drugs.



**3.4.2 Reasons for not offering certain lifesaving maternal and RH medicines**

Table 12 below shows the main reasons why the SDPs do not offer the **Maternal/RH medicines** to clients yet they are expected to offer them, in line with the current national protocols, guidelines and/or laws specific for this level of service delivery.

**Table 12: Reasons for not offering certain lifesaving maternal and RH medicines**

Main reason why the health facility does not offer the Maternal/RH Medicines FP method to clients yet <b>SDP is supposed/ expected to have available this medicine (in line with current national guidelines, etc.)</b>	Maternal/RH Medicines (%)																
	(1) Ampicillin	(2) Azithromycin	(3) Benzathinebenzyl penicillin	(4) <u>Either</u> Betamethasone <u>Or</u> Dexamethasone	(5) Calcium gluconate	(6) Cefixime	(7) Gentamicin	(8) Hydralazine	(9) Magnesium sulfate	(10) Methyldopa	(11) Metronidazole	(12) Mifepristone	(13) Misoprostol	(14) Nifedipine	(15) Oxytocin	(16) <u>Either</u> Sodium chloride <u>Or</u> Sodium lactate compound solution	(17) Tetanus toxoid
Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine.	75.0	79.6	76.6	83.8	75.3	77.1	92.6	76.0	75.0	52.7	61.3	31.5	62.7	74.2	80.0	73.2	51.85
Delays by this SDP to request for supply of the medicine	15.4	14.3	8.5	4.4	11.2	6.6	3.7	10	10.4	10.1	38.7	7.9	12.7	6.5	15	4.9	11.11
The medicine is not available in the market for the SDP to procure	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.1	0.7	0.0	6.7	1.7	1.6	5.0	4.9	7.41
Low or no client demand for the medicine at the SDP.	1.4	0.0	4.3	4.4	5.6	4.9	3.7	8.00	10.4	7.4	0.0	12.4	4.2	6.5	0.0	4.9	11.11
No trained staff to provide this medicine at the SDP	1.4	1.4	4.3	4.4	2.3	4.9	0.0	6.0	4.1	0.0	14.6	4.2	1.6	0.0	2.4	3.70	
Any other reason	5.6	4.6	6.4	2.9	5.6	6.6	0.0	0.0	2.1	25.0	0.0	26.9	14.4	9.7	0.0	9.8	14.81
<b>Total Number of SDPs</b>	<b>72</b>	<b>147</b>	<b>47</b>	<b>68</b>	<b>89</b>	<b>61</b>	<b>27</b>	<b>50</b>	<b>48</b>	<b>148</b>	<b>31</b>	<b>89</b>	<b>118</b>	<b>62</b>	<b>20</b>	<b>41</b>	<b>27</b>

Overall, the main reason given for not offering maternal health medicines was the delay on the part of the supplier/warehouse (75%). The delay on the supplier’s side affected mostly Gentamicin (93%), Betamethasone or Dexamethasone (84%). Delays on the part of the SDP to request a supply (11%) and Low or no client demand for the medicine at the SDP (11%) are the other main reasons for not providing some of the maternal health drugs. The Other reasons specified were (lack of storage facilities, not being included on order forms, and drugs being expensive).

### 3.5 Incidence of No Stockouts of modern Contraceptives

The percentage distribution of service delivery points with ‘No stock-out’ of a modern contraceptive method in the last six months by type of facility was determined. Table 13 below shows the percentage of facilities that had one or more of the contraceptive methods out of stock on a given day of the last six methods before the survey. “No stock-out” meant that all the contraceptive methods offered by the SDP were available in stock on all days in the last six months preceding the survey.

**Table 13: Percentage distribution of service delivery points with “no stock-out” of modern contraceptive method in the last six months by type of facility**

Characteristic	Percentage (%)		
	One or more of the contraceptive methods offered by this SDP has been out-of-stock on a given day in the last six months preceding the survey <sup>5</sup> .	All contraceptive method offered by this SDP has been available/ in-stock on all days in the last six months preceding the survey <sup>6</sup> .	Total
<b>Type of facility</b>			
Primary SDP	82.0	18.0	100
Secondary SDP	64.8	35.2	100
Tertiary SDP	62.5	37.5	100
<b>Region</b>			
Kampala	67.2	32.8	100
Central 1	82.5	17.5	100
Central 2	54.6	45.5	100
East Central	93.6	6.5	100
Eastern	84.0	16.1	100
Karamoja	36.4	63.6	100
Northern	85.7	14.3	100
West Nile	72.4	27.6	100
Western	75.6	24.4	100
South Western	86.1	14.0	100

<sup>5</sup> Therefore, this SDP experienced stock-out in the last six months [STOCK-OUT WITHIN THE LAST SIX MONTHS]

<sup>6</sup> Therefore, this SDP did not experience stock-out in the last six months [NO-STOCK-OUT WITHIN THE LAST SIX MONTHS].

Characteristic	Percentage (%)		
	One or more of the contraceptive methods offered by this SDP has been out-of-stock on a given day in the last six months preceding the survey <sup>5</sup> .	All contraceptive method offered by this SDP has been available/ in-stock on all days in the last six months preceding the survey <sup>6</sup> .	Total
<b>Residence</b>			
Urban	73.5	26.5	100
Rural	81.7	18.3	100
<b>Management</b>			
Government	80.8	19.2	100
Private	71.7	28.3	100
NGO	83.3	16.7	100
Others	0.0	100.0	100
<b>Distance from nearest warehouse /source of supplies (in Km)</b>			
≤ 4	68.8	31.3	100
5-9	87.3	12.7	100
10-14	89.2	10.8	100
15-19	71.4	28.6	100
20-24	71.4	28.6	100
25-29	76.5	23.5	100
30-34	84.2	15.8	100
35-39	100.0	0.0	100
40-44	87.5	12.5	100
45-49	77.8	22.2	100
≥ 50	80.5	19.5	100
<b>Total</b>	<b>79.2</b>	<b>20.8</b>	<b>100</b>

Results of the survey revealed that 79% of the SDPs had a stock-out of one or more methods in the last six months preceding the survey, while 21% did not have a stock-out. SDPs that had no stock-out were only 18% at primary, 35% at secondary and 38% at tertiary level. In terms of regions, SDPs with a high stock-out were common in East Central (94%), South Western (86%), Northern (86%), and Eastern (84%). In terms of residence, the urban SDPs had 74% with stock-out while the Rural based had 82% stock-out. The main reason for this could be linked to the fact that delays by suppliers to deliver affect the rural based SDPs mostly because of the long distance and lack of alternative suppliers within the rural areas. In management of facilities, the NGO managed SDPs had the highest stock-out (83%), followed by government owned SPDs (81%) and the privately owned (72%). In terms of distance, there was a slight trend of stock-outs increasing as the distance increases. For example for SDPs located within 19km utmost distance from the sources, the stock-out rate was 79%, but between 20km -44km of distance, the stock-out increased to 83%.

### 3.6 Supply Chain, including cold chain

The National Drug Policy, operationalised through the Uganda Pharmaceutical Sector Strategic Plan, aims at ensuring the availability and accessibility at all times of adequate quantities of affordable efficacious, safe and good quality essential medicines and health supplies to all who need them. This is a basic requirement for the delivery of the Uganda National Minimum Health Care Package (UNMHCP). Public sector national medicines procurement is mainly through National Medical Stores (NMS), a parastatal organization. NMS statute no. 12 of 1993 mandates NMS to procure and distribute essential medicines nationwide. NMS handles about 50 percent of the volume of essential medicines and health supplies for the public sector (MoH 2010); various other organizations and MoH programs also store and distribute medicines for the public sector. Examples are the Malaria Control Program, which distributes mosquito nets from the Global Fund; UNEPI, which continues to manage vaccines; and Medical Access (U) Ltd, which play a significant role in the supply chain of contraceptives and Joint Medical Store (JMS) which distributes for the PNFP sector.

In this section we show the results of the survey regarding the process of supply chain management, including who determines supplies or who quantifies, who transports and whether cold chain facilities are in place and how they are powered.

#### 3.6.1 Responsibility for ordering of supplies

The national distribution system channels both contraceptives, and other RH Commodities alongside other drug supplies, through National Medical Stores. The ‘pull’ based ordering system used by some facilities aimed to reduce wastage and relies heavily on the capacity in facilities to manage orders and logistics. Table 14 below presents the persons responsible for ordering medical supplies disaggregated by characteristic (i.e level of facility, region, residence, management of SDPs).

**Table 14: Percentage distribution of SDPs with persons responsible for ordering medical supplies by type of SDPs**

Characteristics	Percentage (%)						No. of SDPs
	Medical Doctor	Clinical Officer	Pharmacist	Nurse	Others	Total	
<b>Type of facility</b>							
Primary SDP	7.9	33.1	3.1	30.3	25.6	100	617
Secondary SDP	37.5	26.9	16.4	3.9	15.3	100	104
Tertiary SDP	23.1	7.7	61.5	0.0	7.7	100	13
<b>Region</b>							
Kampala	23.9	15.5	7.8	38.7	14.1	100	142
Central 1	14.9	33.8	0.0	27.0	24.3	100	74
Central 2	12.1	33.3	9.1	25.8	19.7	100	66
East Central	7.5	23.9	9.0	29.8	29.8	100	67
Eastern	11.2	44.9	5.1	16.3	22.5	100	98
Karamoja	10.5	10.5	10.5	21.1	47.4	100	19
Northern	2.1	58.3	10.4	16.7	12.5	100	48
West Nile	13.6	13.6	6.8	36.4	29.6	100	44
Western	5.5	56.1	1.4	13.7	23.3	100	73
South Western	8.7	26.2	4.9	23.4	35.9	100	103
<b>Residence</b>							
Urban	21.5	21.9	9.2	27.7	19.6	100	260
Rural	7.4	37.1	4.2	25.1	26.2	100	474
<b>Management</b>							
Government	9.2	35.9	5.3	20.7	28.9	100	491
Private	22.3	20.9	7.4	34.5	14.9	100	148
NGO	12.2	28.9	5.6	42.2	11.1	100	90
Others	40.0	0.0	40.0	0.0	20.0	100	5
<b>Total</b>	<b>12.4</b>	<b>31.7</b>	<b>6.0</b>	<b>26.0</b>	<b>23.8</b>	<b>100</b>	<b>734</b>

The capacity of persons responsible for ordering medical supplies is critical in the Logistics and supply chain management cycle. Table 14 above shows that the highest percentage of persons that ordered medical supplies are the clinical officers (32%) followed by the Nurse (26%), the medical officers (12%) the pharmacist at (6%). The other personnel accounted for 24% and these include (SDP in-charges, Midwives, procurement officers, DHOs, Laboratory assistants, Human resource officers, store keepers, Dispensers, and medical records officers).

In terms of residence the medical doctors order highest in the SDPs located in urban areas (22%) compared to 8% in the SDPs located in rural areas. This is explained by the fact that in Uganda and perhaps in other developing countries, health facilities located in rural areas are understaffed with Medical Doctors. In addition some Doctors also prefer to work in urban areas where they can serve as part time consultants for various privately managed SDPs. This also explains why there were more medical doctors (22%) making orders in the privately

managed SDPs compared to 9% in the ones owned by Government. The pharmacists have a similar trend to that of the Medical officers as described above. Ordering of medical supplies was mainly done by Clinical officer in SDPs located in the rural areas (37%) compared to 22% in the urban SDPs. This was because in Uganda the primary level SPDs are mainly headed by Clinical officers (In-charges of health facilities). The percentage of SPDs using nurses to order is almost equally distributed between urban and rural based SDPs at 28% and 25% respectively; however in terms of ownership, NGO owned facilities use more of the nurses (42%) compared to the privately owned that use 35% and those owned by government (21%).

### 3.6.2 How resupply is quantified by type of SDP

The study assessed how resupplies for contraceptives were determined per SDP, in terms of whether it was the staff members or another institution that determines the quantities for resupply. Table 15 below shows the results

**Table 15: How resupply is quantified**

Characteristics	Percentage (%)				No. of SDPs
	By staff member of the SDP	By institution or warehouse responsible for re-supply	Others	Total	
<b>Type of facility</b>					
Primary SDP	44.4	48.6	7.0	100	584
Secondary SDP	74.0	22.0	4.0	100	100
Tertiary SDP	100	0.0	0.0	100	13
<b>Region</b>					
Kampala	96.4	2.9	0.7	100	137
Central 1	39.4	59.2	1.4	100	71
Central 2	61.0	37.3	1.7	100	59
East Central	38.5	40.0	21.5	100	65
Eastern	30.5	51.6	17.9	100	95
Karamoja	50.0	31.3	18.7	100	16
Northern	51.1	46.7	2.2	100	45
West Nile	24.4	73.2	2.4	100	41
Western	39.1	56.5	4.4	100	69
South Western	28.3	68.7	3.0	100	99
<b>Residence</b>					
Urban	77.8	18.9	3.3	100	243
Rural	34.5	57.3	8.2	100	454
<b>Management</b>					
Government	32.1	59.3	8.6	100	486
Private	92.7	6.6	0.7	100	136
NGO	85.9	11.3	2.8	100	71
Others	75.0	25.0	0.0	100	4
<b>Total</b>	<b>49.6</b>	<b>43.9</b>	<b>6.5</b>	<b>100</b>	<b>697</b>

Resupplies for contraceptives are mainly quantified by staff members of the SDPs (50%) whereas 44% of SPDs use the warehouse or institutions responsible for resupply as shown in Table 15 above. Out of the SPDs that only used the warehouse or institutions responsible for

resupply, 59% were government owned SDPs, 7% were NGO owned and 11% were privately owned SDPs. However, the SDPs that only used staff members to quantify resupplies were mainly privately owned (93%), followed by NGO owned (86%), and Government owned (32%).

Most urban based SDPs (78%) use their staff members to quantify resupplies, while only 35% of the rural based SDPs use their own staff to determine quantities for resupply. Table 15 above also shows that SDPs in Kampala (97%) used mainly their staff members to quantify re-supply perhaps because most of them are privately owned and uses the pull system or purchase directly from wholesale Pharmacies while regions like West Nile (24%), South Western (28%), and Eastern (30%) have the lowest percentage of SDPs using their staff members for quantification of supplies.

### 3.6.3 Use of logistics forms

The use of logistics forms is standard practice today in the quantification and placing of orders for supplies to the respective responsible bodies. The availability of and use of logistical forms was assessed and results are shown table 16 below.

**Table 16: Availability of logistical forms for ordering supplies**

Characteristics	Percentage (%)			Total	No. of SDPs
	Yes (enumerator verified the availability of forms)	Yes (but availability not observed by enumerator)	No; there are no logistics forms in use		
<b>Type of SDP</b>					
Primary SDP	51.7	14.9	33.4	100	569
Secondary SDP	84.5	11.3	4.1	100	97
Tertiary SDP	51.7	14.9	33.4	100	13
<b>Region</b>					
Kampala	92.3	7.7	0	100	130
Central 1	43.9	10	46.1	100	71
Central 2	94.4	1.4	4.2	100	55
East Central	92.7	1.8	5.5	100	65
Eastern	32.3	38.5	29.2	100	96
Karamoja	55.2	17.7	27.1	100	19
Northern	63.2	31.6	5.2	100	41
West Nile	78.1	12.2	9.7	100	36
Western	61.1	5.6	33.3	100	71
South Western	36.6	21.1	42.3	100	679
<b>Residence</b>					
Urban	56.1	11	32.9	100	237
Rural	57.7	16.1	26.2	100	442
<b>Management</b>					
Government	58.9	14.7	26.4	100	462
Private	45.1	12	42.9	100	133
NGO	64.6	16.5	18.9	100	79
Others	100	0.0	0.0	100	5
<b>Total</b>	<b>57.1</b>	<b>14.3</b>	<b>28.6</b>	<b>100</b>	<b>679</b>

The use of Logistics form is a standard practice for ordering for supplies or for reporting. Out of the SDPs surveyed, 57% were verified to have had the logistics forms, while 14% said they had the forms but no verification was done as shown in Table 16 above. Nearly 29% of the SDPs had no logistics forms. In terms of residence, 33% of the urban based SDPs had no Logistics forms. The main reason being that majority of the health facilities located in the urban areas were at primary level and privately owned.

The NGO owned SPDs had the highest percentage that had verified availability of logistics forms (65%) followed by government (59%) and the private (45%). The low availability of logistics forms in the privately owned facilities is understandable as they normally have their own procurement processes that are different for Government. For example it was noted in the previous sections that while the privately owned SDPs take once a week to resupply, some of the government SDPs get resupplies once a year.

### 3.6.4 Main source of supplies type of SDPs

In Uganda, the main suppliers of contraceptives are the National Medical Store which supplies Reproductive health commodities including family planning methods to public health facilities and Medical Access Ltd which supplies to private facilities. An alternative distribution strategy was developed to improve the supply of contraceptives and it includes the Uganda Health Marketing Group (UHMG), Reproductive Health Uganda (RHU), Program for Access and Community Education (PACE), Marie Stopes Uganda (MSU) and Uganda Private Midwives Association (UPMA).

**Table 16.2: Main source of supplies for contraceptives per type of this facility**

Characteristics	Percentage (%)							Total	No. of SDPs
	Central Medical stores	Regional/district warehouse	Local medical store on site	NGO	Donors	Private source	Others		
<b>Type of facility</b>									
Primary SDP	49.4	19.3	5.1	3.5	1.8	20.7	0.2	100	545
Secondary SDP	59.6	5.3	5.3	9.6	1.1	19.1	0.0	100	94
Tertiary SDP	100	0.0	0.0	0.0	0.0	0.0	0.0	100	12
<b>Region</b>									
Kampala	10.2	0.9	2.6	5.1	5.1	75.2	0.9	100	117
Central 1	81.8	4.6	3.0	3.0	0.0	7.6	0.0	100	66
Central 2	79.6	7.4	3.7	5.6	3.7	0.0	0.0	100	54
East Central	34.3	39.1	1.6	9.4	0.0	15.6	0.0	100	64
Eastern	40.4	32.9	4.3	3.2	1.1	18.1	0.0	100	94
Karamoja	28.6	71.4	0.0	0.0	0.0	0.0	0.0	100	14
Northern	73.2	12.2	14.6	0.0	0.0	0.0	0.0	100	41
West Nile	79.1	13.9	0.0	4.7	0.0	2.3	0.0	100	43



Characteristics	Percentage (%)							Total	No. of SDPs
	Central Medical stores	Regional/district warehouse	Local medical store on site	NGO	Donors	Private source	Others		
Western	64.6	17.0	7.7	4.6	1.5	4.6	0.0	100	65
South Western	62.3	15.1	10.8	3.2	1.1	7.5	0.0	100	93
<b>Residence</b>									
Urban	35.3	5.5	5.1	4.1	3.2	46.3	0.5	100	218
Rural	60.1	22.6	5.1	4.4	0.9	6.9	0.0	100	433
<b>Management</b>									
Government	67.5	20.6	4.5	1.9	0.6	4.9	0.0	100	467
Private	9.3	2.5	4.2	6.0	5.1	72.0	0.9	100	118
NGO	17.8	17.7	8.1	16.1	3.2	37.1	0.0	100	62
Others	0.0	0.0	5.0	5.0	0.0	0.0	0.0	100	4
<b>Total</b>	<b>51.7</b>	<b>16.9</b>	<b>5.1</b>	<b>4.3</b>	<b>1.7</b>	<b>20.1</b>	<b>0.2</b>	<b>100</b>	<b>651</b>

The main source of supplies for contraceptives is the Central Medical Stores (52%), followed by the private source (20%), the regional/district warehouse (17%), and the local medical store on site (5%), NGO (4%), and donors (2%) as shown in Table 16.2 above. In terms of regions, the SDPs in Kampala mainly order from private sources (75%) largely because most of the SDPs in Kampala were privately owned. Most regions used Central medical stores as the main source of supplies, for example, Central 1 (82%), Central II (80%), West Nile (79%), and Northern (73%), Western (65%), and South western (62%). Karamoja region used the regional/district warehouse as the main source of supplies (71%).

In terms of residence, 60% of the facilities in the rural areas used the central medical stores compared to 35% of the urban based facilities as shown in Table 16.2 above. The government owned SDPs used the central medical stores (68%) while the Private owned (72%) and NGO (37%) used the private sources as the main source of supplies for contraceptives.

### 3.6.5 Responsibility for transportation of supplies by type of SDPs

In regard to the supply chain, the study examined the main institution (i.e. the national/central government, the local/district administration and or the facility) responsible for transporting products to the health facility. Results are indicated in Table 17 below.

**Table 17: Responsibility for transportation of supplies**

Characteristics	Percentage (%)				Total	No. of SDPs
	National/ central government	Local/district administration	By the facility	Others		
<b>Type of facility</b>						
Primary SDP	38.3	29.6	27.9	4.2	100	571
Secondary SDP	54.8	14.0	28.0	3.2	100	93
Tertiary SDP	100	0.0	0.0	0.0	100	11

Characteristics	Percentage (%)					No. of SDPs
	National/ central government	Local/district administration	By the facility	Others	Total	
<b>Region</b>						
Kampala	6.3	1.8	91.0	0.9	100	111
Central 1	71.6	11.9	13.4	3.0	100	67
Central 2	63.8	12.1	22.4	1.7	100	58
East Central	33.3	34.9	13.6	18.2	100	66
Eastern	32.6	50.0	13.3	4.1	100	98
Karamoja	16.7	72.2	11.1	0.0	100	18
Northern	64.3	28.5	2.4	4.8	100	42
West Nile	29.3	51.2	14.6	4.9	100	41
Western	49.3	27.4	19.2	4.1	100	73
South Western	56.4	26.7	16.8	0.0	100	101
<b>Residence</b>						
Urban	26.9	11.9	57.1	4.1	100	219
Rural	48.7	34.2	13.2	3.9	100	456
<b>Management</b>						
Government	56.4	36.0	5.9	1.7	100	472
Private	6.6	4.9	84.4	4.1	100	122
NGO	9.0	7.7	65.3	18.0	100	78
Others	0.0	0.0	100	0.0	100	3
<b>Total</b>	<b>41.6</b>	<b>27.0</b>	<b>27.4</b>	<b>4.0</b>	<b>100</b>	<b>675</b>

Overall, the main institution responsible for transportation of supplies/products to the SDPs was the National/central government (42%) through the National Medical Store, followed by Local/district administration (27%), the facilities themselves (27%) and the others (4%), for example, MSU, UHMG, Abacus Pharmacy. Table 17 above also shows that most of the regions transported products using the central government including; Central 1 (72%), Northern (64%), Central II (64% south western (56%). These have the highest percentage of SDPs using the Central government for transportation. Medical supplies in Kampala region were mainly transported by the health facility itself (91%). Medical supplies in Karamoja sub region were mainly transported by Local/district administration (72%). Karomoja (17%), West Nile (29%), Eastern (33%) have the least percentage of facilities using the National central government for transportation.

In terms of residence, the rural based SDPs (49%) used the central government for transportation while only 27% of the urban based SDPs used the national/central government to transport medical supplies. Most of the government facilities use National/central government (56%), while only 7% of privately owned and 9% of NGO owned facilities used the national/central government transportation. It follows that the privately and NGO owned facilities mainly used their own facilities to transport at 84% and 65% respectively.

### 3.6. 5: Estimated length of time between order and receiving of supplies by type of SDPs

The survey established the estimated length of time between order and receiving of supplies by type of SDPs. This is an important indicator of how supply chain is managed and the time it takes to receive supplies when an order is made.

**Table 18: Estimated Length of time between order and receiving of supplies**

Characteristics	Percentage (%)						Total	No. of SDPs
	Less than 2 weeks	More than 2 weeks but not up to 1 month	More than 1 month but not up to 2 months	More than 1 month but not up to 4 months	More than 4 months but not up to 6 months	More than 6 months		
<b>Type of facility</b>								
Primary SDP	27.7	13.9	7.8	24.5	7.8	18.3	100	552
Secondary SDP	33.3	22.6	8.8	22.6	5.8	6.9	100	102
Tertiary SDP	10.0	10.0	10.0	30.0	0.0	40.0	100	10
<b>Region</b>								
Kampala	85.6	8.5	3.4	0.8	0.0	1.7	100	118
Central 1	33.7	31.1	8.1	12.2	2.7	12.2	100	74
Central 2	8.8	22.8	7.0	36.8	7.0	17.5	100	57
East Central	7.6	7.6	4.5	54.5	7.6	18.2	100	66
Eastern	12.5	11.5	6.3	33.3	13.5	22.9	100	96
Karamoja	42.1	21.1	10.5	10.5	5.3	10.5	100	19
Northern	13.9	19.4	8.3	16.7	13.9	27.8	100	36
West Nile	22.6	16.1	0.0	45.2	3.2	12.9	100	31
Western	12.7	18.3	15.5	35.2	4.2	14.1	100	71
South Western	11.5	10.4	14.6	15.6	15.6	32.3	100	96
<b>Residence</b>								
Urban	57.9	12.3	6.1	14.0	2.2	7.5	100	228
Rural	12.8	16.7	8.9	29.6	10.1	21.8	100	436
<b>Management</b>								
Government	12.6	13.3	9.5	31.5	10.6	22.4	100	451
Private	74.4	13.2	3.9	4.6	0.8	3.1	100	129
NGO	39.2	29.1	6.3	16.5	0.0	8.9	100	79
Others	80.0	20.0	0.0	0.0	0.0	0.0	100	5
<b>Total</b>	<b>28.3</b>	<b>15.2</b>	<b>7.9</b>	<b>24.3</b>	<b>7.4</b>	<b>16.9</b>	<b>100</b>	<b>664</b>

The time it takes between ordering and receiving supplies is important as this determines whether services are offered on time when clients demand for them. As such, the estimated average time between ordering and receiving products was mainly less than 2 weeks for 28% of the SDPs, 24% took more than 1 month but not up to 4 months, 17% took more than 6 months and 15% took more than 2 weeks but not up to 1 month to receive supplies. In terms of type of regional distribution, 86% of the facilities in Kampala took less than two weeks to receive supplies after ordering. Table 18 also shows that only 8% of SDPs in East Central, 9% in

Central 2 and 13% in Western regions received supplies within two weeks after an order was placed. The argument is that privately owned facilities that dominate in Kampala, take a shorter time to receive their orders because it is privately done. Additionally, 31% and 22% of government owned facilities reported to receiving supplies between one and four months and more than six months respectively. The reason for delays to receive supplies at government hospitals is attributed to the many orders received by the Central medical stores and the processing time. In terms of Urban and rural divide, 58% of the urban SDPs receive orders within two weeks while those from the rural areas that receive orders in one week are 13%. This is because most of the rural SDPs are government owned and these take a longer time to receive supplies as already mentioned.

### 3.6.6 Frequency of resupply by Administrative Unit

How often resupplies are made was assessed and this was divided into five options from which the SDPs chose what mainly applied (Once every two weeks, once every month, once every three months, once every six months and once a year) as shown in the table 19 below.

**Table 19: Frequency of resupply by type of SDPs**

Characteristics	Percentage (%)					Total	No. of SDPs
	Once every two weeks	Once every month	Once every three months	Once every six months	Once a year		
<b>Type of facility</b>							
Primary SDP	12.3	5.2	11.1	11.1	60.3	100	522
Secondary SDP	14.6	10.4	17.7	8.3	49.0	100	96
Tertiary SDP	0.0	0.0	11.1	0.0	88.9	100	9
<b>Region</b>							
Kampala	57.5	19.2	14.9	2.1	6.3	100	94
Central 1	1.5	2.9	14.5	15.9	65.2	100	69
Central 2	8.0	6.0	10.0	20.0	56.0	100	50
East Central	2.9	0.0	9.0	6.0	82.1	100	67
Eastern	3.2	4.2	14.7	8.4	69.5	100	95
Karamoja	15.8	15.8	21.1	10.5	36.8	100	19
Northern	9.4	3.1	15.6	21.9	50.0	100	32
West Nile	2.8	2.9	5.7	2.9	85.7	100	35
Western	7.4	4.4	7.4	5.8	75.0	100	68
South Western	2.0	2.0	11.2	17.4	67.4	100	98
<b>Urban Rural</b>							
Urban	32.5	11.0	15.0	5.5	36.0	100	200
Rural	3.0	3.5	10.8	12.9	69.8	100	427
<b>Management</b>							
Government	4.8	2.9	9.1	11.3	71.9	100	442
Private	47.6	15.5	18.4	4.9	13.6	100	103
NGO	9.1	10.4	18.2	12.9	49.4	100	77
Others	20.0	0.0	60.0	20.0	0.0	100	5
<b>Total</b>	<b>12.4</b>	<b>5.9</b>	<b>12.1</b>	<b>10.5</b>	<b>59.0</b>	<b>100</b>	<b>627</b>

Overall, the frequency of resupply was once every two weeks for 12% of the SDPs, 59% received supplies once a year, 11% received supplies once every six months, and another 12% received supplies once every three months as shown in Table 19 above. The urban based SDPs received supplies once every two weeks (33%), and once every year (35%) while the rural based SDPs received supplies once every two weeks (3%) and once every year (70%). The government owned SDPs received supplies mainly once a year (72%), while the privately owned SPDs mainly received supplies once every week (48%).

### 3.6.7 Existence of Cold Chain at SDP

“Cold chain” refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines/medicines/POC consumables. The cold chain system requires that processes be in place to ensure that vaccines and medicines reach the recipients and also remain safe for use. Maintenance of a satisfactory temperature range will not only ensure that this occurs but will prevent potential costly wastage. In this survey, cold chain involved storage facilities at the health facilities. The study determined which SPDs had cold chains, what type of cold chain they used, and the source of power used.

**Table 20: Availability of cold chain by type of SDP**

Characteristics	Percentage (%)						No. of SDPs
	Type of cold chain available					Total	
	No cold chain available	Electric Fridge	Ice box (SDP have to regularly replenish ice supply)	Others	Sub Total of SDPs with cold chain		
<b>Type of Facility</b>							
Primary SDP	31.2	65.6	2.8	0.4	68.8	100	390
Secondary SDP	7.7	92.3	0.0	0.0	92.3	100	94
Tertiary SDP	0.0	100	0.0	0.0	100	100	13
<b>Region</b>							
Kampala	61.2	37.3	1.5	0.0	38.8	100	51
Central 1	25.7	74.3	0.0	0.0	74.3	100	50
Central 2	10.9	87.4	0.0	1.7	89.1	100	52
East Central	6.2	82.9	11.0	0.0	93.9	100	60
Eastern	19.4	76.3	3.2	0.0	80.6	100	75
Karamoja	5.6	88.1	6.3	0.0	94.4	100	15
Northern	17.0	83.0	0.0	0.0	83.0	100	36
West Nile	18.2	76.4	5.5	0.0	81.8	100	30
Western	26.0	72.6	1.4	0.0	74.0	100	54
South Western	28.2	71.8	0.0	0.0	71.8	100	74
<b>Urban Rural</b>							
Urban	41.6	57.6	0.8	0.0	58.4	100	142
Rural	19.6	76.8	3.2	0.5	80.4	100	355
<b>Management</b>							
Government	19.7	77.5	2.4	0.4	80.3	100	370
Private	56.4	41.4	2.2	0.0	43.6	100	59
NGO	24.1	73.5	2.4	0.0	75.9	100	64
Others	0.0	100	0.0	0.0	100	100	4
<b>Total</b>	<b>27.2</b>	<b>70.1</b>	<b>2.3</b>	<b>0.3</b>	<b>72.8</b>	<b>100</b>	<b>497</b>

Table 20 above shows that of all the SDPs surveyed, only 27% did not have cold chain facilities. The SDPs with no cold chain included 30% at primary, 8% at Secondary, while all of the tertiary SDPs had cold chain facilities.

In terms of regional distributions, Kampala (61%) had the highest percentage of SDP with no cold chain. This was because most SDPs in Kampala are HCIIIs which did not keep drugs/medicine in cold chains because they could easily access/purchase medicines from Pharmacies and or private clinics at the level of HCIIIs. Nearly 42% of the SDPs in the urban areas had no cold chain while only 20% of the SDPs in rural areas had no cold chain. Out of the 73% SDPs with cold chain, 70% used the electric fridge, while 3% use ice boxes. The SDPs reported to store a number of medicines in the cold chain including; Pitocin/ Oxytocin, Tetanus Toxoid (TT) Vaccines (e.g Polio, DPT, BCG, PCV, Measles), and Syrups.

### 3.6.8 Sources of Power for Fridge used for cold chain by type of SDP

The SDP was asked the main source of power if the cold chain was an electric fridge.

**Table 21: Source of power for Fridges used for cold chain by type of SDP**

Characteristics	Percentage (%)					Total	No. of SDPs.
	Electricity from national grid	Generator plant at the SDP	Kerosene/paraffin fuel	Electricity generated from solar panel	Others (Gas)		
<b>Type of Facility</b>							
Primary SDP	21.2	0.0	0.3	26.4	52.2	100	349
Secondary SDP	64.8	2.2	0.0	9.9	23.1	100	91
Tertiary SDP	92.3	0.0	0.0	7.7	0.0	100	13
<b>Region</b>							
Kampala	100	0.0	0.0	0.0	0.0	100	44
Central 1	44.2	0.0	0.0	7.0	48.8	100	43
Central 2	30.4	0.0	0.0	28.3	41.3	100	46
East Central	32.7	0.0	1.9	11.5	53.9	100	52
Eastern	14.1	0.0	0.0	14.1	71.8	100	71
Karamoja	0.0	7.7	0.0	30.8	61.5	100	13
Northern	17.2	0.0	0.0	44.8	37.9	100	29
West Nile	14.3	0.0	0.0	28.6	57.1	100	28
Western	22.6	0.0	0.0	43.4	34.0	100	53
South Western	27.0	1.4	0.0	29.7	41.9	100	74
<b>Urban Rural</b>							
Urban	74.0	0.0	0.8	8.7	16.5	100	127
Rural	15.6	0.6	0.0	27.9	55.8	100	326
<b>Management</b>							
Government	22.7	0.0	0.3	26.5	50.6	100	340
Private	83.0	0.0	0.0	5.7	11.3	100	53
NGO	39.3	3.6	0.0	12.5	44.6	100	56
Others	50.0	0.0	0.0	50.0	0.0	100	4
<b>Total</b>	<b>32.0</b>	<b>0.4</b>	<b>0.2</b>	<b>22.5</b>	<b>44.8</b>	<b>100</b>	<b>453</b>

Table 21 above shows that overall the main source of power for the fridge was the National grid (32%), followed by solar generated power (23%), among other sources, for example, gas cylinders (45%). All SDPs in Kampala region used electricity from the national grid as the main source of power. The regions that mainly used power from solar panels included Northern (45%), Western (43%), Karamoja (31%), and South Western (30%). Specifically, the urban based SDPs used mainly electricity from the national grid (74%) while the SDPs located in rural areas mainly used electricity from the national grid (16%). Most of the SPDs located in the rural areas used power from other sources (56%) such as gas.

### **3.7 Staff Training and Supervision**

Staff capacity is important in the provision of quality health services. GoU and its partners like UNFPA have continued to provide training to health workers to improve their capacities in the delivery of health services. Training of staff in providing FP services especially FP and removal of implants has been going on in various health facilities. As seen from the assessment, the lack of trained staff to provide some FP methods is a main cause of stock-outs for some methods. The survey therefore sought to establish the staff trained and whether they use the knowledge acquired to provide services.

Supervision and monitoring of performance is critical engagement spelled out in the HSSP III 2010/11-2014/15, where the system for the supervision, monitoring and evaluation of the health sector is spelt out. It clearly spells out three levels of supervision: (i) at the central level including central level institutions, (ii) local governments, and (iii) hospitals and lower level health units. The HSSP III recommended having quarterly Area Team reports, quarterly District Health Teams (DHTs) supervision reports, technical and support programme specific reports and Health Sub District monthly supervision reports.

This 2014 health facility survey further assessed the occurrence of supervision, the frequency (i.e the last time this facility was visited by a direct supervisory authority in the past 12 months with respect to RH including family planning) and issues included in the supervision of staff for reproductive health including FP in order to determine how well SDPs are provided with oversight and guidance.

#### **3.7.1 Availability of staff trained to provide FP services**

This was intended to determine whether staff trained to provide FP services specifically the removal and insertion of implants were available. Results are shown in the table 22 below.

**Table 22: Percentage of SDPs with staff trained to provide FP services including insertion and removal of Implants**

Characteristic	Percentage of SDPs with staff trained		Number of SDPs	
	To provide FP services	For the insertion and removal of Implants	With staff trained to provide FP services	With staff members trained for the insertion and removal of implants
<b>Facility type</b>				
Primary SDP	78.9	49.8	470	389
Secondary SDP	94.1	83.2	95	92
Tertiary SDP	100	100	13	13
<b>Region</b>				
Kampala	71.3	69.1	97	94
Central 1	84.9	84.9	62	62
Central 2	91.7	91.7	55	55
East Central	89.4	62.1	59	41
Eastern	88.5	57.3	85	55
Karamoja	83.3	83.3	15	15
Northern	87.0	86.7	40	40
West Nile	83.3	83.3	35	35
Western	72.9	60.0	51	42
South Western	77.5	53.9	79	55
<b>Residence</b>				
Urban	78.1	72.9	193	180
Rural	83.3	68.1	385	314
<b>Management</b>				
Government	85.6	71.8	416	348
Private	67.6	64.0	94	89
NGO	82.3	69.6	65	55
Others	60.0	40.0	3	2
<b>Total</b>	<b>81.5</b>	<b>69.8</b>	<b>578</b>	<b>494</b>

Table 22 above shows that overall, out of the total 578 SDPs (82%) which had staff trained to provide family planning services, a total of 494 SDPs (70%) had staff trained for the insertion and removal of implants. All the tertiary level facilities had staff trained in provision of FP services and insertion and removal of implants. At the primary level, out of the nearly 79 percent staff trained to provide FP services, 50% were trained to insert and remove implants..

In all regions, most facilities (over 50%) had staff trained to provide FP services including insertion and removal of implants. In the Eastern region, the difference between percentage of staff trained to provide FP services (89%), and insertion and removal of implants (57%) was highest (31%), followed by East Central (27%) and South West (24%).



The SDPs located in the rural areas had the highest number of staff trained to provide FP services (83%) out of which 68% were trained to insert and remove implants. The government facilities had the highest percentage of staff trained in provision of FP services (86%) including insertion and removal of implants (73%).

### 3.7.2 Trained staff who are actually providing services

Health facility staff who provide family planning services are expected to use the skill acquired to provide the services to clients at the SDP. Table 23 below shows the percentages of staff trained who were actually providing FP services and those who were not.

**Table 23: Trained staff in FP who are actually providing services**

Characteristic	Trained staff actually providing FP service (%)	Trained staff not actually providing FP service (%)	Total (%)	No. of SDPs
<b>Type of Facility</b>				
Primary SDP	51.9	27.1	79.0	428
Secondary SDP	75.9	18.2	94.1	88
Tertiary SDP	76.9	23.1	100.0	13
<b>Region</b>				
Kampala	52.4	18.9	71.3	83
Central 1	62.5	22.4	84.9	53
Central 2	74.0	17.6	91.7	52
East Central	61.3	28.1	89.4	54
Eastern	47.9	40.7	88.5	74
Karamoja	66.7	16.7	83.3	15
Northern	73.6	13.4	87.0	39
West Nile	47.2	36.1	83.3	30
Western	48.6	24.3	72.9	48
South Western	46.9	30.6	77.5	81
<b>Residence</b>				
Urban	56.0	22.1	78.1	173
Rural	55.7	27.6	83.3	356
<b>Management</b>				
Government	59.6	26.0	85.6	378
Private	44.8	22.8	67.6	86
NGO	53.1	29.2	82.3	62
Others	40.0	20.0	60.0	3
<b>Total</b>	<b>55.8</b>	<b>25.7</b>	<b>81.5</b>	<b>529</b>

Out of the 529 SDPs with facility staff trained to offer FP services, 56% were actually providing FP services in all regions. Overall, nearly 26% of trained staff were not actually providing the FP services. The main reasons why the trained staff did not actually provide FP services included the following:

- i. Staff not trained in provision of major FP methods leaving a gap in the skills acquired.
- ii. Lack of equipment or instrument for use to provide FP services

- iii. Lack of materials and consumables to use for FP services;
- iv. Low demand for FP services
- v. Understaffing where staff are engaged in other services rather than provision of FP
- vi. Internal staff rotations within the SDPs.

### 3.7.3 The last time staff received training for FP including provision of implants

The survey explored the last time when the health facility staff received training for provision of FP services including implants. The periods considered included; last two months, between two month and six months ago, between 6 months and one year ago and more than one year ago. Table 44 below shows the percentage distribution of the last time staff received training for FP including for insertion and removal of implants.

**Table 44: Percentage distribution of the last time staff received training for FP including insertion and removal of Implants.**

Characteristics	Percentage (%)						Training exercise included the insertion and removal of implant contraceptive
	In the last two months	Between two and six months ago	Between six month and one year ago	More than one year ago	Total	No. of SDPs	
<b>Type of Facility</b>							
Primary SDP	8.6	11.9	15.0	64.5	100	428	56.4
Secondary SDP	16.5	18.8	21.2	43.5	100	85	84.2
Tertiary SDP	0.0	50.0	30.0	20.0	100	10	83.3
<b>Region</b>							
Kampala	11.6	20.3	13.0	55.1	100	69	66.7
Central 1	14.3	3.6	10.7	71.4	100	56	82.1
Central 2	5.9	15.7	41.2	37.3	100	51	51.9
East Central	15.5	10.3	13.8	60.3	100	58	56.9
Eastern	4.7	11.8	15.3	68.2	100	85	52.4
Karamoja	14.3	35.7	7.1	42.9	100	14	85.7
Northern	11.8	20.6	23.5	44.1	100	34	62.5
West Nile	6.7	40.0	13.3	40.0	100	30	67.9
Western	8.0	8.0	20.0	64.0	100	50	58.0
South Western	9.2	5.3	6.6	79.0	100	76	54.0
<b>Residence</b>							
Urban	10.1	17.0	21.4	51.6	100	159	69.6
Rural	9.6	12.4	14.0	64.0	100	364	57.4
<b>Management</b>							
Government	9.0	13.4	16.2	61.4	100	389	60.3
Private	10.5	14.5	17.1	57.9	100	76	61.6
NGO	14.6	14.6	16.4	54.6	100	55	67.2
Others	0.0	33.3	0.0	66.7	100	3	66.7

Total	9.8	13.8	16.3	60.2	100	523	61.3
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Out of 523 SDPs which had staff trained in provision of FP, majority of them (60%) had this training conducted more than one year ago overall. Analysis based on each of the 10 regions revealed that most regions (6), that is, South Western (79%), Central 1 (71%), Eastern (68%), Western (64%), East Central (60%), and Kampala (55%), had most of the staff receive training for provision of FP, in the more than one year ago. Out of the staff trained to provide FP services, all the regions had more than 50% staff received a training exercise which included the insertion and removal of implant contraceptive. However, in Central 2 region 41% of SDP had their staff last trained between six months and one year.

In regard to level of SDP, majority of the trainings at primary (65%) and secondary SDP (44%) levels were done more than a year ago while at tertiary level, five out of 10 SDPs had their staff last trained between two and six months ago.

**Table 44 above also shows that overall, out of the staff trained to provide FP services, the training majority staff (61%) received training a training exercise which included the insertion and removal of implant contraceptive thus making the training exercise comprehensive in building skills of medical staff to offer the FP services.**

### 3.7.4 Time and Frequency of Supervision

The Health Sector Strategic Investment Plan (HSSIP) provides for support supervision in order to strengthen the quality of service delivery and reporting at all SDPs. The supervision is usually conducted by a higher supervisory authority. From the survey, the last time the SDP was supervised in the past 12 months prior to the survey was determined using the options of (less than one month, between one month and three months ago, between three and six months, between six month and one year , and not supervised in the past 12 months).

The 2014 health facility survey examined staff supervision for reproductive health including family planning. Table 24 below shows the percentage distribution of the last time the facility was visited by a direct supervisory authority in the past 12 months with respect to RH including family planning.

**Table 24: Percentage distribution of the last time the facility was supervised in the past 12 months with respect to RH including family Planning**

Characteristics	Last time the facility was supervised in the past 12 months (%)					Total (%)	No. of SDPs
	In less than one Month	Between one and three Months ago	Between three and six months ago	Between six month and one year ago	Not supervised in the past 12 month (%)		
Facility type							
Primary	22.7	26.9	11.0	8.3	31.2	100	581

Secondary	24.5	28.6	21.4	4.1	21.4	100	98
Tertiary	16.7	25.0	8.3	16.7	33.3	100	12
<b>Region</b>							
Kampala	8.1	8.1	8.9	8.1	66.9	100	124
Central 1	37.0	16.4	5.5	4.1	37.0	100	73
Central 2	10.3	43.1	17.2	15.5	13.8	100	58
East Central	13.6	50.0	12.1	6.1	18.2	100	66
Eastern	39.2	28.9	9.3	4.1	18.6	100	97
Karamoja	68.4	15.8	5.3	5.3	5.3	100	19
Northern	25.6	28.2	23.1	10.3	12.8	100	39
West Nile	25.6	53.5	9.3	7.0	4.7	100	43
Western	14.1	16.9	21.1	8.5	39.4	100	71
South Western	23.8	29.7	14.9	9.9	21.8	100	101
<b>Residence</b>							
Urban	16.0	18.5	12.6	7.6	45.4	100	238
Rural	26.5	31.6	12.4	8.0	21.6	100	453
<b>Management</b>							
Government	25.6	29.0	13.7	7.9	23.9	100	469
Private	13.5	12.8	7.5	9.0	57.1	100	133
NGO	21.4	38.1	14.3	6.0	20.2	100	84
Others	40.0	40.0	0.0	0.0	20.0	100	5
<b>Total</b>	<b>22.9</b>	<b>27.1</b>	<b>12.5</b>	<b>7.8</b>	<b>29.8</b>	<b>100</b>	<b>691</b>

Out of 691 facilities surveyed, 70% of the SDPs had received support supervision. About 27% of primary SDP, 29% of secondary SDP and 25% of tertiary SDPs had their supervisions conducted between one month and three months prior to day of survey as shown in Table 24 below. In Karamoja region, majority of the SDP (68%) had these supervisions conducted in less than a month prior to the survey. Important to note is that about 30% of SDPs had not been supervised in the last 12 months by their respective supervisory authority.

### Frequency of supervision visits

The survey assessed how frequent supervision was made by a direct authority in the past 12 months with respect to RH including family planning. The frequency was categorized as; weekly, monthly, every three months, every six month and once a year. Table 25 below shows the percentage distribution of the frequency of supervisory visits at SDP within the periods mentioned above.

**Table 25: Frequency of supervisory visits**

Characteristics	Frequency of supervisory visits (%)					Total (%)	No. of SDPs
	Monthly	Every two to three months	Every four to six months	Every seven to nine months	Every eight to twelve months		
<b>Facility Type</b>							
Primary	27.4	42.9	18.3	2.3	9.1	100	394
Secondary	28.2	39.4	29.6	0.0	2.8	100	71
Tertiary	33.3	33.3	0.0	16.7	16.7	100	6
<b>Region</b>							
Kampala	12.8	38.5	30.8	5.1	12.8	100	39
Central 1	50.0	31.8	13.6	0.0	4.6	100	44
Central 2	6.1	44.9	24.5	0.0	24.5	100	49
East Central	39.6	43.8	12.5	0.0	4.2	100	48
Eastern	25.9	50.6	14.1	0.0	9.4	100	85
Karamoja	52.6	26.3	5.3	10.5	5.3	100	19
Northern	48.3	37.9	6.9	6.9	0.0	100	29
West Nile	26.3	63.2	7.9	2.6	0.0	100	38
Western	23.3	37.2	32.6	4.7	2.3	100	43
South Western	19.5	36.4	32.5	1.3	10.4	100	77
<b>Residence</b>							
Urban	24.8	36.8	25.6	3.2	9.6	100	125
Rural	28.6	44.2	17.6	1.7	7.8	100	346
<b>Management</b>							
Government	28.3	43.3	19.0	1.4	7.9	100	353
Private	31.5	27.8	22.2	7.4	11.1	100	54
NGO	18.0	49.2	23.0	1.6	8.2	100	61
Others	66.7	33.3	0.0	0.0	0.0	100	3
<b>Total</b>	<b>27.6</b>	<b>42.3</b>	<b>19.8</b>	<b>2.1</b>	<b>8.3</b>	<b>100</b>	<b>471</b>

Overall, the SDPs received the direct supervisory visits from the authorities mainly every two to three months (42%), followed by the monthly visits (28%), every four to six months (20%) and the least was every seven to nine months (2%).

Table 46 above also shows that at facility level, primary SDPs received supervisory visits mainly every two to three months (43%), followed by monthly visits (27%) among others. The secondary SDPs received supervisory visits mainly every two to three months (40%), followed by every four to six months (30%), and monthly (28%) among others. The tertiary SDPs received supervisory visits mainly on a monthly basis (33%) and every two to three months (33%) among others. At regional level, most SDPs were visited every two to three months in West Nile (63%), and Eastern (51%). In addition, most SDPs were mainly visited monthly especially in Karamoja (53%), Central 1 (50%) among others.

Results in Table 25 also show that health facilities received supervisory visits every two to three months (44%) in the rural areas as compared to 37% in the urban areas. In addition, health facilities located in urban areas were visited every four to six months (26%) and nearly 1 in every four SDPs were visited monthly (25%) which was less than the monthly supervisory visits to SDPs located in the rural areas (27%). The SDPs under other management received supervisory visits mainly on a monthly basis (67%), followed by the private (32%) and government (28%) among others. SDPs under NGO management mainly received visits every two to three months (50%), followed by government (43%) among others.

### 3.7.5 Issues included in supervisory visits for reproductive health including FP

In conducting supervision, the supervising authority uses a supervision tool based on supervision objectives to systematically execute the task. This survey also assessed whether the following issues were included in the supervision; staff clinical practices, drug stock-out and expiry, staff availability and training, data completeness, quality, and timely reporting, review and use of specific guideline or job aids for reproductive health. Table 26 below gives the details of the assessment.

**Table 26: Issues included in the supervision of staff for reproductive health including FP**

Characteristics	Staff clinical practices	Drug stock out and expiry	Staff availability and training	Data completeness, quality, and timely reporting	Review use of specific guideline or job aid for reproductive health	Others	Total (%)	No. of SDPs
<b>Facility type</b>								
Primary	38.8	20.6	14.8	16.9	5.5	3.4	100	379
Secondary	42.3	15.5	11.3	21.1	8.5	1.4	100	71
Tertiary	50.0	25.0	12.5	12.5	0.0	0.0	100	8
<b>Region</b>								
Kampala	73.5	11.8	8.8	2.9	2.9	0.0	100	34
Central 1	45.0	7.5	20.0	27.5	0.0	0.0	100	40
Central 2	23.4	23.4	34.0	4.3	14.9	0.0	100	47
East Central	22.2	14.8	7.4	51.9	1.9	1.9	100	54
Eastern	31.7	12.7	7.6	20.3	12.7	15.2	100	79
Karamoja	64.7	29.4	5.9	0.0	0.0	0.0	100	17
Northern	13.8	34.5	27.6	10.3	13.8	0.0	100	29
West Nile	53.2	18.4	10.5	5.3	2.6	0.0	100	38
Western	69.1	14.3	2.4	9.5	4.8	0.0	100	42
South Western	28.2	34.6	18.0	16.7	1.3	1.3	100	78
<b>Residence</b>								
Urban	51.7	15.8	11.7	10.0	6.7	4.2	100	120
Rural	35.2	21.3	15.1	20.1	5.6	2.7	100	338
<b>Management</b>								
Government	37.4	20.8	15.8	17.9	5.9	2.4	100	341
Private	61.5	15.4	5.8	11.5	1.9	3.9	100	52
NGO	34.4	19.7	13.1	19.7	8.2	4.9	100	61
Others	25.0	0.0	0.0	25.0	25.0	25.0	100	4
<b>Total</b>	<b>39.5</b>	<b>19.9</b>	<b>14.2</b>	<b>17.5</b>	<b>5.9</b>	<b>3.1</b>	<b>100</b>	<b>458</b>

From this survey, the most frequent issues included in the supervision were staff clinical practice (39%) followed by drug stock-out and expiry (20%), data completeness quality and timely reporting (17%) and staff availability and training (15%) across all types of SDPs, region and location and management. About 34% SDPs in Northern and 35% SDP in South Western regions had drug stock-out and expiry more frequently included in support supervision while in Central 2 staff availability and training occurred more frequently included in support supervision. Staff clinical practice issues were more common (52%) in the urban based SDPs as compared to the rural based SDPs (35%), while drug stock-out issues were more common in the rural based SDPs (21%) as compared to the urban based SDPs (16%).

### 3.8 Availability of guidelines, Checklists and Job aids

The Guidelines, checklist, job-aids are important tools that facilitate quality service provision by acting as reference materials for the health worker while providing services to a client. The survey assessed the availability of these tools. Table 27 below shows results of this assessment;

**Table 27: Percentage of SDPs with guidelines, check-lists and job aids**

Percentage Availability of guidelines, check-lists and job aids										
Characteristics	Facility has available family planning guidelines (National or WHO)	Facility has available family planning check-lists and/or job-aids	Facility has available maternal health (including PNC and ANC) guidelines (National or WHO)	Facility has available maternal health (including PNC and ANC) check-lists and/or job-aids	Facility has available HIV/AIDS (including PMTCT, ART etc.) guidelines (National or WHO)	Facility has available HIV/AIDS (including PMTCT, ART etc.) check-lists and/or job-aids (National or WHO)	Facility has available national Waste disposal guideline	Facility has available national waste disposal check-lists and/or job-aids	Facility has available infection prevention and control guideline	Facility has available infection prevention and control check-lists and/or job-aids
<b>Facility Type</b>										
Primary SDP	59.5	51.3	48.8	45.8	57.6	56.1	50.8	46.6	50.6	47.8
Secondary SDP	73.3	74.0	70.3	70.3	88.4	86.4	77.5	66.7	78.6	72.8
Tertiary SDP	100.0	51.3	84.6	84.6	100.0	92.3	100.0	92.3	92.3	84.6
<b>Region</b>										
Kampala	51.5	92.3	20.9	27.4	26.3	32.6	35.3	40.3	40.3	46.0
Central 1	63.5	52.6	60.8	63.5	77.0	78.4	63.5	63.0	64.9	63.5
Central 2	63.6	60.8	58.5	56.9	72.7	72.3	68.2	63.6	62.1	62.1
East Central	81.8	62.1	57.6	31.8	71.2	53.0	83.3	37.9	77.3	36.4
Eastern	75.3	39.4	71.4	63.9	80.6	71.4	69.4	51.0	75.5	66.3
Karamoja	83.3	65.3	82.4	100.0	83.3	77.8	55.6	66.7	55.6	61.1
Northern	80.9	83.3	82.6	85.1	85.1	89.4	76.6	72.3	72.3	74.5
West Nile	64.3	78.3	72.7	65.1	88.6	81.8	47.7	50.0	51.2	53.5
Western	54.9	61.9	50.0	41.8	66.7	60.9	49.3	39.7	45.2	37.0
South Western	41.8	46.5	36.9	38.8	44.7	50.5	35.0	47.6	32.0	39.8



Percentage Availability of guidelines, check-lists and job aids										
Characteristics	Facility has available family planning guidelines (National or WHO)	Facility has available family planning check-lists and/or job-aids	Facility has available maternal health (including PNC and ANC) guidelines (National or WHO)	Facility has available maternal health (including PNC and ANC) check-lists and/or job-aids	Facility has available HIV/AIDS (including PMTCT, ART etc.) guidelines (National or WHO)	Facility has available HIV/AIDS (including PMTCT, ART etc.) check-lists and/or job-aids(National or WHO)	Facility has available national Waste disposal guideline	Facility has available a national waste disposal check-lists and/or job-aids	Facility has available infection prevention and control guideline	Facility has available infection prevention and control check-lists and/or job-aids
<b>Residence</b>										
Urban	59.1	57.3	41.1	44.2	51.6	53.4	53.4	51.6	55.9	55.1
Rural	63.9	54.1	58.5	53.1	68.7	65.3	56.6	49.5	55.0	50.3
<b>Management</b>										
Government	67.5	59.8	58.2	55.1	71.1	68.6	60.7	55.0	59.1	54.8
Private	51.4	47.9	27.9	31.0	30.8	36.8	37.0	37.4	40.8	43.5
NGO	50.0	41.7	60.0	52.3	67.4	58.1	55.8	44.2	57.0	48.8
Others	60.0	40.0	60.0	60.0	80.0	80.0	80.0	60.0	80.0	80.0
<b>Total (%)</b>	62.2	59.8	52.5	50.0	62.7	61.1	55.5	50.2	55.3	52.0
<b>No. of SDPs</b>	722	721	713	714	722	722	725	727	727	727

Results from the health facility survey revealed that on the overall, family planning guidelines (National or WHO), family planning check-lists, Maternal health (including PNC and ANC) guidelines, and/or job-aids, national waste disposal guideline, national waste disposal check-lists and/or job-aids were on a whole available at most of the SDPs across the region and irrespective of rural urban divide and management of facility (Table 27 above). By type of SDP, these guidelines are most available at Secondary and tertiary levels. The relatively low availability of guidelines at the Primary level is a cause of concern. It was determined that only 60% had FP guidelines, and only 51% had FP checklists and job aids at primary level.

### 3.9 Use of Information Communication and Technology and Waste disposal

#### 3.9.1 ICT tools available and how they were acquired

With advances in technologies, provision of reproductive health services has advanced with the use of ICT which includes computers, phones, tablets, internet connectivity through local area network and Wi-fi. Table 28 below shows the percentage of SDPs with types of Information Communication Technology (ICT) available.

**Table 28 Percentage of SDPs with types of ICT tools available**

Characteristic	PERCENTAGE (%)							No. of SDPs
	Computer	Mobile phones - basic handsets	Mobile phones - Smart phones	Tablet	Internet facilities – through Local Area Network (LAN)	Internet facilities – through Wi-Fi	Others	
<b>Facility Type</b>								
Primary	32.6	71.4	10.6	0.8	1.7	2.5	2.5	602
Secondary	74.8	71.8	35.9	8.7	29.1	24.3	1.0	103
Tertiary	69.2	76.9	53.9	7.7	30.8	46.2	0.0	13
<b>Region</b>								
Kampala	34.3	89.8	21.2	2.2	10.2	13.9	0.0	137
Central 1	44.6	96.0	16.2	2.7	6.8	4.1	0.0	74
Central 2	23.4	100.0	4.7	0.0	3.1	0.0	0.0	64
East Central	35.9	56.3	1.6	0.0	4.7	9.4	1.6	64
Eastern	26.5	93.9	30.6	3.1	10.2	9.2	3.1	98
Karamoja	26.3	89.5	31.6	0.0	10.5	5.3	0.0	19
Northern	30.2	60.5	16.3	0.0	7.0	2.3	25.6	43
West Nile	34.1	95.5	11.4	0.0	9.1	6.8	2.3	44
Western	53.4	26.0	12.3	5.5	0.0	2.7	0.0	73
South Western	64.7	23.5	5.9	2.9	1.0	2.0	0.0	73
<b>Residence</b>								
Urban	42.5	81.0	21.0	3.2	10.3	12.7	0.4	252
Rural	37.6	66.5	11.8	1.5	3.9	3.0	3.2	466
<b>Management</b>								
Government	38.5	68.7	13.0	1.9	4.1	4.8	3.3	483
Private	37.5	79.9	20.1	4.2	7.6	11.8	0.0	144
NGO	44.2	72.1	18.6	0.0	11.6	5.8	0.0	86
Others	80.0	100	0.0	0.0	60.0	20.0	0.0	5
<b>Overall</b>	<b>39.3</b>	<b>71.6</b>	<b>15.0</b>	<b>2.1</b>	<b>6.1</b>	<b>6.4</b>	<b>2.2</b>	<b>718</b>

About 72% of SDPs had Mobile phones - basic handsets, 39 % computers and 15% Mobile phones - Smart phones. Tablets, LAN and internet Wi-Fi were least available at SDPs. In regard to the type of SDP, 71% of SDPs had mobile phones- hand set, 75 % and 72 % of secondary SDP had computers and mobile phones- hand set while 75%, 69% and 54 % of tertiary SDP had mobile phones- hand set, computers and mobile phones- smart phones respectively.

3.9.1 Percentage of SDPs by how ICT was acquired

Table 29: Percentage of SDPs by how ICT was acquired at the SDP

Type of Facility	Type of ICT	How it was acquired (%)					Total	No. of SDPs
		Personal item of staff member	Provided by government	Provided by proprietor of SDP	Received as Donation	Others		
Primary SDP (i.e HCII & HCIII)	Computer	46.0	7.3	20.2	22.6	4.0	100	124
	Mobile phones - basic handsets	93.6	3.2	1.4	1.6	0.2	100	496
	Mobile phones - Smart phones	94.1	1.5	2.9	1.5	0.0	100	68
	Tablet	100	0.0	0.0	0.0	0.0	100	6
	Internet facilities – through Local Area Network (LAN)	57.1	14.3	14.3	14.3	0.0	100	7
	Internet facilities – through Wi-Fi	37.5	0.0	31.3	18.8	12.5	100	16
	Others e.g radio calls, Landlines	0.0	22.2	33.3	44.4	0.0	100	9
Secondary SDP (i.e HCIV & General Hospital)	Computer	40.2	26.4	21.8	10.3	1.2	100	87
	Mobile phones - basic handsets	86.8	5.5	6.6	1.1	0.0	100	91
	Mobile phones - Smart phones	82.4	0.0	11.8	5.9	0.0	100	34
	Tablet	77.8	11.1	0.0	11.1	0.0	100	9
	Internet facilities – through Local Area Network (LAN)	29.0	19.4	32.3	19.4	0.0	100	31
	Internet facilities – through Wi-Fi	25.0	20.0	30.0	25.0	0.0	100	20
	Others e.g radio calls, Landlines	0.0	0.0	50.0	50.0	0.0	100	2
Tertiary SDP (i.e. RRH and NRH)	Computer	53.9	46.2	21.8	0.0	0.0	100	13
	Mobile phones - basic handsets	75.0	25.0	0.0	0.0	0.0	100	12
	Mobile phones - Smart phones	85.7	14.3	0.0	0.0	0.0	100	7

Facility Assessment for reproductive health commodities and services- 2014

FINAL REPORT

Type of Facility	Type of ICT	How it was acquired (%)					Total	No. of SDPs
		Personal item of staff member	Provided by government	Provided by proprietor of SDP	Received as Donation	Others		
	Tablet	0.0	0.0	0.0	100.0	0.0	100	1
	Internet facilities – through Local Area Network (LAN)	0.0	100	0.0	0.0	0.0	100	5
	Internet facilities – through Wi-Fi	0.0	100	0.0	0.0	0.0	100	6
	Others e.g radio calls, Landlines	0.0	100	0.0	0.0	0.0	100	1

It is important to note that a lot of staff were using personal gadgets like phones, tablets and laptops for SDP work. At primary, secondary and tertiary SDP, most of the phones and computers are personal properties. However, all internet facilities at tertiary SDP are government properties.

### 3.9.2 Uses of ICT by SDPs

ICT tools are used by staff to facilitate execution of various tasks at the SDP. The survey assessed the following main purposes for which ICT tools are used; patient registration, facility record keeping, individual patient records/electronic medical records, mobile money cash transfers, routine communication, awareness and demand creation activities, supply chain management/stock control, health worker training, clinical consultation and others like data storage. Table 30 below show the percentage of SDPs by main purpose for which ICT is used.

**Table 30: Main purpose of ICT per type of SDP, region and management of SDP**

Characteristic	PERCENTAGE (%)											No. of SDPs
	Patient registration	Facility record keeping	Individual patient records/ Electronic Medical Record	Health Insurance Claims and Reimbursement System	Mobile money cash transfers and payments	Routine communication	Awareness and demand creation activities	Supply chain management/stock control	Health worker training	Clinical consultation (long distance communication with experts)	Others e.g Data storage	
<b>Type of facility</b>												
Primary SDP	27.1	15.9	6.5	1.7	8.2	68.1	1.5	1.3	0.9	2.8	0.9	536
Secondary SDP	61.8	50.0	10.8	5.9	11.8	80.4	5.9	13.7	3.9	4.9	2.0	102
Tertiary SDP	23.1	69.2	30.8	7.7	38.5	100.0	0.0	46.2	7.7	15.4	0.0	13
<b>Region)</b>												
Kampala	31.8	12.2	0.9	0.0	0.0	100.0	1.9	3.7	1.9	4.7	0.9	107
Central 1	20.6	17.8	2.7	1.4	32.9	78.1	2.7	2.7	0.0	1.4	4.1	73
Central 2	19.1	4.8	3.2	1.6	0.0	96.8	0.0	1.6	1.6	1.6	0.0	63
East Central	8.9	31.1	2.2	0.0	2.2	73.3	0.0	8.9	6.7	2.2	0.0	45
Eastern	11.5	15.6	3.1	1.0	20.8	100.0	4.2	3.1	0.0	11.5	2.1	96
Karamoja	0.0	16.7	0.0	5.6	5.6	100.0	0.0	0.0	0.0	5.6	0.0	18
Northern	40.6	25.0	3.1	0.0	6.3	62.5	3.1	3.1	0.0	0.0	0.0	32
West Nile	16.7	7.1	7.1	0.0	0.0	95.2	2.4	4.8	0.0	4.8	2.4	42
Western	68.5	27.4	19.2	12.3	15.1	6.9	4.1	8.2	4.1	0.0	0.0	73
South Western	63.7	52.0	22.6	2.9	2.0	2.0	1.0	3.9	1.0	0.0	0.0	102

Characteristic	PERCENTAGE (%)											No. of SDPs
	Patient registration	Facility record keeping	Individual patient records/ Electronic Medical Record	Health Insurance Claims and Reimbursement System	Mobile money cash transfers and payments	Routine communication	Awareness and demand creation activities	Supply chain management/stock control	Health worker training	Clinical consultation (long distance communication with experts)	Others e.g Data storage	
<b>Residence</b>												
Urban	35.2	24.5	6.9	3.2	11.6	88.9	3.2	6.9	3.7	3.2	2.3	216
Rural	31.0	21.2	8.1	2.1	8.3	62.3	1.6	2.8	0.5	3.5	0.5	435
<b>Management</b>												
Government	33.3	21.9	7.6	2.5	8.3	64.5	1.8	4.9	0.7	3.4	0.9	448
Private	32.2	15.3	6.8	2.5	10.2	93.2	2.5	3.4	5.1	2.5	0.9	118
NGO	27.5	33.8	10.0	2.5	15.0	75.0	3.8	1.3	1.3	2.5	1.3	80
Others e.g CBOs	40.0	40.0	0.0	0.0	0.0	80.0	0.0	0.0	0.0	40.0	20.0	5
<b>Total</b>	<b>32.4</b>	<b>22.3</b>	<b>7.7</b>	<b>2.5</b>	<b>9.4</b>	<b>71.1</b>	<b>2.2</b>	<b>4.2</b>	<b>1.5</b>	<b>3.4</b>	<b>1.1</b>	<b>651</b>

Majority of ICT are used for routine communication (71%) followed by patient registration (32%) and facility record keeping (22%) as shown in Table 30 below. At primary SDPs, majority of ICT was used for communication (68%) and patient registration (27%). At secondary SDPs, majority of ICT is used for communication (80%) followed by patient registration (62%) and facility record keeping (50%). At tertiary SDPs on the other hand, ICTs are used for communication (100%), facility record keeping (69%) and mobile money cash transfers and payments (39%).

### 3.9.3 Methods of Waste disposal

Uganda National Infection Prevention and Control Guidelines 2013 provide for treatment and disposal of health wastes through burying, burning, incineration and encapsulation to prevent risks and hazards associated with them. The survey assessed how medical wastes were disposed off. Table 31 below shows that the percentage distribution of SDPs per methods of disposal of health wastes.

**Table 31: Main method used by the SDP to dispose of health waste**

Characteristics	PERCENTAGE (%)					Total	No. of SDPs
	Burning on the grounds of the SDP	Bury in special dump pits on the grounds of the SDP	Use of Incinerators	Centrally collected by specific agency for disposal away from the SDP	Disposed with regular garbage		
<b>Type of facility</b>							
Primary SDP	70.5	6.8	7.3	13.4	2.0	100	604
Secondary SDP	42.6	6.9	36.6	12.9	1.0	100	101
Tertiary SDP	25.0	0.0	75.0	0.0	0.0	100	12
<b>Region</b>							
Kampala	18.7	5.2	12.7	56.7	6.7	100	134
Central 1	80.8	2.7	15.1	1.4	0.0	100	73
Central 2	87.9	3.0	9.1	0.0	0.0	100	66
East Central	74.6	4.5	11.9	9.0	0.0	100	67
Eastern	64.9	8.3	13.4	10.3	3.1	100	97
Karamoja	47.4	26.3	26.3	0.0	0.0	100	19
Northern	73.9	15.2	10.9	0.0	0.0	100	46
West Nile	68.2	9.1	22.7	0.0	0.0	100	44
Western	79.4	5.5	12.3	1.4	1.4	100	73
South Western	87.8	6.1	6.1	0.0	0.0	100	98
<b>Residence</b>							
Urban	41.6	4.8	18.4	32.0	3.2	100	250
Rural	78.8	7.7	9.4	3.0	1.1	100	467
<b>Management</b>							
Government	77.2	7.9	9.3	5.0	0.6	100	483
Private	29.1	4.3	14.8	46.1	5.7	100	141
NGO	63.6	4.6	23.8	5.7	2.3	100	88
Others	40.0	0.0	60.0	0.0	0.0	100	5
<b>Total</b>	<b>65.8</b>	<b>6.7</b>	<b>12.6</b>	<b>13.1</b>	<b>1.8</b>	<b>100</b>	<b>717</b>

Overall, out of the 717 SDPs which responded to this question, majority SDPs dispose health wastes by burning (66%) followed by central collection by specific agency for disposal away from SDP (13%) and by use of incinerator (13%). In regard to the type of facility most of the primary SDPs disposed health waste by burning on the grounds of the SDP (71%), The secondary SDPs disposed health waste by burning and incineration (43%), while most of the tertiary SDPs mainly disposed medical waste by incineration (75%). Other methods of waste disposal are indicated in Table 31 above.

### 3.10 Charges for User fees

Public health services in Uganda are delivered through HCIIIs, HCIIIIs, HCIVs, General Hospitals, RRHs and NRHs. The range of health services delivered varies with the level of care. In all public health facilities curative, preventive, rehabilitative and promotive health services are free, following the abolishment of user fees in 2001. However, user fees in public facilities remain in private wings of public hospitals. The private facilities generally charge user fees as well as some of the NGO owned facilities depending on the services. This 2014 health facility survey analyzed data for all SDP which charge consultation fees with no exemption on FP services, ANC services, delivery services, PNC services, new born care, care of sick children under 5 and HIV care. Table 32 below shows the percentage distribution of SDPs charging consultation fees for RH including family planning.

#### 3.10.1 Charges for user fees- Consultation

**Table 32: Percentage distribution of SDPs by issues for which user fee is charged**

Characteristic	PERCENTAGE (%)							
	Family planning services	Antenatal care services	Delivery services	Post natal care services	Newborn care services	Care of sick children under 5 years	HIV care (e.g. HTC and ART)	Others <sup>7</sup>
<b>Type of facility</b>								
Primary SDP	26.1	45.8	44.0	35.0	42.2	49.3	44.0	56.5
Secondary SDP	31.9	31.9	59.6	54.1	59.6	65.2	20.8	59.6
Tertiary SDP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Region</b>								
Kampala	4.1	37.4	62.4	62.4	54.1	62.4	54.1	62.4
Central 1	37.4	0.0	0.0	20.8	37.4	54.1	20.8	0.0
Central 2	0.8	20.8	20.8	10.8	20.8	40.8	20.8	0.0
East Central	42.2	56.5	42.2	56.5	42.2	63.6	63.6	49.3
Eastern	20.8	60.8	60.8	30.8	40.8	50.8	0.8	20.8
Karamoja	45.8	4.3	0.0	4.3	20.8	45.8	4.3	0.0
Northern	37.4	4.1	4.1	0.0	0.0	4.1	37.4	0.0
West Nile	50.8	10.8	10.8	50.8	0.0	50.8	30.8	50.8
Western	45.8	45.8	45.8	0.0	0.0	45.8	0.0	0.0
South Western	42.2	56.5	56.5	27.9	0.0	0.0	0.0	0.0
<b>Residence</b>								
Urban	29.6	35.5	56.0	50.2	53.1	59.0	47.2	50.2
Rural	26.9	46.4	39.0	31.7	41.5	48.8	31.7	63.4
<b>Management</b>								
Government	15.2	26.3	37.4	48.5	37.4	37.4	37.4	59.6
Private	18.6	49.0	57.7	40.3	53.4	62.1	49.0	53.4
NGO	40.0	42.5	40.0	40.0	45.1	50.2	34.9	57.9
Others	4.3	20.8	0.0	20.8	45.8	0.0	20.8	0.0

<sup>7</sup> Other services included cervical cancer screening, Immunisation, Condoms, TB testing, and services to needy children e.g OVCs.



Overall	28.1	41.4	46.8	40.1	46.8	53.4	38.8	57.4
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Out of the 734 SDPs which participated in the study, only 106 SDPs (14.4%) charged consultation fees for reproductive health including family planning while majority SDPs (85.6%) did not charge. Table 32 above shows that out of the 106 SDPs that charged consultation fees for reproductive health including family planning, 53% charged consultation on care of sick children, 46 % on delivery and new born services and 41% on antenatal services irrespective rural- urban location. By the type of SDP, consultation fees are charged at primary and secondary SDPs creating a barrier to uptake of RH services including FP. No consultation fees are charged at tertiary SDPs.

### 3.10.2 Charges for any medication, supplies or consumables

The user fee charged on any medication, and supplies or consumables was assessed during the survey. During data analysis, all SDPs that charge user fees on any medication, and supplies or consumables without exemption on FP commodities, maternal health medicines, child health medicines and HIV medication. Results of the study are shown in table 33 below.

**Table 33: Percentage distribution of SDPs by issues for which user fee is charged**

Characteristic	PERCENTAGE (%)				
	Family planning commodities	Maternal health medicines	Child health medicines	HIV Medication	Others <sup>8</sup>
<b>Type of facility</b>					
Primary SDP	21.2	29.7	43.8	49.4	51.1
Secondary SDP	10.8	19.0	35.8	48.3	0.0
Tertiary SDP	35.8	41.1	43.5	0.0	0.0
<b>Region</b>					
Kampala	25.6	11.1	42.8	49.8	0.0
Central 1	24.2	33.9	37.7	49.9	0.0
Central 2	22.4	36.7	37.6	0.0	0.0
East Central	33.3	35.4	45.2	43.8	0.0
Eastern	26.7	36.6	39.0	46.1	0.0
Karamoja	40.7	43.5	40.7	0.0	46.0
Northern	42.9	46.7	40.8	0.0	0.0
West Nile	39.9	39.7	42.1	0.0	0.0
Western	36.1	41.9	48.5	49.8	0.0
South Western	28.9	35.2	48.3	0.0	0.0
<b>Residence</b>					
Urban	4.9	6.5	41.6	47.4	4.9
Rural	33.7	40.4	43.2	50.4	33.7
<b>Management</b>					
Government	44.3	44.7	49.4	50.8	0.0
Private	22.4	5.3	40.4	48.5	0.0
NGO	37.7	3.4	12.3	42.3	50.1
Others	48.8	11.2	8.8	0.0	0.0
<b>Total</b>	<b>20.0</b>	<b>28.4</b>	<b>42.6</b>	<b>49.3</b>	<b>0.0</b>

<sup>8</sup> Other services included Condoms, Counseling, deworming, Vitamin A, Mosquito nets, and Immunization, VCT, TB testing.

Table 33 shows that all SDPs charged user fee on HIV medication (49%), 43% on child health medicines (43%), maternal health medicines (28%) and family planning commodities (20%). There were no user charges for HIV medicines at tertiary SDPs. User fees were mainly charged by facilities located in rural areas, for example, user charges were mainly charged for HIV medication (50%), child health medicines (43%), maternal health medicines (40%) and family planning commodities (34%).

### **3.10.3 Charges for user fees- Services provided by a qualified health care provider**

SDPs that charge user fees on services provided by a qualified health care provider and which are not exempted at the SDP were included in table 34 below. Family planning services, Antenatal care services, Delivery services, Post natal care services, Newborn care services, HIV care, and Caesarean Section as shown in table 34 below:

**Table 34: Percentage distribution of SDPs by issues for which user fee is charged for services provided by a qualified health care provider**

Characteristic	Percentage (%)							
	Family planning services	Antenatal care services	Delivery services	Post natal care services	Newborn care services	HIV care	Caesarean Section	Others <sup>9</sup>
<b>Facility type</b>								
Primary	38.1	45.2	69.9	55.7	71.0	66.3	61.6	78.1
Secondary	59.1	50.4	80.8	67.8	59.1	67.8	72.1	76.5
Tertiary	14.9	14.9	0.0	0.0	0.0	14.9	14.9	0.0
<b>Region</b>								
Kampala	11.0	65.8	75.5	72.3	72.3	65.8	62.6	78.7
Central 1	58.5	51.8	71.8	38.5	58.5	71.8	45.2	78.5
Central 2	43.5	1.8	51.8	35.2	68.5	51.8	60.2	76.8
East Central	60.2	60.2	35.2	72.7	60.2	72.7	60.2	72.7
Eastern	38.5	51.8	0.0	45.2	58.5	51.8	45.2	65.2
Karamoja	0.0	14.9	0.0	0.0	0.0	0.0	0.0	0.0
Northern	0.0	14.9	72.7	72.7	0.0	60.2	0.0	0.0
West Nile	0.0	14.9	0.0	0.0	0.0	0.0	0.0	0.0
Western	45.2	65.2	0.0	65.2	65.2	0.0	0.0	0.0
South Western	54.4	54.4	0.0	62.1	77.5	77.5	0.0	0.0
<b>Residence</b>								
Urban	31.7	52.4	76.5	61.0	69.6	69.6	61.0	76.5
Rural	53.8	38.1	67.5	55.7	67.5	61.6	65.5	79.3
<b>Management</b>								
Government	53.2	21.2	69.2	65.2	61.2	53.2	69.2	0.0
Private	24.6	61.5	79.9	66.7	72.0	74.6	69.4	79.9
NGO	48.8	48.8	67.0	48.8	69.2	64.7	55.6	73.8
Others	0.0	14.9	0.0	35.2	0.0	0.0	35.2	0.0
<b>Total</b>	<b>42.0</b>	<b>45.7</b>	<b>72.3</b>	<b>58.5</b>	<b>68.6</b>	<b>65.9</b>	<b>63.1</b>	<b>77.8</b>

Results in Table 34 above show that overall majority of SDPs charge user fees for services provided by a qualified health care provider for family planning services (42%), antenatal care services (46%), delivery services (72%), post natal care services (59%), newborn care services (69%), HIV care (66%), and caesarean section (63%) among others. Most of these fees are charged at primary and secondary SDPs. However, there was no user fees charged for health worker proving deliveries, PNC and new born care services at tertiary level.

### 3.11 Availability of Maama Kits

The MoH acknowledges the significance of investing in the health of women and children as a way of addressing the Millennium Development Goals 4 and 5. Consequently, in an effort to reduce maternal and neonatal mortality and morbidity in Uganda, Ministry of Health

<sup>9</sup> Other services included Condoms, Counseling, deworming, Vitamin A, Mosquitoe nets, and Immunization, VCT, TB testing and medication, Safe Male Circumcision (SMC), and Eye care & treatment.

devised the *Maama Kit* as an urgent and cost-effective measure to ensure that child birth is conducted in a clean environment. The Ministry of Health incorporated the maama kit into the Essential Medicines list as an important element of the safe motherhood initiative. The *Maama Kit* consists of basic supplies that are required at child birth i.e. sterile gloves, plastic sheets, cord ligature, razor blades, tetracycline, cotton, soap and sanitary pads. The Maama kit is by policy supposed to be free of charge and is distributed by the National Medical Stores (NMS) and working with Health Sector Development Partners. This 2014 health facility determined whether facilities were supposed to provide Maama kit by policy, whether they had the Maama kits available by the time of the survey and what reasons were responsible for their failure to have Maama kits available.

**Table 35: Percentage of facilities offering Maama kits**

Characteristic	Percentage (%)		Total	No. of SDPs
	Yes, this SDP is expected /supposed to have available Maama Kits in line with the current national protocols, guidelines and/or laws specific for this level of service delivery	No, this SDP is NOT expected/ supposed to have available Maama Kits		
<b>Type of facility</b>				
Primary	77.2	22.8	100	452
Secondary	93.5	6.5	100	93
Tertiary	100.0	0.0	100	12
<b>Region</b>				
Kampala	35.1	64.9	100	77
Central 1	97.1	2.9	100	70
Central 2	75.6	24.4	100	41
East Central	77.4	22.6	100	62
Eastern	88.9	11.1	100	90
Karamoja	94.1	5.9	100	17
Northern	94.3	5.7	100	35
West Nile	88.9	11.1	100	36
Western	94.6	5.4	100	56
South Western	82.2	17.8	100	73
<b>Residence</b>				
Urban	66.7	33.3	100	180
Rural	87.0	13.0	100	377
<b>Management</b>				
Government	88.2	11.8	100	390
Private	45.7	54.3	100	92
NGO	81.7	18.3	100	71
Others	100	0.0	100	4
<b>Total</b>	<b>80.4</b>	<b>19.6</b>	<b>100</b>	<b>557</b>

Table 35 above shows that out of the total 577 SDPs that responded to this question, majority facilities (80%) were supposed to provide Maama kits as a matter of policy. In terms of facility level, 77% of the primary level facilities were expected to provide Maama kits, while 94% of secondary and 100% of tertiary were also expected to provide Maama kits. In terms of regions, 97% in Central 1, 95% in western had the highest percentages of SDPs expected to offer Maama kits. In terms of urban and rural divide, 87% of the rural based SDPs were

supposed to offer Maama kits while 67% of the urban based SDPs were also expected to offer Maama kits.

### 3.11.1 Availability of Maama kits by the time of the survey

Out of the 448 SDPs (80.4%) that are supposed to provide Maama kits, the study further ascertained whether the Maama kits were currently available at those SDPs. Results of the assessment are shown in Table 36 below.

**Table 36: Availability of maama kits by the time of the survey**

Characteristic	Percentage (%)			Total	No. of SDPs
	Yes, Maama Kits are currently available	No, Maama Kits are not available	Not Applicable		
<b>Type of facility</b>					
Primary	71.1	28.0	0.9	100	332
Secondary	75.6	24.4	0.0	100	82
Tertiary	100	0.0	0.0	100	11
<b>Region</b>					
Kampala	29.6	66.7	3.7	100	27
Central 1	68.3	31.8	0.0	100	63
Central 2	85.7	10.7	3.6	100	28
East Central	76.1	23.9	0.0	100	46
Eastern	79.0	19.8	1.2	100	81
Karamoja	64.3	35.7	0.0	100	14
Northern	79.3	20.7	0.0	100	29
West Nile	66.7	33.3	0.0	100	24
Western	69.8	30.2	0.0	100	53
South Western	83.3	16.7	0.0	100	60
<b>Residence</b>					
Urban	66.7	32.5	0.9	100	117
Rural	75.0	24.4	0.7	100	308
<b>Management</b>					
Government	82.6	16.5	0.9	100	327
Private	38.5	61.5	0.0	100	39
NGO	41.1	58.9	0.0	100	56
Others	33.3	66.7	0.0	100	3
<b>Total</b>	<b>72.71</b>	<b>26.59</b>	<b>0.71</b>	<b>100</b>	<b>425</b>

Out of the 448 SDPs that were supposed to provide Maama kits, only 425 SDPs responded to this question. Table 36 above shows that majority facilities (73%) had Maama kits available by the day of the survey while 27% did not have Maama kits at the time of the survey. In terms of availability of Maama kits by level of facility, all tertiary level SDPs (100%), 75% of secondary level and 71% of primary level had Maama kits. In regional terms, South western (83%), Northern (79%) and Eastern (79%) had the highest percentages of SDPs with Maama kits available. Kampala (66%), Karamoja (36%), and West Nile (33%) had the highest percentages of SDPs without Maama kits on the day of the survey.

**Main reasons why SDP is not currently having the Maama Kits yet the SDP is supposed have available Maama Kits (in line with current national guidelines).**

Reasons given for not having Maama kits available were varied and are indicated in table 37 below. The main reason for not having Maama kits was the delay on the part of the main source institution to supply Maama kits on time (58%), followed by the delay by SDPs in placing orders for the Maama kit (18%), and low or no demand/need for the Maama kit at this SDP (9%) as shown in Table 37 below. Other reasons accounted for nearly 13% and those included the following;

- Hospital used to get supplies from PREFA but stopped
- Maama kits are expensive;
- Maternity wing not yet operational
- Mothers buy from the pharmacy
- SDP was not supplied with Maama Kit

**Table 37: Reasons for not offering maama kits when SDP has a mandate to offer them**

Characteristic	Main reason this SDP is NOT expected/ supposed to have available Maama Kits (%)							Total	No. of SDPs
	Delays on the part of main source institution/warehouse to re-supply this SDP with Maama kits	Delays by this SDP to request for supply of the Maama kit	The Maama kit is not available in the market for the SDP to procure	Low or no demand/need for the Maama kit at this SDP	No trained staff to provide Maama kits at the SDP	Others			
<b>Type of facility/SDP</b>									
Primary SDP	55.9	20.3	1.7	8.5	1.7	11.9	100	59	
Secondary SDP	66.7	8.3	0.0	8.3	0.0	16.7	100	12	
<b>Region</b>									
Kampala	55.6	22.2	0.0	11.1	0.0	11.1	100	9	
Central 1	37.5	37.5	12.5	0.0	12.5	0.0	100	8	
Central 2	100	0.0	0.0	0.0	0.0	0.0	100	1	
East Central	57.1	14.3	0.0	14.3	0.0	14.3	100	7	
Eastern	57.1	7.1	0.0	0.0	0.0	35.7	100	14	
Karamoja	100	0.0	0.0	0.0	0.0	0.0	100	2	
Northern	75	25.0	0.0	0.0	0.0	0.0	100	4	
West Nile	100	0.0	0.0	0.0	0.0	0.0	100	3	
Western	56.3	25	12.5	0.0	0.0	6.2	100	16	
South Western	42.9	28.5	0.0	14.3	0.0	14.3	100	7	
<b>Residence</b>									
Urban	50.0	22.2	0.0	5.6	5.6	16.6	100	18	
Rural	60.4	17.0	1.9	9.4	0.0	11.3	100	53	
<b>Management</b>									
Government	75.0	6.3	3.1	6.3	0.0	9.3	100	32	
Private	53.3	26.7	0.0	6.7	0.0	13.3	100	15	
NGO	40.9	31.8	0.0	13.6	0.0	13.6	100	22	
Others	0.0	0.0	0.0	0.0	50	50.0	100	2	
<b>Total</b>	<b>57.8</b>	<b>18.3</b>	<b>1.4</b>	<b>8.5</b>	<b>1.4</b>	<b>12.6</b>	<b>100</b>	<b>71</b>	

## 4 RESULTS OF THE EXIT INTERVIEW

### 4.1 Background Characteristics of clients for exit interviews

#### 4.1.1 Sex Distribution of clients

The largest proportion of FP clients was female (93%) while the rest were males (7%) as shown in Table 38 below. In terms of regional distribution, Karamoja (30%) and Northern (17%) had the highest proportion of males who participated in the exit interview, while the highest proportion of females was from Central 1 (98%), Western (95%), Central II, Eastern, and East central all at (94%).

**Table 38: Showing Sex distribution of FP clients**

Characteristics	Percentage		
	No. of Clients	Male	Female
<b>Type of facility</b>			
Primary level	2353	7.8	92.2
Secondary level	821	5.6	94.4
Tertiary Level	191	10.5	89.5
<b>Region</b>			
Kampala	344	13.1	86.9
Central 1	527	1.7	98.3
Central 2	316	5.7	94.3
East Central	218	6.0	94.0
Eastern	590	5.6	94.4
Karamoja	23	30.4	69.6
Northern	204	17.2	82.8
West Nile	358	12.3	87.7
Western	226	5.3	94.7
South western	559	6.1	93.9
<b>Residence</b>			
Urban	1135	8.2	91.8
Rural	2230	7.0	93.0
<b>Management</b>			
Government	2638	7.1	92.9
Private	311	12.2	87.8
NGO/PNFP	395	5.6	94.4
Other	21	14.3	85.7
<b>Total</b>	<b>3365</b>	<b>7.4</b>	<b>92.6</b>



#### 4.1.2 Age distribution of clients

The largest number of FP clients (1837) was aged between 20-29 years and the least (4) were those aged 10-14 years and (7) were 50 and above years as shown in Table 39 below. Since the study focused on those clients actively engaged in child bearing and family planning services, it was expected that those below 18 years and above 40 years would be very few.

**Table 39: Age distribution of FP clients**

Characteristic	Age groups								
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
<b>Type of facility</b>									
Primary level	4	248	647	660	441	226	98	23	6
Secondary level	0	89	222	228	158	82	35	7	0
Tertiary Level	0	21	45	45	41	27	7	4	1
<b>Region</b>									
Kampala	0	40	79	122	65	22	14	2	0
Central 1	1	52	138	172	107	42	14	1	0
Central 2	0	21	93	104	68	26	2	2	0
East Central	0	18	52	62	42	27	11	5	1
Eastern	0	59	174	152	99	62	36	7	1
Karamoja	0	3	7	4	6	1	2	0	0
Northern	1	16	45	45	48	28	19	2	0
West Nile	1	60	111	80	59	32	12	1	2
Western	1	41	48	50	49	23	10	2	2
South western	0	48	167	142	97	72	20	12	1
<b>Residence</b>									
Urban	1	118	293	329	218	116	47	11	2
Rural	3	240	621	604	422	219	93	23	5
<b>Management</b>									
Government	3	269	726	698	520	275	112	30	5
Private	0	38	72	110	54	22	13	1	1
NGO/PNFP	1	48	109	123	63	36	11	3	1
Other	0	3	7	2	3	2	4	0	0
<b>Total</b>	<b>4</b>	<b>358</b>	<b>914</b>	<b>933</b>	<b>640</b>	<b>335</b>	<b>140</b>	<b>34</b>	<b>7</b>

#### 4.1.3 Marital status

Most of the Family planning clients were currently married (54.8%) followed by those living together as partners (28%) as shown in Table 40 below. The widowed and divorced categories were the least at about 3% and 1% respectively. Urban areas had the highest number of unmarried/never married clients seeking FP services (18%) compared to a few clients in the rural areas (10%). Kampala had the highest (36%) number of unmarried clients. This could be due to the urban population pressures that come with vices like prostitution and multiple partners.

**Table 40: Marital Status of FP Clients**

Characteristics	Percentage					
	N	Never married	Currently Married	Living together	Divorced/ separated	Widowed
<b>Type of facility</b>						
Primary level	2331	13.5	54.0	28.0	3.0	1.5
Secondary level	815	11.0	57.3	28.6	2.1	1.0
Tertiary Level	187	11.8	52.9	33.2	2.1	0.0
<b>Region</b>						
Kampala	335	35.5	49.25	12.8	1.5	0.9
Central 1	524	7.1	38.4	51.7	2.3	0.6
Central 2	312	11.2	57.1	29.8	0.6	1.3
East Central	218	10.6	67.0	17.0	3.7	1.8
Eastern	588	11.2	62.2	21.3	3.7	1.5
Karamoja	23	30.4	52.2	13.0	0.0	4.4
Northern	202	9.4	36.6	43.6	6.9	3.5
West Nile	357	12.3	51.3	32.2	3.1	1.1
Western	221	12.7	54.3	26.7	5.4	0.9
South western	553	8.9	68.7	20.6	0.9	0.9
<b>Residence</b>						
Urban	1117	17.6	53.0	26.4	2.2	0.7
Rural	2216	10.4	55.6	29.5	3.0	1.5
<b>Management</b>						
Government	2619	10.3	55.0	30.4	3.0	1.3
Private	301	34.2	48.5	14.0	2.3	1.0
NGO/PNFP	392	13.5	56.4	28.1	1.3	0.8
Others	21	9.5	85.7	0.0	0.0	4.8
<b>Total</b>	<b>3333</b>	<b>12.8</b>	<b>54.8</b>	<b>28.4</b>	<b>2.7</b>	<b>1.3</b>

#### 4.1.4 Percentage distribution of clients by educational level

The majority of clients had primary education (48%), followed by had secondary education (27%) and the least had higher education (8%) as shown in table 41 below. In terms of the rural and urban divide, the percentage of respondents with primary level was higher in the rural areas, while the percentage of secondary and higher levels of education increases in the urban areas.

Analysis based regional distribution revealed that within Karamoja sub region, had 27 in every 100 clients with no formal education (27%), while other clients ended in secondary (41%) and primary (18%). Overall most of the FP clients in Karamoja sub region attended formal education which pointed to the fact that it is majorly the educated persons who go for family planning services. Kampala region had the smallest percentage of FP clients with no formal education (9%). Nearly 86% of currently married FP clients attended SDPs under other management such as Community Based Organisations (CBOs) that mainly provide preventive health services which include health education, counselling, health promotion and support to community health workers.

**Table 41: Percentage distribution of clients by educational level**

Characteristics	N	Percentage			
		No Education	Primary	Secondary	Higher level
<b>Type of facility</b>					
Primary level	2337	18.9	49.2	25.8	6.2
Secondary level	814	18.9	44.8	26.4	9.8
Tertiary Level	189	7.4	38.1	38.6	15.9
<b>Region</b>					
Kampala	341	8.5	32.8	33.1	25.5
Central 1	525	8.8	46.1	37.3	7.8
Central 2	307	27.0	54.1	18.2	0.7
East Central	218	13.3	41.7	28.9	16.1
Eastern	590	18.1	56.4	21.7	3.7
Karamoja	22	27.3	18.2	40.9	13.6
Northern	204	21.1	45.1	28.9	4.9
West Nile	356	30.1	52.0	16.3	1.7
Western	224	15.2	54.5	25.5	4.9
South western	553	22.6	43.2	27.5	6.7
<b>Residence</b>					
Urban	1126	11.8	41.9	31.7	14.6
Rural	2214	21.5	50.3	24.1	4.1
<b>Management</b>					
Government	2620	20.5	49.0	25.0	5.5
Private	307	8.5	33.2	37.1	21.2
NGO/PNFP	392	11.5	46.9	30.6	11.0
Other	21	9.5	76.2	9.5	4.8
<b>Total</b>	<b>3340</b>	<b>18.2</b>	<b>47.5</b>	<b>26.7</b>	<b>7.6</b>

#### 4.1.5 Percent Distribution of clients by frequency of visit to the SDP for FP services

Table 42 below shows that most Family planning clients visited the SDPs once in three months (52%). The highest number of those clients were NGO supported SDPs which could be attributed to good service delivery in those facilities (60%). The FP clients located in the rural areas who visited the SDPs once every three months were slightly higher (52%) compared to 51% in the urban based SDPs. The government facilities had the highest percentage (52%) of clients visiting once in every three months. Nearly 12% of FP clients visited SDPs during other periods mainly due to problems such as missed periods and during ART, ANC.

**Table 42: Percent Distribution of clients by frequency of visit to the SDP for FP services**

Characteristics	N	Percentage			
		Once a month	Once every 2 month	Once every 3 month	Other periods
<b>Type of facility</b>					
Facility type					
Primary level	2353	26.7	10.4	52.6	10.3
Secondary level	821	23.5	11.6	51.5	13.5
Tertiary	191	17.8	9.4	46.7	26.2
<b>Region</b>					
Kampala	344	37.8	16.6	40.4	5.2
Central 1	527	20.7	10.1	65.3	4.0
Central 2	316	20.3	28.5	50.3	1.0
East Central	218	26.2	4.6	55.5	13.8
Eastern	590	18.6	6.1	62.4	12.9
Karamoja	23	52.2	4.4	34.8	8.7
Northern	204	36.3	7.8	38.2	17.7
West Nile	358	18.4	3.4	43.6	34.6
Western	226	42.9	5.3	36.3	15.5
South western	559	24.5	12.3	52.8	10.4
<b>Residence</b>					
Urban	1135	25.4	12.8	51.2	10.7
Rural	2230	25.5	9.5	52.4	12.7
<b>Management</b>					
Government	2638	24.9	10.2	52.2	12.7
Private	311	37.9	15.8	40.2	6.1
NGO/PNFP	395	20.3	9.6	60.0	10.1
Other	21	4.8	0.0	47.6	47.6
<b>Total</b>	<b>3365</b>	<b>25.4</b>	<b>10.6</b>	<b>52.0</b>	<b>11.9</b>

## 4.2 Client's Perception of family Planning Service provision

### 4.2.1 Percentage distribution of client's perception of FP service provider's adherence to technical issues

There was general adherence to technical aspects in provision of FP services. Table 43 below shows that 94% of the clients reported to have received a method of their choice, 95% were treated as they wished, 89% were taught how to use the family planning method of choice, 87% were told about the common side effects of family planning methods. The lowest satisfaction was on provision of information on side effects at 78%. The satisfaction level were highest at tertiary level SDP which could be due to availability of well trained and skilled staff, space and equipment while the lowest satisfaction level was at primary level.

Additionally, the satisfaction of the rural based clients was averagely higher than the urban based clients on most aspects of service delivery.

**Table 43: Percentage distribution of client’s perception of FP service provider’s adherence to technical issues**

Characteristics	Percentage						
	Provided with the family planning method of your choice	Provider took client preference and wishes into consideration	Client taught how to use the family planning method:	Client told about the common side effects of the family planning meth	Provider informed Client about what to do regarding the side effects	Provider informed client about what to do in case of any serious complications	Client given date to return to SDP for check-up and/or additional supplies
<b>Type of facility</b>							
Primary level	93.4	94.4	89.3	86.7	84.1	77.9	86.6
Secondary level	94.0	94.6	89.0	86.4	84.7	75.5	86.8
Tertiary Level	93.1	97.9	91.5	90.0	87.8	80.4	91.1
<b>Region</b>							
Kampala	90.5	97.1	82.8	80.2	78.1	72.2	78.6
Central 1	96.3	98.3	91.1	90.2	88.3	76.1	96.5
Central 2	94.5	83.4	96.1	96.4	94.2	94.8	94.1
East Central	96.3	96.8	86.7	83.9	84.9	77.5	93.6
Eastern	95.1	97.1	84.9	81.7	78.1	68.0	90.8
Karamoja	87.0	87.0	100.0	95.7	82.6	60.9	91.3
Northern	79.8	86.0	90.5	87.6	88.1	86.9	86.4
West Nile	94.7	94.5	93.4	92.5	91.7	85.3	67.2
Western	89.4	97.3	83.1	82.6	82.8	79.1	84.7
South western	95.5	94.7	92.8	86.5	81.3	74.5	86.0
<b>Residence</b>							
Urban	91.1	94.8	87.6	85.9	83.9	77.4	86.2
Rural	94.8	94.6	90.2	87.3	84.8	77.5	87.3
<b>Management</b>							
Government	93.2	94.3	89.6	86.8	84.4	77.9	87.3
Private	90.8	98.1	84.9	82.4	80.4	75.2	81.5
NGO/PNFP	97.4	93.8	90.5	90.0	88.4	77.1	89.5
Other	100.0	100.0	100.0	95.2	85.7	71.4	75.0
<b>Total</b>	<b>93.5</b>	<b>94.7</b>	<b>89.3</b>	<b>86.8</b>	<b>84.5</b>	<b>77.5</b>	<b>86.9</b>

#### 4.2.2 Percentage distribution of client’s perceptive of FP service organizational aspect

Apart from the waiting time which was perceived to be long with 36% clients dissatisfied overall, most FP clients were satisfied with the organization aspects of the SDPs. For instance 95% were satisfied with privacy, 93% satisfied with time allocation to cases and 92% on satisfied with cleanliness. The observed high levels of satisfaction could be attributed to

the training provided to the providers that enabled them to exercise professionalism in provision of services. In terms of ownership, the private SDPs had slightly higher satisfaction levels, which could be due to the fact that services are paid for and there are fewer clients. The satisfaction in the urban based SDPs was higher than the rural based SDPs. For example Kampala ranked highest on average among regions. This could be due to the high concentration of private SDPs in urban areas and Kampala in particular.

**Table 44: Percentage distribution of client's perceive of FP service organizational aspect**

Characteristics	Percentage			
	Client perceived waiting time as too long	Client satisfied with the cleanliness of the health facility	Client satisfied with the privacy at the exam room	Client satisfied with the time that was allotted his/her case
<b>Type of facility</b>				
Primary level	32.2	91.7	95.5	91.1
Secondary level	42.0	92.2	94.5	92.8
Tertiary Level	47.4	93.2	95.2	95.1
<b>Region</b>				
Kampala	40.2	97.9	98.4	92.2
Central 1	17.5	93.8	97.1	94.6
Central 2	67.2	90.2	95.1	92.2
East Central	14.8	92.7	96.3	93.6
Eastern	31.2	93.6	94.2	91.3
Karamoja	47.8	100.0	91.3	80.0
Northern	52.3	79.5	85.4	64.0
West Nile	39.6	85.8	94.0	87.1
Western	46.9	79.5	95.5	95.0
South western	29.6	94.8	96.9	96.7
<b>Residence</b>				
Urban	39.2	94.6	97.2	95.1
Rural	33.5	90.5	94.3	90.4
<b>Management</b>				
Government	35.9	90.8	95.0	91.5
Private	30.2	97.4	98.2	94.1
NGO/PNFP	36.6	94.9	94.9	93.6
Other	38.1	95.2	95.2	68.8
<b>Total</b>	<b>35.5</b>	<b>91.9</b>	<b>95.2</b>	<b>91.6</b>

#### 4.2.3 Percentage distribution of clients' perspective of FP service inter-personal aspects

Family planning providers exhibited great interpersonal skills during the course of service provision. A high percentage of the clients reported to have been treated with Courtesy (95%) while majority were also satisfied with the attitude of health care providers (94%) as shown in Table 45 below. Nearly 1 in every 5 FP clients (20%) said that they had been forced

to accept a particular family planning method. The satisfaction was higher at tertiary level (99%) on attitude and (98%) on respect and courtesy. The high satisfaction rates among the clients can be attributed to the trainings received by service providers on patient handling. Among the private SDPs, only 5% of the clients reported being forced to use a method while 99% were satisfied with all other services as shown in table 45 below. Analysis based on regions revealed that Kampala had the highest satisfaction levels (99% Client satisfied with the attitude of the health provider towards him/her generally) which can also be attributed to the high concentration of private SDPs.

**Table 45: Percentage distribution of clients' perspective of FP service inter-personal aspects**

Characteristics	Percentage		
	Client indicated he/she was treated with courtesy and respect by SDP staff:	Client indicated he/she was forced by the health service providers to accept or insisted he/she should accept FP method	Client satisfied with the attitude of the health provider towards him/her generally
<b>Type of facility</b>			
Primary level	94.6	19.5	93.9
Secondary level	94.5	21.2	92.2
Tertiary Level	97.9	14.5	99.2
<b>Region</b>			
Kampala	98.1	4.9	99.0
Central 1	88.3	16.4	97.5
Central 2	93.5	44.9	94.9
East Central	96.2	10.3	96.2
Eastern	98.1	24.3	95.1
Karamoja	100.0	60.0	80.0
Northern	98.8	64.0	69.8
West Nile	90.8	15.1	92.2
Western	96.5	22.7	94.5
South western	92.9	7.7	94.6
<b>Residence</b>			
Urban	96.6	16.8	96.4
Rural	94.1	20.7	92.9
<b>Management</b>			
Government	94.0	20.1	93.4
Private	99.1	4.8	99.1
NGO/PNFP	98.0	20.7	95.0
Other	100.0	50.0	93.8
<b>Total</b>	<b>94.8</b>	<b>19.6</b>	<b>93.9</b>

#### 4.2.4 Percentage distribution of clients perceptive of FP service outcome aspect

Overall most clients (96%) were satisfied with the services received and expressed willingness to return to the SDP in future as shown in table 46 below. In addition, 98%

reported that they would refer relatives to the SDP. The highest percentages of clients satisfied with FP services (100%) were recorded in the Karamoja and Northern. The high outcomes could be attributed the efficiency especially in the stocking level for the essential commodities and the trainings provided by different agencies especially on customer care.

**Table 46: Percentage distribution of clients perceptive of FP service outcome aspect**

characteristic	Percentage		
	Client satisfied with the service received:	Client will continue visiting this SDP in future	Client would recommend this SDP to relatives or friends
<b>Type of facility</b>			
Primary level	96.3	97.7	97.9
Secondary level	95.8	97.2	97.0
Tertiary Level	98.3	97.2	98.0
<b>Region</b>			
Kampala	97.8	98.4	98.4
Central 1	95.9	98.2	97.1
Central 2	93.4	95.7	96.2
East Central	96.6	93.1	96.3
Eastern	99.5	99.2	98.8
Karamoja	100	100	100
Northern	100.0	100	100
West Nile	98.5	99.7	98.9
Western	95.9	98.2	97.7
South western	93.3	95.5	96.3
<b>Residence</b>			
Urban	97.3	97.9	97.7
Rural	95.9	97.5	97.7
<b>Management</b>			
Government	96.0	97.4	97.4
Private	97.2	99.0	98.9
NGO/PNFP	98.0	98.0	98.8
Other	100	100	100
<b>Total</b>	<b>96.3</b>	<b>97.6</b>	<b>97.7</b>

### 4.3 Client appraisal of Cost of family Planning Services

#### 4.3.1 Percentage of clients reporting paying for service and average amount paid by type of SDP, administrative Unit (Region), Urban rural residence, management of facility

FP services are generally for free in government managed facilities in Uganda. The results in table 47 below show that about 12% of the clients paid for FP services. Of these, 63% were from the private SDPs of which 56% were in Kampala while there were no clients who



reported to have paid for FP services in the Karamoja region. The charging of high fees for FP services in Kampala is attributed to the high number of private SDPs. On average Contraceptives from service provider (Provider dependent such as BTL, IUD, Implants) were more expensive (UGX 7000) compared to those purchased from pharmacy (Provider independent such as Condom or pills). Consultation fees were UGX 10,000 on average and were highest in Kampala (UGX 31,000), while Laboratory/X-ray cost UGX 6,200 on average. FP services were generally more expensive in urban areas compared to rural areas. On average, those that reported to have paid for FP services, paid UGX 4,200 in government facilities, UGX 5, 400 in private facilities and 6,000 in NGO based facilities.

Table 47: Client appraisal of cost of Family Planning methods

Characteristic	Percentage of clients reporting paying for service	Average amount paid in Uganda shillings					
		Card	Laboratory test/x-ray	Contraceptive received from service provider	Contraceptive purchased from pharmacy	Consultation fee	others
<b>Type of facility</b>							
Primary level	12.2	2,422	7,429	7,412	3,710	15,718	0.00
Secondary level	12.3	1,681	4,038	6,130	8,069	3429	0.00
Tertiary Level	3.1	2,000	3,000	20,000	3,000	0.00	0.00
<b>Region</b>							
Kampala	56.1	5,200	7,350	9,223	4,048	31,428	0.00
Central 1	11.9	1,750	5,000	4,710	2,727	4,167	0.00
Central 2	4.8	1,667	6,000	1,000	3,833	3,500	0.00
East Central	8.3	0	0	4,892	3,000	5,000	0.00
Eastern	7.9	1,720	1,857	5,097	3,000	1,667	0.00
Karamoja	0.00	0	0	0	0	0	0.00
Northern	4.4	500	0	0	2,000	500	0.00
West Nile	0.8	750	0	0	0	0	0.00
Western	2.7	6,000	0	3,667	3,000	0	0.00
South western	7.2	1,744	8,214	4,577	5,500	4111	0.00
<b>Residence</b>							
Urban	24.1	3,267	6,295	8,408	3,985	19,240	0.00
Rural	5.4	1,537	6,250	2,333	2,846	3,286	0.00
<b>Management</b>							
Government	3.2	1,495	9,083	4,500	2,857	3,222	0.00
Private	63.3	3,727	6,678	7,515	4,150	5,250	0.00
NGO/PNFP	28.6	1,875	3,812	7,178	3,000	14,590	0.00
Others	4.8	0	0	0	0	0	0.00
<b>Total</b>	<b>11.71</b>	<b>2,202</b>	<b>6,274</b>	<b>7,112</b>	<b>3,823</b>	<b>10,000</b>	<b>0</b>

### 4.3.2 Percentage distribution of clients by mode of transportation, distance travelled and cost of transportation

The Health Sector Strategic plan asserts that 72% of the households in Uganda live within 5km from a health facility (public or PNFP). It is further noted that besides the long distance, utilisation is limited due to poor infrastructure, lack of medicines and other health supplies, shortage of human resource in the public sector, low salaries, lack of accommodation at health facilities and other factors that further constrain access to quality service delivery.<sup>10</sup> Under this section, this 2014 facility assessment determined the mode of transportation used by the Family planning clients, as this can have a bearing on timely delivery of services. The distance travelled and the cost was also determined. Results are shown in Table 48 below.

**Table 48: Percentage distribution of clients by mode of transportation, distance travelled and cost of transportation**

Characteristic	Mode of transportation					Distance travelled	Average travel cost (to and from SDP)
	Walked	Bicycle	Motorcycle	Bus/Taxi	Private vehicle		
<b>Facility type</b>							
Primary	65.0	11.6	18.20	3.8	1.4	1.04	3,620
Secondary	54.3	11.4	25.0	7.4	1.9	3.38	3,666
Tertiary	39.6	8.0	28.9	17.7	5.9	4.43	3,778
<b>Region</b>							
Kampala	51.5	3.6	8.7	24.3	11.9	1.46	4,141
Central 1	57.6	6.9	29.5	5.1	1.0	<b>2.11</b>	2,838
Central 2	47.7	11.9	28.5	11.9	0.00	<b>3.79</b>	3,056
East Central	60.7	13.4	19.4	6.0	0.5	<b>3.41</b>	2,380
Eastern	63.9	16.3	18.2	1.2	0.3	<b>3.07</b>	2,860
Karamoja	65.2	8.7	21.7	0.0	4.4	<b>5.32</b>	7,000
Northern	56.2	23.9	17.4	1.5	1.0	<b>5.08</b>	5,227
West Nile	79.7	10.8	8.7	0.6	0.3	<b>3.35</b>	3,965
Western	63.4	7.2	26.2	1.8	1.4	<b>3.65</b>	4,900
South western	61.7	10.9	23.9	2.7	0.9	<b>3.52</b>	4910
<b>Residence</b>							
Urban	51.9	8.9	23.1	11.5	4.7	<b>3.21</b>	3,758
Rural	65.5	12.6	19.2	2.5	0.3	3.21	3,568
<b>Management</b>							
Government	62.1	12.5	20.82	4.0	0.63	3.32	3,570
Private	56.0	5.1	11.6	17.3	10.1	1.61	4,627
NGO/PNFP	56.2	8.2	25.1	7.1	3.4	3.04	3,566
Others	75.0	10.0	15.0	0.00	0.00	2.95	1,500
<b>Totals</b>	<b>60.92</b>	<b>11.34</b>	<b>20.48</b>	<b>5.48</b>	<b>1.77</b>	<b>3.21</b>	<b>3,649</b>

<sup>10</sup> HSSP III 2010/11-2014/15 p5

Most FP clients (61%) walked to the SDP for services. In regard to type of facility, most FP clients walked to primary level SDPs (65%), secondary level (54%) and tertiary level (40%) as shown in table 49 below. In the rural areas, 66% walked compared to 52% in the urban areas. Analysis based on regions revealed that most clients walked in West Nile (80%) walked which was the highest followed by Karamoja (65%), Western & Eastern (64%) and Southwestern (62%). The high incidences of clients who reported to have walked to SDPs in the rural areas was due to limited transportation facilities. The motorcycle was mostly used (21%) in transportation of clients to the SDP. Only about 2% of clients used private vehicles mostly in Kampala (12%).

On average, FP clients covered 3.2 km to reach the SDP (see Table 48 above). The distance covered to the tertiary level SDPs was highest (4.4 km) as compared to 3.4 km (at secondary) and 1.1km at (primary). The average cost of travel to SDPs was UGX 3600 with significant regional disparities. Karamoja region was the most expensive at an average of UGX 7,000 while East central was the cheapest at an average of UGX 2300. Karamoja region is a hard-to-reach area with poor road infrastructure and network thus increasing the costs of transport to SDPs.

#### **4.3.3 Average time spent by client for FP service**

On average, FP clients spent 1.9 hours to travel to the SDP from their place residence. FP clients spent on average 2 hours waiting for services, and 1.9 hours to travel from the SDP back to the place of residence as shown in table 49 below. As earlier seen in previous tables, only 36% perceived this waiting time as too long. There was no significant disparity in time spent to walk and to wait for services by level of SDPs. However in terms of regions, Karamoja had the highest distance from residence to SPD (3km), while Kampala had the lowest (1.5km). The average waiting time at the tertiary level SDPs was the lowest (1.9hours), while the least waiting time at the primary SDPs (1.7 hours). The average waiting time was lowest at tertiary SDPs because of the many number of service points and large numbers of staff available to provide FP services as compared to primary level and secondary facilities.

In terms of residence, results in table 49 also revealed that the FP clients waited for 1.7 hours on average at primary SDPs as compared to 2.1 hours in the government managed SDPs. The waiting time was shortest at private SDPs because of the limited number of clients who can afford to pay for the FP services. In terms of regional distributions, Karamoja sub region had the shortest waiting time (30 minutes) while Northern had the longest (6 hours). This could be attributed to the small numbers of FP clients received besides the traditional cultures, distance and education in hard-to-reach areas such as Karamoja. The longest waiting time experienced by clients at SDPs located in the Northern region could be attributed to the limited number of SDPs serving a big population and the limited availability of health workers.

**Table 49: Average time spent by client for FP service**

Characteristic	Average time spent (Hours)		
	Travelling from place of residence to SDP	Waiting for and receiving services	Travel from the SDP to place of residence
<b>SDP type</b>			
Primary level	1.9	2.0	1.8
Secondary level	2.0	2.1	2.0
Tertiary Level	1.8	1.9	2.0
<b>Region</b>			
Kampala	1.5	1.4	1.4
Central 1	1.8	2.4	1.8
Central 2	2.0	1.7	1.8
East Central	1.7	1.7	1.9
Eastern	1.8	2.1	1.9
Karamoja	3.0	0.5	3.5
Northern	2.3	6.0	3.0
West Nile	1.9	2.4	2.0
Western	1.9	2.0	1.9
South western	1.9	2.0	3.0
<b>Residence</b>			
Urban	1.8	2.0	1.8
Rural	1.9	2.1	1.9
<b>Management</b>			
Government	1.9	2.1	1.9
Private	1.5	1.7	1.5
NGO/PNFP	2.0	1.8	2.0
Other	2.0	1.8	1.9
<b>Total</b>	<b>1.9</b>	<b>2.0</b>	<b>1.9</b>

#### 4.3.4 Percentage distribution of clients by activities they would have engaged in during the time spent receiving FP services

Household chores 38% and working on household farm 36% were the most important activities FP clients reported they would be engaged in if they had not gone for FP services. This was especially among those aged between 20-24 years and 40-44 years respectively. The females dominated the household core (40%) while the men dominated selling and marketing (24%). Only 4% of women reported that they would be doing nothing, while 22% of men would be doing nothing in the time that they spent receiving for FP services.

**Table 50: Percentage distribution of clients by activities they would have engaged in during the time spent receiving FP services**

Respondents background characteristics	Percentage of activity supposed to be done								TOTAL
	N	Household chores	Working on household farm	Selling in the market/trading	Employed as an unskilled laborer	Employed as skilled laborer	Clerical or professional work	Not applicable (Nothing was to be done)	
Male	128	9.4	32.8	23.4	7.0	3.1	3.13	21.09	100
Female	1889	40.1	35.5	12.7	1.6	4.3	1.75	3.97	100
<b>Age in years</b>									
10-14	0	0	0	0	0	0	0	0	0
15-19	210	34.8	33.3	12.9	1.4	1.9	0.5	15.2	100
20-24	546	42.5	32.4	13.4	2.8	1.7	1.3	6.0	100
25-29	568	36.8	33.8	16.6	1.9	5.8	2.1	3.0	100
30-34	369	35.0	39.0	11.4	2.0	8.1	2.2	2.4	100
35-39	212	43.0	35.9	10.0	1.0	3.3	3.3	3.8	100
40-44	85	31.8	48.2	12.9	1.2	1.2	1.2	3.5	100
45-49	22	40.9	40.9	4.6	0.00	9.1	4.6	0.0	100
≥ 50	5	0.0	80.0	20.0	0.0	0.0	0.0	0.0	100
<b>Marital status</b>									
Never married	252	30.6	22.2	22.6	1.6	4.0	1.2	17.9	100
Currently Married	1141	39.4	35.1	12.7	1.8	4.7	2.2	4.1	100
Living together	534	40.8	39.3	11.1	2.4	3.6	1.3	1.5	100
Divorced/separated	53	39.6	43.4	9.4	0.0	1.9	1.9	3.8	100
Widowed	21	14.3	71.4	14.3	0.0	0.0	0.0	0.0	100
<b>Total</b>	<b>2017</b>	<b>38.2</b>	<b>35.6</b>	<b>13.4</b>	<b>1.9</b>	<b>5.1</b>	<b>1.80</b>	<b>5.10</b>	<b>100</b>

**4.3.5 Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were away receiving FP services and the estimated payment**

Nearly half of the FP clients left nobody to do their work while they attended FP services (49%), followed by those who while 35% left a family member (35%) and a co-worker (8%) as shown in table 51 below. The clients who left a family member were mainly

widowed (46%), currently married (39%), living together (33%), and never married (23%) as shown in table 51 below. This could be due to the fact that if the activity especially income generation was left unattended among this category, the household would not have any source of income to rely on. Most of the FP clients who left nobody to perform activities on behalf of client were living together (56%), and divorced/separated (54%), and few were never married (43%). In addition, most of the FP clients who left nobody to perform activities were aged 25-29 years (53%), 20-24 years (51%), and 50 or more years (50%) among others.

**Table 51: Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were away receiving FP services and the estimated payment**

Respondents' background characteristics	Percentage of person who performed activities on behalf of client					TOTAL	Average amount paid by client (UGX)
	N	Family member	Co-worker	No body	Not applicable		
<b>Sex</b>							
Male	188	25.5	12.2	43.6	18.6	100	3,000
Female	2213	35.9	7.6	49.4	7.1	100	17,930
<b>Age in years</b>							
10-14	0	00.0	0.0	0.0	0.0		0
15-19	260	29.2	5.0	46.5	19.2	100	0
20-24	651	34.7	5.5	51.3	8.6	100	3125
25-29	672	31.9	9.8	52.5	5.8	100	18,500
30-34	436	37.4	10.8	47.5	4.4	100	19,600
35-39	249	42.6	8.4	42.2	6.8	100	27,200
40-44	97	41.2	5.2	44.3	9.3	100	17,600
45-49	28	50.0	7.1	35.7	7.1	100	5,000
≥ 50	6	33.3	0.0	50.0	16.7	100	0
<b>Marital status</b>							
Never married	320	22.8	11.3	42.8	23.1	100	28,750
Currently Married	1358	38.88	8.03	47.0	6.1	100	18,795
Living together	613	33.6	5.7	56.0	4.7	100	11,888
Divorced/separated	65	29.2	7.7	53.9	9.2	100	6,500
Widowed	28	46.4	7.1	46.4	0.0	100	0
<b>Total</b>	<b>2401</b>	<b>35.2</b>	<b>7.8</b>	<b>48.9</b>	<b>8.1</b>	<b>100</b>	<b>18,166</b>

#### 4.3.7 Average amount paid to persons who performed activities on behalf of clients by activities while client was away receiving FP services

On average the person who took over household chores was paid UGX 5000 if the person was a family member and UGX 20,000 if it were a co-worker as shown in table 52 below. Those who worked on the household farm, were paid UGX 11,100 if it was a family member and UGX22,000 if it was a co-worker. It is clear that the FP clients who left nobody to perform activities on their behalf while receiving FP services, earned no income, and thus lost UGX15,327 as overall average as well.

**Table 52: Average amount paid to persons who performed activities on behalf of clients by activities while client was away receiving FP services**

Respondents Characteristics	Background	Average Amount paid to persons (in national currency-UGX)				Total Average Amount
		Family Member	Co-worker	Nobody	Others	
Household chores		5,000	20,000	0	0	12,500
Working on household farm		11,166	22,000	0	0	14,778
Employed as unskilled labourer		0	10,000	0	0	10,000
Employed as killed laborer		0	1,250	0	0	1,250
Clerical or professional work		0	27,875	0	0	27,875
Others		0	0	0	0	0
<b>Total</b>		<b>9,000</b>	<b>19,206</b>	<b>0</b>	<b>0</b>	<b>15,327</b>



**4.3.6 Percentage distribution of clients by source of funds used to pay for FP services**

Most FP clients, who reported paying for services got the money from their own sources. All male clients (100%) used own sources compared to the females who got money from their spouses (58%) and family members other than spouse (41%) as shown in table 53 below . Most FP clients who paid from own sources were widowed (100%), divorced (80%), never married (76%) and those living together (67%). The currently married mainly got money from their spouses (50%) which indicated that the spouse highly support their wives to go for FP services.

**Table 53: Percentage distribution of clients by source of funds used to pay for FP services**

Respondents' background characteristics	No. of clients	Percentage Source of fund used to pay for FP		
		Client(self)	Spouse	Family members other than spouse
<b>Sex</b>				
Male	21	100	0	0
Female	289	58.1	41.0	0.9
<b>Age in years</b>				
10-14	0	0	0	0
15-19	30	96.7	0.0	3.3
20-24	52	55.8	44.2	0.0
25-29	87	52.9	47.1	0.00
30-34	52	59.6	38.5	1.9
35-39	14	57.1	42.9	0.0
40-44	7	85.7	14.3	0.0
45-49	0	0.0	0.0	0.0
50+	0	0.0	0.0	0.0
<b>Marital status:</b>		0.0	0.0	0.0
Never married	67	76.1	23.9	0.0
Currently Married	119	47.9	50.4	1.7
Living together	43	67.4	32.6	0.0
Divorced/separated	5	80.0	20.0	0.0
Widowed	2	100	0.0	0.0

**4.3.7 Average amount paid from each source by background characteristics of client**

The highest amount of money paid for FP services was obtained from the client own sources. The other most important source was from the spouse. Clients between the age of 25 and 34 years paid the highest amount from own source. In total, the females FP clients paid more money (UGX 51,400) as compared to the males (UGX 3,500) mainly because females were the majority who went for FP services at SDPs. In total the currently married women also paid more money from all sources overall (UGX 55,179). The average amount of money paid was high because different clients go to different SDPs some of which are privately owned and offer specialized services which are expensive and or unsubsidized.

**Table 54: Average amount paid from each source by background characteristics of client**

Respondents' background characteristics	Average amount from each source used to pay for FP (UGX)			
	Client(self)	Spouse	Family members other than spouse	Total
<b>Sex</b>				
Male	3,500	0	0	3,500
Female	7,542	11,368	32,500	51,400
<b>Age in years</b>				
10-14	0	0	0	0
15-19	5,258	0	0	5,258
20-24	3,810	7,260	5,000	16,070
25-29	8,336.9	7,500	0	15,836.9
30-34	10,645	12,150	0	22,795
35-39	3,875	52,000	60,000	115,875
40-44	5,250	5,000	0	10,250
45-49	0	0	0	0
50+	0	0	0	0
<b>Marital status:</b>				
Never married	5,833.	13,250	0	19,083
Currently Married	10,596	12,083	32,500	55,179
Living together	3,068	6,428	0	9,496
Divorced/separated	3,625	7,500	0	11,125
Widowed	5,500	0	0	5,500

## 5 CONCLUSIONS AND RECOMMENDATIONS

**5.1 Availability of Modern Contraceptive methods:** There was a gap in availability of modern contraceptive methods. The finding that 17% of the primary SDPs did not offer a minimum of three contraceptive methods presents potential missed opportunities for delivery of FP as the range of products may not be sufficient to meet specific demands in some facilities. The reasons given for this included mainly the delay from the suppliers to deliver the supplies after an order has been placed. Another major reason was related to lack of trained staff to provide particular methods like insertion and removal of implants. Some methods like the female condom had low or no demand.

**5.2 Not all staff trained on insertion and removal of implants were providing FP services:** It was determined that while 70% of SDPs providing family planning services had received training in insertion and removal of implants, over 25% of the trained staff were not actually providing FP services. This sometimes was due to staff being transferred to other departments that are not involved in FP service provision especially in the referral level facilities, lack of equipment or staff leaving the SDPs. Also important to note is that out of the 523 SPDs who had staff trained in provision of FP, majority of these (60%) had this training provided beyond one year ago.

**5.3 Lack of Guidelines and job aids for FP:** It was determined that guidelines for FP services were available in 60% of facilities, implying that two in five SDPs lacked these guidelines. Checklists and job aids for FP were available in only 51% of the facilities at the Primary level. This is a challenge since facilities are supposed to use the guidelines for reference purposes while job aides are critical in proper execution of duties.

**5.4 Charging of user fees for family planning services:** In the majority of health facilities, Family Planning services are generally provided free-of-charge in accordance with the Ministry of Health guidelines. However 11% of the SDPs were charging user fees. While the private wings in Public facilities charge for services, the 15% of government owned facilities that charge consultation fees on FP was a cause for concern. The high fees paid by clients of private facilities for FP also needs to be checked before some clients are discourage. For example an FP client in Kampala pays consultation fees of up to UGX 31,000.

**5.5 High transportation costs for FP clients:** The low uptake of contraceptives in Karamoja region is well documented and sometimes blamed on cultural and traditional beliefs. However, the survey points us to the fact that on average, a client seeking FP services in Karamoja would spend about UGX 7,000 on transportation alone per visit. This is quite high for a region where general income is low compared to other parts of the country.

**5.6 Long waiting time for FP services by clients in Karamoja:** The average waiting time for FP clients in Karamoja and Northern Uganda was six hours compared to the regional

average of two hours for the Eastern Region. This is partly attributed to the limited availability of health workers in these two regions categorized as hard-to-reach.

**5.7 High levels of satisfaction with services by FP clients:** Findings from the exit interviews show that there is high level of satisfaction with FP services among the FP clients. For example, 93% expressed satisfaction with the services offered while 98% would continue visiting the SDP for services in future, and 98% would recommend the services to other people.

However, 20% of FP clients reported to have been forced to accept a method of FP, and this was mainly in government facilities. It implies that one in five clients feel they were coerced into a method that they were not comfortable with.

**5.8 Un-availability of essential lifesaving maternal and RH medicines:** The 38% of SDPs that did not meet the minimum indicative standard for availability of essential and life-saving maternal and RH Medicines (i.e. at least seven indicator medicines including the two essential lifesaving maternal and RH medicines). This included 26% of the secondary level facilities. This was a cause of concern as it showed gaps in emergency RH care. The main reason given for not having certain maternal health medicines was the delay on the part of the supplier/warehouse (75% of respondents).

**5.9 Support supervision had some gaps:** About 30% of SDPs had not been supervised in the last 12 months by their respective supervisory authority. However, of those who were supervised in the past 12 months, 42 % were supervised monthly, a positive indication of monitoring and support for quality RH service delivery. The MoH notes that supervision is affected by limited budgets and untimely release of funds. It is important that supervision is given priority and release of funds is done in time, to enable support supervision which is a critical component of health services provision.

**5.10 Stock-outs of Maama kits:** We established that 30% of facilities that are supposed to provide maama kits had stock-outs on the day of the survey, the main reason being the delay on the part of the suppliers. There seems to be major delays for most supplies. In addition, the private facilities do not routinely provide maama kits.

**5.11 Long time taken between ordering and receiving of supplies:** The average time it takes between ordering and receiving of supplies was six months and above for 17% of the SDPs. This when further analysed included 22% of facilities that are government owned. This is a long period that can potentially lead to disastrous events in the affected facilities; the rural based facilities (21%) also take more than six months to receive supplies.

**5.12 Waste disposal methods:** Majority of the primary and secondary SDPs dispose health wastes by burning on their grounds while tertiary SDPs dispose their wastes by incineration. At these levels, the methods used are in conformity with the Uganda National Infection

Prevention and Control Guidelines 2013 and there is no specific recommendation arising from this finding.

### **5.13 Recommendations:**

Regarding availability of modern contraceptive methods, the Ministry of health together with its partners and NMS should review the supply chain management process and ensure that supplies do not take long to get to the facilities. A business process re-engineering of the supply chain management system is recommended to ensure delays and unnecessary process are eliminated to reduce time it takes to supply from when orders are placed.

Continuous training for the insertion and removal of implants is encouraged to cater for the gap of lack of trained service providers, a major reason for the stock-out of two methods including Implants (33%) and IUDs (8%). This would ensure that even when staff leave a facility or are transferred to another department, there is continuity in provision of FP services.

Sensitization is recommended to increase the demand for some contraceptives like the female condom which was mainly out of stock due to lack of demand. Government and its partners should further sensitize on the use of condoms (male and female) in particular regions like Karamoja and northern Uganda where demand was low.

It is also recommended for staff that makes supply orders to be trained in supply chain and stock management including the filling in of order forms in the respective formats. Also important is to ensure that more than one staff has the ability to make the orders to cater for periods when another staff is either on leave, sick or when they leave the facility. The Facility in-charges especially at the primary level have to manage exquisitely the supplies unit and to continually monitor its performance to ensure internal processes do not lead to drug stock-outs.

Regarding the finding that not all staff trained on insertion and removal of implants were providing FP services; this may be a desirable situation as it implies that there is sufficient capacity to fill gaps that may arise due to staff attrition, provided that available excess trained staff within units are deployed in a way that ensures continuity of services. It is important that staff are continuously trained as already noted, and that training is followed up with provision of essential equipment or supplies that ensure that a method is complete and ready for provision at specific SDPs. Also, the health in-charges should be trained and guided on how to utilize internal staff capacity without necessarily hampering the provision of services that are specialized.

Regarding the availability of guidelines and job aids for FP, it is recommended that the MoH and its partners intensify the distribution and use of the guidelines and job aids in the different facilities where they were missing. The MoH and its partners should ensure that all

SDPs at all levels have the requisite job-aids in all departments that deliver FP services, and in a form that is easily usable as reference material by health workers.

Regarding payment for FP services, it is recommended that further investigation be done on the issue of user fees payment in facilities where FP services are supposed to be provided for free. Government should provide guidance to private wings in tertiary level health facilities where user-fees are permitted to differentiate between chargeable and non-chargeable services. Government should further intensify the sensitization drive to the public in regards to FP services being free. Government and other actors in RH service delivery should also where possible incentivize provision of free FP services in private-for-profit health facilities where such partnerships are possible

Regarding transport costs hindering access to FP services in Karamoja, it is recommended that government and its partners consider taking FP services closer to the people in Karamoja, or incentivize transportation on particular days to cater for those that cannot afford the cost of transport to attend FP. SDPs in such hard-to-reach areas should be supported to conduct supplemental integrated outreaches to reach the areas farther from health facilities.

Regarding the long waiting times for FP services in Karamoja region and Northern Uganda, it is recommended that further efforts to have more health workers in these regions be considered through incentivization and better pay, for as long as it brings medical services to these regions up to standard.

Regarding the high levels of satisfaction of FP clients with the services provided, appropriate positive feed-back loops should be initiated by government and stakeholders who support FP services to enhance the best practices in health facilities. Very often, the positive aspects of health service delivery are not reinforced by commending health workers where performance is good. The findings of this study should therefore be used to provide positive feed-back to health workers providing FP services regarding the community's general satisfaction with the care they give. On the other hand, forcing clients to take FP methods is ethically inappropriate. It is recommended that the training and technical support supervision given to the FP providers should include modules on ethical codes of conduct and issues to do with respect to the individual choices and autonomy over methods of FP.

Regarding the glaring gap in availability of essential life-saving maternal and RH medicines, the recommendation to improve supply chain management has already been made and cannot be overstated. In particular, since most facilities (especially the government facilities) cited that the gap was on the side of the suppliers, it is important that the recurrent problem of central stores constraining service delivery be dealt with through persistent leadership actions targeting these stores. This recommendation is also pertinent to the finding that about one in six health facilities (one in five government health facilities) receive their

supplies on average six months from the time they are ordered. It indicates clearly that the central level plays a key role in propagating stock-outs of RH commodities.

Regarding support supervision, Ministry of Health in collaboration with the District Health Office and implementing partners should design a schedule for support supervision for SDPs to ensure continued quality RH services including family planning. This schedule should include the MOH Regional Performance Monitoring Team (RPMT), a structure that is currently in all regions of Uganda.

Regarding availability of mama kits, it is recommended as already stated that supplies systems be reviewed to eliminate the irregularities and delays, but also importantly provision of maama kits by private providers should be promoted where such public-private partnerships are possible.

**Regarding the availability of guidelines and job aids for FP:**

It is recommended that the MoH and its partners strengthen and intensify the distribution and use of the guidelines and job aids in the different facilities where they were missing. The MoH and its partners should ensure that all SDPs at all levels have the requisite job-aids in all departments that deliver FP services, and in a form that is easily usable as reference material by health workers.

**Regarding payment for FP services**

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Regarding transport costs hindering access to FP services in Karamoja, it is recommend that government and its partners consider taking FP services closer to the people especially in hard-to-reach such as Karamoja region and in rural areas, or incentivize transportation on particular days to cater for those that cannot afford the cost of transport to attend FP. SDPs in such hard-to-reach areas should be supported to conduct supplemental integrated outreaches to reach the areas farther from health facilities.

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