

# Preventing Unintended and Unplanned Pregnancy among In-school Youth: An Acceptability and Feasibility Assessment



## **Advancing Partners & Communities**

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# ACRONYMS

APC: Advancing Partners & Communities

AYSRH: Adolescent and Youth Sexual and Reproductive Health

FP-CIP: Family Planning Costed Implementation Plan

FP/RH: Family Planning and Reproductive Health

FY: Financial Year

GOU: Government of Uganda

GREAT: Gender Roles, Equality and Transformation

m4RH: Mobile for Reproductive Health

MOESTS: Ministry of Education, Science, Technology and Sports

MOH: Ministry of Health

PHSC: Protection of Human Subjects Committee

SRH: Sexual and Reproductive Health

STI: Sexually Transmitted Infection

UDHS: Uganda Demographic and Health Survey

UGX: Uganda Shillings

USAID: U.S. Agency for International Development

WHO: World Health Organization



# EXECUTIVE SUMMARY

## WHY FOCUS ON PREVENTING UNINTENDED AND UNPLANNED PREGNANCY AMONG IN-SCHOOL YOUTH?

Young people's sexual and reproductive health (SRH) and education outcomes are inextricably linked. In Uganda, like many other places in the world, early and unintended pregnancy is a major contributor to school dropout for many girls — in fact, adolescent pregnancy is estimated to account for 59 percent of school dropout cases in Uganda.<sup>1</sup> However, when young people stay in school, they are more likely to initiate sexual activity later in life; and higher rates of education are associated with a lower prevalence of both HIV and pregnancy among adolescents. Capitalizing on the opportunity to reach many young people with critical SRH programming in a school setting can help to improve both health and education outcomes. To better understand the feasibility and acceptability of interventions to reduce unintended pregnancy among in-school youth, the Advancing Partners & Communities (APC) project in Uganda conducted a formative assessment in the Lira, Amuru, Oyam, Pader, Agago, and Dokolo districts.

## METHODOLOGY

APC conducted a series of key informant interviews with government officials (both local and national officials), school administrators, and members of youth-serving organizations. The respondents were based in six districts in Northern Uganda: Lira, Amuru, Oyam, Pader, Agago, and Dokolo as well as in Kampala. Respondents were asked about their perceptions of the SRH challenges faced by youth in Uganda, the perceived barriers to implementing a school-based approach, and the perceived acceptability and feasibility of implementing a school-based approach.

## RESULTS

Overwhelmingly, stakeholders interviewed for this assessment supported the idea of an intervention that offers in-school youth links to contraceptive information and services. The largest perceived barrier to participation in such a program was school dropout due to early pregnancy and early marriage. Participants were also concerned that parents and religious leaders might oppose a school-based program that promotes the use of youth-friendly SRH services. Finally, despite legal restrictions on the provision of contraceptives in school, there appeared to be widespread acceptance for establishing links between schools and SRH services.

Our analysis of the assessment data produced the following recommendations and conclusions:

- Programs seeking to link in-school youth to contraceptive information and services should target students during the last years of primary school, before dropout rates peak.

- Linkages between community health centers and schools should be strengthened so that students feel more comfortable turning to a trusted service provider for information or services that cannot be delivered at school.
- More research is needed to understand the perceptions of parents, adolescents, and political and religious leaders on the feasibility and acceptability of such an approach.
- Establishing a technical working group of implementing partners on preventing adolescent pregnancy through school-based links will ensure that all partner efforts are complementary and strengthen the sector response to adolescent pregnancy prevention.
- Engaging stakeholders such as parents and community members should be part of the development and implementation of any intervention.



# INTRODUCTION

Pregnancy during adolescence has devastating health consequences. Young women who become pregnant are at increased risks of maternal mortality, anemia, postpartum hemorrhage, prolonged obstructed labor, obstetric fistula, and malnutrition as compared with women age 20 and over.<sup>2</sup> Furthermore, infant and child mortality is higher for young mothers under age 20 than for mothers in any other age group. Lack of access to contraceptives is one major contributor to early pregnancy. Data suggest that the unmet need for contraception leads to 7.3 million unintended adolescent pregnancies annually.<sup>2</sup> Young women around the world face multiple barriers to accessing contraception, including restrictive laws and policies, negative gender and social norms, and a lack of youth-friendly reproductive health services.

Adolescent pregnancy not only is harmful to young women's health but also hinders young women's socioeconomic advancement. Young women who become pregnant are more likely to leave school early, have a lower income, and bear more children at shorter intervals throughout their lifetimes — increasing their risks of negative maternal and child health outcomes. In contrast, young women who avoid unintended pregnancy are more likely to stay in school, participate in the workforce, and have healthier, better-educated children.

Sexual and reproductive health (SRH) and education outcomes are inextricably linked. Capitalizing on the opportunity to reach many young people with critical SRH programming in a school setting can help to improve both health and education outcomes. World Health Organization (WHO) guidance for health-promoting schools emphasizes the importance of not only providing students with comprehensive sexuality education but also linking existing SRH education programs to contraceptive services.<sup>3</sup> Research demonstrates that such an approach can increase contraceptive use among sexually active young people and subsequently delay age at first birth.<sup>3</sup> Few programs in developing countries have specifically sought to improve access to adolescent-friendly SRH services through schools; however, results from a recent pilot program in South Africa offering students SRH information through small groups in schools, individual SRH counselling in schools, and clinic referrals demonstrated that the program was feasible, acceptable, and likely a scalable approach.<sup>4</sup>

In Uganda, 24 percent of young women under age 18 have begun childbearing, and adolescent mothers are more likely to give birth at shorter intervals than their older counterparts — further increasing the risks of negative maternal health outcomes associated with adolescent pregnancy.<sup>5</sup> Contraceptive use among this age group is generally low; the unmet need for contraceptives among married female adolescents ages 15–19 is 31 percent.<sup>3</sup> There is an evident and urgent need to increase young women's access to contraceptive information and services.

The direct relationship between education and adolescent pregnancy in Uganda is salient. A 2010 study by the Uganda Ministry of Education and Sports (MOES) revealed that 59 percent of school dropouts from the Universal Secondary Education program are due to early pregnancy (MOES, 2012).<sup>1</sup> Furthermore, out-of-school girls are more likely to become pregnant and less likely to use

contraception than those who have received some secondary education (UBOS, 2012).<sup>5</sup> Increasing young people's access to contraceptive information and services in Uganda could decrease the risk of adolescent pregnancy, avert the negative maternal and child health consequences of early childbearing and limited birth spacing, and improve school attendance and retention among girls.

The Advancing Partners and Communities (APC) project's mission is to advance and support community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. In 2015, the APC project in Uganda conducted a formative assessment in the Lira, Amuru, Oyam, Pader, Agago, and Dokolo districts to determine the feasibility and acceptability of linking in-school youth to contraceptive information and services, to potentially reduce unplanned and unintended pregnancy in Northern Uganda. This assessment is complementary to APC Uganda's existing portfolio in Northern Uganda, including collaboration with the Gender Roles, Equality and Transformation (GREAT) Project; the launch of Mobile for Reproductive Health (m4RH); promotion of the Marie Stopes Uganda toll-free hotline; and mapping of outreach activities for family planning service providers. All of these activities, including this assessment, aim to increase access to SRH information and services and improve the reproductive health outcomes of youth in Northern Uganda.

## GOALS AND OBJECTIVES OF THE ASSESSMENT

The goal of this activity was to determine the feasibility and acceptability of reducing unintended pregnancy among in-school youth in Uganda through links to contraceptive information and services. The main objectives were:

- To understand the laws and policies in place that may support or hinder young people's access to pregnancy-prevention information and services.
- To understand the feasibility of linking students to pregnancy-prevention information and services as a part of existing school-based health initiatives.
- To determine the acceptability of linking students to pregnancy-prevention services among key education stakeholders, including ministry and other education officials, educators, and school-health providers.
- To identify referral networks for in-school youth to help them access pregnancy-prevention information and services.
- To inform future policy and programming related to school health and adolescent pregnancy prevention in Uganda.

# BACKGROUND

## I. ADOLESCENTS AND YOUTH IN UGANDA

Uganda has one of the largest youth populations in the world. Approximately 52.7 percent of the population is under 15 years of age. One in every four Ugandans (23.3 percent) is an adolescent, and one in every three (37.4 percent) is a young person.<sup>6</sup> Young people in Uganda, like in many other countries, are vulnerable to diverse health challenges including poor SRH outcomes such as sexually transmitted infections (STIs), HIV/AIDS, early or unwanted pregnancy, and unsafe abortion. Economic inequality and lack of employment opportunities can increase the vulnerability of young people. This situation is compounded by a lack of adequate social services, low access to information, poor demand for and utilization of reproductive health services, and high levels of school dropout.<sup>6</sup>

## II. UNINTENDED PREGNANCY AMONG YOUNG PEOPLE IN UGANDA

According to the 2011 Uganda Demographic and Health Survey (UDHS), the proportion of adolescents (ages 10–19 years) who have started childbearing has declined over time, from 43 percent in 1995 to 24 percent in 2011.<sup>5</sup> Despite a decreasing trend, adolescent pregnancy remains a major health and social concern in Uganda. Rates of adolescent pregnancy are higher among adolescents in rural areas than among their urban counterparts.<sup>5</sup> Adolescent pregnancy also varies greatly with level of education; in Uganda, 16 percent of girls with secondary education have begun childbearing, compared with 45 percent of those with no education.<sup>5</sup> A high prevalence of adolescent pregnancy is also observed among adolescents of lower socioeconomic status than among those who are relatively well off.

Infants born to adolescents are generally prone to higher morbidity and mortality than those born to older women; infant mortality among adolescent mothers in Uganda is 105 deaths per 1,000 live births, compared with a national average of 77 deaths per 1,000 live births.<sup>5</sup> High rates of adolescent pregnancy often lead to unsafe abortions and related complications, including death or disability. Of the nearly 1.83 million pregnancies that occur each year in Uganda, an estimated 16 percent end in induced abortion.<sup>7</sup> Mortality associated with unsafe abortion contributes nearly one-third of maternal deaths among young people in Uganda.<sup>8,9</sup> According to the United Nations Joint Programme on Population, adolescent pregnancy in Uganda is associated with various factors including early marriage and school dropout.<sup>10</sup> Current school policy requires pregnant girls to terminate their education.<sup>5</sup>

### III. CONTRACEPTIVE USE AMONG YOUNG PEOPLE IN UGANDA

Contraceptive use among young women in Uganda is relatively low. Only 14 percent of married women ages 15–19 report current use of any contraceptive method, and contraceptive use is lowest among women younger than age 25 than among women of any other age group.<sup>5</sup> Concerns about side effects, low perception of pregnancy risk, opposition from partners or others, inadequate knowledge about methods, and limited access to contraceptives all contribute to low rates of contraceptive use and high rates of discontinuation, even among women who do not want to become pregnant.<sup>10,11</sup> Other barriers such as distance, cost, stock-outs, lack of friendly services, and inconvenient hours also contribute to non-use. These barriers are often exacerbated for young women. In addition, inadequate counseling or information contributes to inconsistent or incorrect contraceptive use among this age group.<sup>10,11</sup>

A study conducted in Western Uganda identified side effects, stigma associated with contraceptives, cost, lack of contraceptive varieties, partner refusal, lack of contraceptive knowledge, and unplanned sexual encounters as some of the key barriers to contraceptive use among both in- and out-of-school adolescents.<sup>12</sup> Another study conducted in Uganda found that more than one-third of the providers interviewed would not provide contraceptives to those who were younger than 18 years of age, unmarried, still in school, or without children.<sup>8</sup> The providers felt that as parents, it was morally unacceptable to offer contraceptives to young people.

Meeting the needs of unmarried women, particularly young never-married women, requires innovative efforts. These could include improving the information and services targeted to this group, offering a wide selection of appropriate methods, implementing broad public-education campaigns to reduce stigma around unmarried women's sexual activity, and changing providers' attitudes toward this group.<sup>11</sup>

### IV. POLICIES AND LEGAL FRAMEWORK THAT AFFECT YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH IN UGANDA

Following the 1994 International Conference on Population and Development, several international policies in support of young people's health and development were created. As a result, many policies and guidelines in Uganda now prioritize adolescent and youth needs and interests, and support the SRH of young people. As shown by the policies reviewed below, the current policy framework in Uganda promotes the provision of SRH information in school, as well as access to and availability of family planning information and services irrespective of age, marital status, and schooling status, as long as a person is sexually active and is in need of the information and services. There is no provision in the current policy framework that requires consent from parents or a spouse before family planning services are provided to an individual. This means that access to family planning services is supported for young people under age 18, including those who may be in primary or secondary school. However, it is important to note that despite the existence of supportive policies and guidelines, nationwide dissemination and implementation remains a

challenge. This may partly explain why some Ugandan providers decline to provide family planning services to young people, as documented in some studies.

*Health Sector Strategic Plan II 2010/11–2014/15*<sup>13</sup>

A strategic focus of this plan is to strengthen both adolescent SRH services and the legal and policy environment, to promote effective access to and delivery of SRH services. The key strategic interventions are to integrate and implement adolescent SRH in school health programs; increase the number of facilities providing adolescent-friendly SRH services; review SRH and related policies to address institutional barriers to quality SRH; and review standards, guidelines, and strategies.

*Health Sector Development Plan 2015/16–2019/20*<sup>14</sup>

Objective 1 of the Health Sector Development Plan, “To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services,” and Objective 2, “To address the key determinants of health,” include a focus on adolescent and youth sexual and reproductive health (AYSRH). AYSRH is prioritized within the following program areas: (1) reproductive, maternal, and newborn health, where the key intervention is the implementation of the costed plan for family planning services at all levels of care; and (2) school-age and adolescent health (6–24 years of life), where the key interventions are the establishment or functionalization of adolescent-friendly corners at all levels of care, promotion of good nutrition, and sexual and reproductive health education in schools and communities. The document further highlights “school health” as one of the program areas aimed at addressing the key determinants of health.

*Uganda Family Planning Costed Implementation Plan (2015–2020)*<sup>15</sup>

The Uganda Family Planning Costed Implementation Plan (FP-CIP) details the country’s plans to achieve its vision and goals to improve the health and well-being of its population and the nation through providing high-quality, right-based family planning information and services. The plan describes the necessary program activities and costs associated with achieving national goals, providing clear program-level information on the resources the country must raise domestically and from partners. The FP-CIP intends to achieve two main operational goals by 2020; (1) reduce unmet need for family planning to 10 percent and (2) increase the modern contraceptive prevalence rate among married women and women in union to 50 percent by 2020.

The operational goals will be met through realization of 42 strategic outcomes structured around six essential components or thematic areas of a family planning program: (1) demand creation; (2) service delivery and access; (3) contraceptive security; (4) policy and enabling environment; (5) financing; and (6) stewardship, management, and accountability. Furthermore, five strategic priorities have been identified representing key areas for financial resource allocation and implementation performance. The first priority among the set of five key priorities is to “increase age-appropriate information, access, and use of family planning amongst young people, ages 10–

24 years.” This confirms the commitment of the sector ministry and stakeholders for improved access to family planning information and services among adolescents and youth.

*National School Health Policy for Uganda (Final Draft, 2014)*<sup>16</sup>

The goal of this policy is to adopt the guidance in the National Adolescent Health Policy (2004) for providing sexuality education. It recommends the integration of life skills-based education at all levels of education and the improvement of access to and utilization of SRH services among young people. The policy has six main themes, with sexuality education and school health services among those that are prioritized, and it highlights the importance of sexuality education in enhancing life skills and decision making among young people. It further outlines topics to be included in a comprehensive sexuality curriculum including gender, special needs, sexual health, HIV, sexuality, relationships, communication and negotiation skills, self-respect, non-discriminatory attitudes, intimate partner violence, puberty and menstrual hygiene, contraception and prevention of adolescent pregnancy, unsafe abortion, and rights of young people. The policy also encourages linkages between schools with qualified health service providers or health facilities, to ensure access to services for those in need. It states that all educational institutions in collaboration with school communities should establish measures to prevent teenage/early pregnancies; they should also work with the Ministry of Education, Science, Technology and Sports (MOESTS) and the Ministry of Health (MOH) to establish guidelines on managing cases of adolescent pregnancy in which the adolescents wish to continue their education both during pregnancy and upon giving birth. It places a special emphasis on nondiscrimination and psychosocial support for young parents.

*The National Policy Guidelines and Service Standards for Reproductive Health Services (2001)*<sup>17</sup>

These guidelines promote the increased availability and accessibility to SRH services for all people in need, including young people. Chapter three of the guidelines highlights the importance of family planning and clearly states that “all sexually active males and females in need of contraception are eligible for family planning services provided that: they have been educated and counseled on all available family planning methods and choices; [and] attention has been paid to their current medical, obstetric contra-indications and personal preferences.”<sup>17</sup> It further recommends that clients be counseled individually and in a dignified manner. It states that discussions between service providers and their clients must be private and confidential, and should never include incentives or coercion for the adoption of any method. The guidelines emphasize that “no verbal or written consent is required from parent, guardian or spouse before a client can be given family planning services.” This therefore means that that all young people are eligible for family planning services, and that access to family planning should not be restricted based on issues of consent, even when a person is below the age of consent.

*Guidelines for Prevention, Mitigation and Management of HIV and Teenage/Unintended Pregnancy in School Settings of Uganda (2014)*<sup>18</sup>

The overall purpose of these guidelines, which reference the School Health Policy, is to prevent and manage teenage/unintended pregnancy and HIV in school settings. The guidelines outline some key interventions to help prevent pregnancy, including the creation and support of school safety nets; the provision of life skills; and age-appropriate, gender-segregated, and culturally acceptable sexuality information, including information on family planning. They further stress the need to campaign for and create support mechanisms for abstinence in secondary schools, advocate and tailor behavior-change teaching and learning in secondary schools, create opportunities to understand and make safer sex negotiations/options including condom use, and deliberately create room for reintegrating young mothers back into school. Like the School Health Policy, these guidelines do not advocate for consent of any sort for a learner to access family planning information.

*The National Adolescent Health Strategy (2011)*<sup>19</sup>

The goal of this strategy is to mainstream adolescent health into the national development process to improve adolescents' quality of life and standards of living. They suggest the provision of adolescent-friendly health services and highlight the need for a minimum package of adolescent-friendly services and national uniformity in their provision.

*National Adolescent Health Policy for Uganda (2004)*<sup>20</sup>

This policy provides a framework for the development of adolescent health programs and services, outlines the roles that the various government ministries can play in ensuring adolescent health, and establishes key target areas. Reducing pregnancy among adolescents, increasing contraceptive use among sexually active adolescents and youth, ensuring the integration of post-abortion care into all health centers, and improving rates of readmission into the education system for young mothers are some of the key sexual and reproductive health targets established in this policy.

*The Republic of Uganda, National Youth Strategy (2001)*<sup>21</sup>

The goal of this policy is to provide a framework for enabling youth to develop socially, economically, culturally, and politically to enhance their participation in the overall development process and improve their quality of life. The policy highlights eight priority areas/actions, including health. The policy emphasizes the importance of advocating for the improvement, provision, and expansion of access to health services, and of making the services youth-friendly by removing all legal, regulatory, structural, medical, and attitudinal barriers to access. It further stresses the importance of advocacy for the adoption and implementation of the Adolescent Health Policy and Service Standards, and the right for youth to participate in making decisions that affect them.

*National Population Policy Action Plan (2011–2015)*<sup>22</sup>

The aim of this policy and action plan is to address population issues in Uganda. The policy categorizes population issues into five thematic areas, including SRH and rights. The policy stresses the need for information and access to safe, affordable, and acceptable methods of contraceptives for both men and women. It further highlights the need for attention to the promotion of mutually respectful and equitable gender relations, with an emphasis on the educational needs of children and the service needs of adolescents. The key actions recommended include advocating for the affordability, availability, and accessibility of quality health services; promoting the strengthening and expansion of a functional referral system; promoting the strengthening of adolescent and youth-friendly SRH services; and advocating for an increased budget for reproductive health and the institutionalization of adolescent and youth-friendly services.

*National Strategic Plan on Violence Against Children in Schools (2015–2020)*<sup>23</sup>

This is a five-year framework to guide national action on violence against children in schools. The framework lays out a plan for providing a safe learning environment that encourages and enables children to finish school. The expected outcome is to decrease violence against children in schools by 50 percent. The objectives are to (1) foster a positive and progressive attitude toward the protection of children; (2) improve the ability of institutions to provide prevention and response services for children that is age, ability, and gender appropriate; (3) empower children and promote their participation in preventing and reporting cases of violence; (4) improve knowledge management of evidence-based policy and advocacy about violence against children in schools; and (5) bolster coordination, collaboration, and partnerships among stakeholders engaged in preventing and responding to violence against children in schools.

*The Gender in Education Strategic Plan (2015–2020)*<sup>24</sup>

This plan aims to ensure that children—no matter their social status, location, ability, or gender—benefit from equal educational opportunities. The objectives for this policy are to effectively respond to gender concerns at all levels of the education sector; accumulate comprehensive, user-friendly, and up-to-date gender-disaggregated data; ensure that key actors and decision makers in the education sector are aware of gender issues and have skills in gender analysis, research, and documentation; and finally, ensure that gender-related initiatives in the education sector are well-coordinated by a gender unit that will be funded and implemented through the Ministry of Education and Sports' budget.

*The National Strategy to End Child Marriage and Teenage Pregnancy (NSCM&TP) (2014/2015–2019/2020)*<sup>25</sup>

This is a detailed, multisectoral guideline for the Government of Uganda and all partners and stakeholders involved in helping to end child marriage and teen pregnancy. The guideline's objectives are to (1) strengthen child protection mechanisms and uphold current legislation to encourage an environment conducive to ending child marriage and teen pregnancy and (2) alter social and cultural norms to reduce the practice of child marriage and teen pregnancy in Uganda.



The strategy focuses on bolstering policies that protect children; modifying social norms that uphold child marriage and teen pregnancy; increasing access to protection, education, and reproductive health services for children; empowering boys and girls and providing relevant life skills; creating and reinforcing structures to implement the NSCM&TP plan; and developing coordinating mechanisms to manage the NSCM&TP strategy.

*National Strategy for Girls' Education (NSGE) in Uganda (2014–2019)*<sup>26</sup>

The purpose of this strategy is to address gender inequalities, especially in the school system, that create barriers to young girls' ability to receive education. Only certain aspects of this strategy pertain to sexual and reproductive health education in schools. As a result of this strategy some schools have developed programs to promote girls' education; curriculum reviews include creating a more gender-responsive school environment, separate sanitary facilities for girls and boys, promoting sex education, and recruitment of teachers that are good role models for young girls. Some schools have emphasized messages that promote girls' education, such as "sexual and reproductive health is your right," "be proud of your virginity—it is a virtue," and "early marriage blocks your future." There is also an increased emphasis on removing taboos associated with menstruation. Some schools provide emergency sanitary pads and additional sets of school uniforms, and some classrooms are even making sanitary pads during arts and crafts.

Despite this forward movement in some schools, the vast majority of national-level education experts have only heard of the NSGE and haven't implemented the strategy into school districts. Due to this lack of action, at the district level virtually no one has heard of the NSGE. Unfortunately, many barriers to education still exist for young girls; sexual abuse, both in and out of school, is one of the top challenges.

*Creating a Gender Responsive Learning Environment (July 2015)*<sup>27</sup>

This is a practical guide for mainstreaming gender in education. The objectives are to alter teacher attitudes toward equitable gender relations, help teachers reduce gender-related barriers to learning, promote healthy teacher–student relations, and encourage gender responsiveness. It provides case studies and classroom activities.

*Reporting, Tracking, Referral and Response (RTRR) Guidelines on Violence Against Children in Schools (May 2014)*<sup>28</sup>

This document offers legal and policy framework on violence against children in schools in Uganda. One study showed that 98 percent of children ages 8–18 years had experienced either physical or mental violence, and 24 percent of these cases had occurred at school. This is a major threat to children's health, as well as to their school retention and performance. This document provides guidelines for reporting, tracking, referral pathways, and responses that all individuals (children, teachers, parents, community members, and school administrators) need to follow when cases of violence against children occur in schools.

## V. FUNDING MECHANISM FOR SEXUAL AND REPRODUCTIVE HEALTH IN UGANDA

Financing for the Uganda health sector is provided by the Government of Uganda (GOU) and development partners. The GOU has steadily increased its budget allocation of funds to the health sector. However, it continues to allocate less than 10 percent of its budget, which is less than the 15 percent agreed on in the Abuja Declaration.<sup>29</sup> During the 2013/2014 fiscal year, the GOU allocated 8.6 percent of the approved budget to the health sector.<sup>30</sup> The majority of health funding comes from development partners, with between 50 percent and 70 percent of the MOH budget for drugs and services provided by donor organizations.<sup>30</sup>

The GOU has demonstrated a commitment to increase funding for family planning and reproductive health (FP/RH) commodities; its contribution for the provision of FP/RH commodities increased from US\$5 million in financial year (FY) 2009/10 to US\$6.8 million in FY2013/14.<sup>30</sup> The GOU has increased its expenditure on the procurement of contraceptives and selected reproductive health supplies more than five-fold — from approximately Uganda Shillings (UGX) 1.4 billion in FY2009/10 to UGX 7.5 billion in FY2012/13 — a great milestone for the Uganda family planning program. Despite an increase in the budget allocation by the government, 68 percent of the FP/RH commodities are funded by development partners.<sup>30</sup> The major foreign sources of commitment include the U.S. Agency for International Development (USAID), the Department for International Development, the United Nations Population Fund, and the World Bank DELIVER Project.<sup>30</sup>

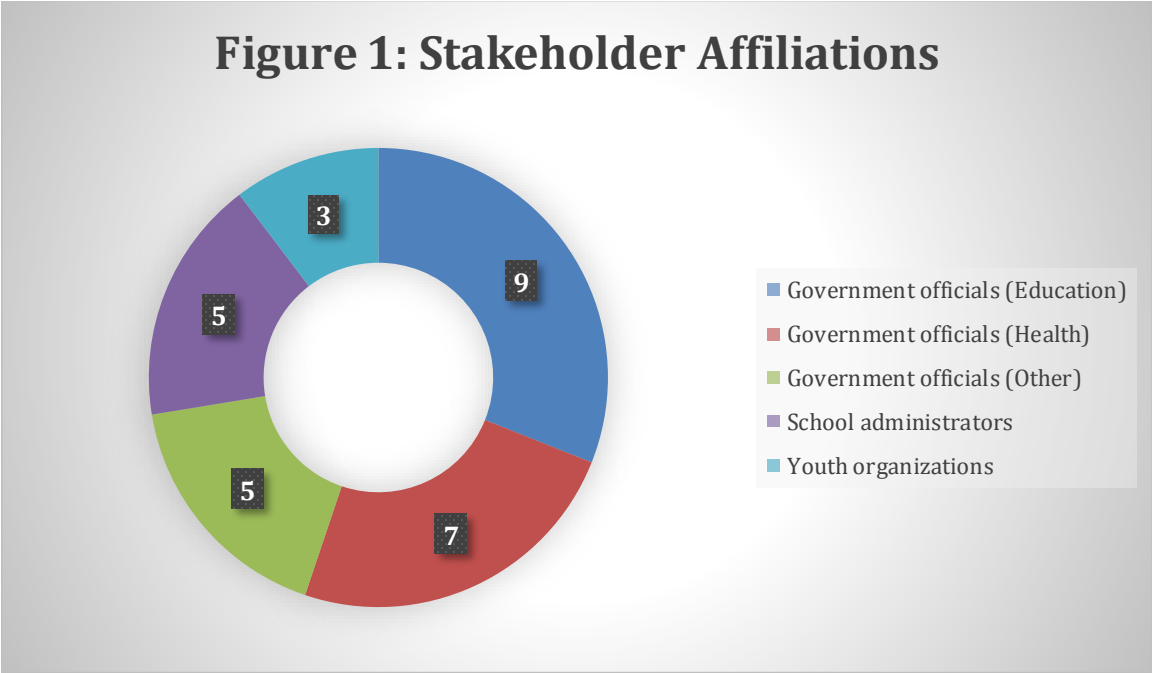
## VI. HEALTH SECTOR RESPONSE TO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

The Ministry of Health (MOH) is the organizing body for the national adolescent sexual and reproductive health technical working group in Uganda. The MOH is also responsible for providing guidance and technical assistance to partner organizations implementing adolescent sexual and reproductive health programs, coordinating programs nationally, promoting the scale-up of AYSRH programs, setting service standards, conducting research, and ensuring the integration of adolescent health into existing programs.<sup>20</sup>

# METHODS

To determine the feasibility and acceptability of reducing unplanned and unintended pregnancy among adolescents and youth in Northern Uganda through links to FP/RH information and services, APC conducted a series of key informant interviews. Sample sizes were determined through convenience and feasibility, and purposive sampling was used to identify assessment participants. Working in collaboration with MOES officials in Lira, Amuru, Oyam, Pader, Agago, and Dokolo, we identified a representative sample of key informants including national and district MOES and MOH officials, school administrators, school health providers, and teachers stratified by school and district.

The respondents were based in six districts in Northern Uganda: Lira, Amuru, Oyam, Pader, Agago, and Dokolo. Twenty-nine respondents from three stakeholder affiliations in Uganda participated in the survey: local and national government officials (education [9], health [7], other [5]), school administrators, and members of youth-serving organizations. The number of stakeholders in each affiliation is depicted in Figure 1.



## VII. ETHICAL CONSIDERATIONS

This assessment was submitted to FHI 360's Protection of Human Subjects Committee (PHSC), which determined that the project did not meet the regulatory definition of research involving human subjects, as defined under the Department of Health and Human Services Code of Federal Regulations [45 CFR part 46.102(d)(f)]. Given this determination, review and approval of this project by the PHSC was not required.

Even though PHSC review was not required, the study team made every effort to protect participant confidentiality. Prior to beginning key informant interviews, data collectors obtained informed consent from each participant. Interview participants were told that their participation was optional, they could terminate their participation at any time, and they could refuse to answer any items. As part of the consent process, participants were provided detailed information about the assessment goals and objectives. They were also asked to sign an informed consent form but were told that their names would not be linked to any of the information they provided, or be written on any other project materials. All data collectors had previous ethics training.

## RESULTS

### VIII. PERCEPTIONS OF THE SEXUAL AND REPRODUCTIVE HEALTH CHALLENGES FACED BY ADOLESCENTS AND YOUTH IN UGANDA

Interview participants were asked about their perceptions of the most salient SRH challenges faced by adolescents and youth in Uganda. Across all stakeholder types, there was a consensus that perhaps the most overarching SRH challenge was the high rate of unplanned pregnancies among primary and secondary school-age children. Many stakeholders noted that unplanned pregnancies, sexual abuse, and child marriage were the main factors that resulted in significant rates of school dropout and intergenerational poverty.

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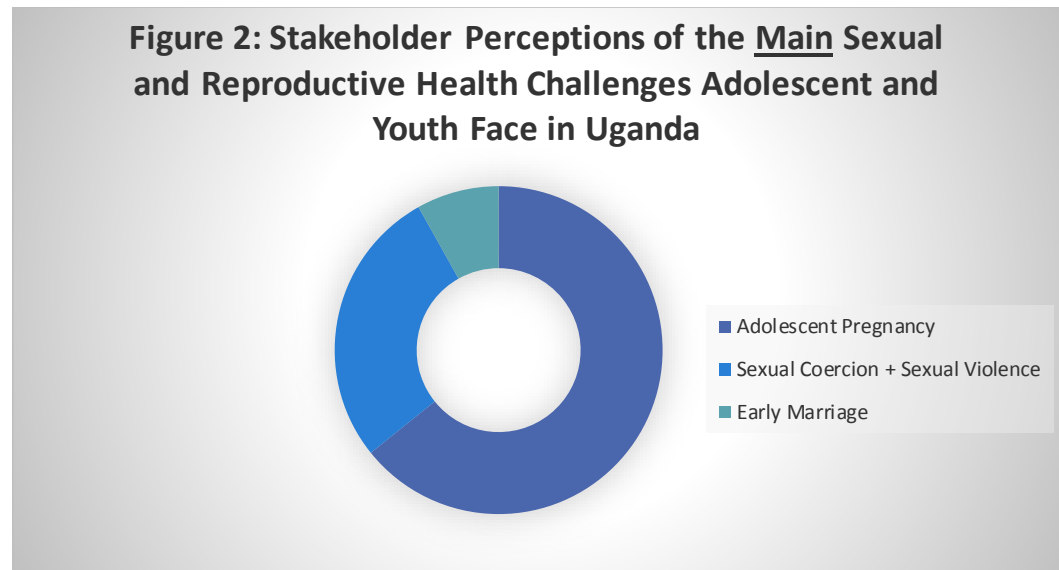
*“When you begin to reflect on the trend of the enrollment of the girl child in our schools, you find that from primary one to primary three girls are outnumbering boys but from primary five, six and seven, the number of enrollment of girls drastically comes down as a result of defilement, early marriages and early pregnancies.”*

*—School Inspector*

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Respondents were also queried on their perceptions of the main SRH challenges faced by youth in Uganda. As Figure 2 reflects, respondents believed adolescent pregnancy to be an overwhelming challenge in Uganda, followed by sexual coercion/sexual violence and, finally, child marriage. Of

note, respondents were able to select more than one answer for this question; however, across all stakeholder groups, 100 percent of those who responded viewed adolescent pregnancy as a problem (main problem or additional problem) in Uganda.

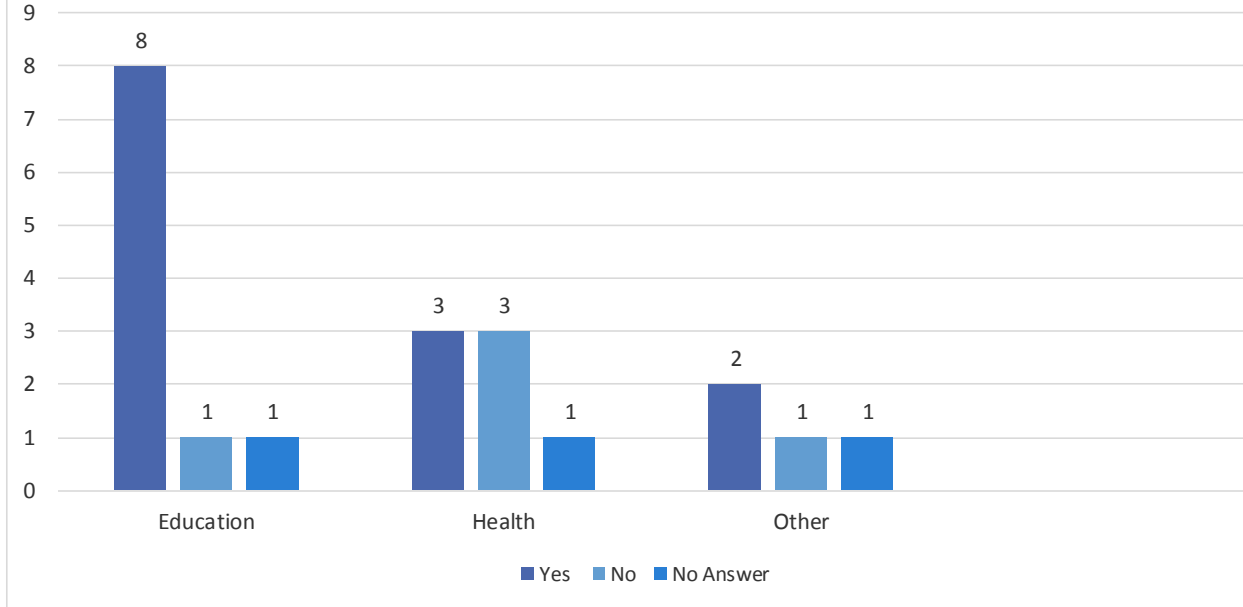


In addition to mentioning the factors listed in Figure 2, stakeholders shared that the additional determinants that exacerbate SRH challenges in Uganda include low levels of education for girls (brought on by gender inequality), lack of correct SRH information, lack of affordable and accessible contraceptive methods, and lack of youth-friendly services free of stigma and discrimination.

As a follow-up question to the perceived SRH challenges Ugandan youth face, respondents were asked whether youth SRH was a priority issue for the GOU. The majority of school officials, particularly head teachers, did not respond to this question. All youth-serving organizations replied that youth SRH was not a priority in Uganda.

Figure 3 demonstrates that among government officials, responses were mixed. The majority of government officials working in the education sector felt that youth SRH was prioritized. Among government officials in the health sector and those categorized as “other,” there was a divisive split. Officials who determined that youth SRH was not a priority issue in Uganda provided the following rationale: (1) very little funding and resources are allocated for youth SRH in the national (and consequently local) health work plan and budget; and (2) limited FP/RH services exist, and those that do exist are not generally youth-friendly and have stigma attached to them, which inhibits young people from accessing the rights-based quality care they need.

**Figure 3: Government Officials' Opinions as to Whether Adolescent and Youth Sexual and Reproductive Health Is a Priority in Uganda**



In Uganda, stakeholders noted that it is uncommon for students to ask where they can obtain contraceptive or family planning services. As such, respondents were asked their opinions on the most appropriate age for which to offer youth access to contraceptive services. There was a firm division of opinion, with half of respondents indicating that contraceptive services are only appropriate for students in secondary school, in accordance with the legal age for consent — 18. Respondents in this category feared that exposing youth to contraceptive knowledge and services too early might encourage or entice them to begin engaging in sexual activity.

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*“Contraception is for adults who have consented to live a family life and go ahead to spacing their children. If we introduce these methods to young people they will become reckless and will go into the habit of getting themselves engaged into sexual activities. For those in secondary schools I would prefer sexuality education for them but not family planning contraceptives.” –District School Inspector*

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Other stakeholders felt that given the rise of unplanned pregnancies among girls younger than 18, there was a dire need for contraceptive information and services beginning at age 10 or 11.

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*“Any girl who is in reproductive age should access the services who cannot abstain [from sex], and when they request for family planning services, give them. We cannot go ahead to tag the figures that from 18 to 49 years. Some girls get pregnant much earlier than 18 years and they are the ones that are having sex and they are not protecting themselves. So they are the ones who get pregnant easily so they must not be denied the services.” –District Health Officer*

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## IX. PERCEIVED BARRIERS TO IMPLEMENTING A SCHOOL-BASED APPROACH

Respondents also provided feedback on potential barriers that could affect the implementation of youth family planning programs, either at schools or within youth-serving organizations. Results indicated more perceived barriers to school-based family planning programs than to out-of-school programs. For in-school programs, parents need to give consent and also need to be encouraged to allow their daughters to stay in school so that they can take full advantage of the interventions. Another barrier is that if the interventions are at school, the programs will not be able to provide contraceptive methods (in accordance with a mandate from the Ministry of Education); however, education on contraceptives is acceptable. Given that the interventions might discuss topics that are not in accordance with religious, traditional, or cultural values of the community, getting community buy-in from local and religious leaders was cited as another potential obstacle.

To circumvent the barriers described above, the respondents suggested that the following stakeholders be engaged from the program outset:

- Representatives from the MOH and the Ministry of Education, for their support at the national and district levels.
- Selected pupils who could be trained as advocates for the program and recruit other adolescents and youth (both in and out of school).
- Teachers, who ideally could be trained to deliver SRH themselves.
- Parents, so they can create an enabling environment at home in which to discuss family planning options with their children.
- Representatives from the School Management Committee and the local council, to ensure their sessions are being held and to advocate for the long-term sustainability of the programs.
- Religious leader, to advocate for, support, and recruit parents and guardians to participate and allow their children to participate in the interventions.

## X. PERCEIVED ACCEPTABILITY AND FEASIBILITY OF IMPLEMENTING A SCHOOL-BASED APPROACH

Respondents were also asked their opinions on the acceptability and feasibility of primary and secondary school-level reproductive health interventions. As detailed above, some of the potential barriers regarding the acceptability of a school-based program would stem largely from the parents.

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*“The parents may not accept if the teachers are to come out with such programme and that’s why I am saying it’s the parents and stakeholders to be convinced first. The parent would really object to it just because for them they don’t know importance of family planning to especially these young girls since for them they think that family planning is only for married people or a woman and husband who stay together in a home. But cases of pregnancies are not only with married people.”*

*–District Education Officer*

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Respondents also warned that given the fact that a school-based program might condone family planning practices that contradict the religious beliefs and traditional values of the community, stakeholders such as religious and local leaders may not support its implementation. Other stakeholders were assured that with enough community sensitization and meaningful participation of key stakeholders, opponents of such a program would become more amenable and open-minded.

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*“The community just needs a gradual change to change people’s perception. They still think that girls should be married early but with information they can change.”*

*–Youth-serving Organization*

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There were many perspectives on whether a school-based intervention would be feasible. Poverty was seen as an overriding barrier to the feasibility of the program, primarily due to early school dropout to transition girls to early marriage. With such low school attendance during developmentally formative years, adolescents would not be able to take advantage of a school-based intervention unless community members and parents were sensitized to the benefits of keeping their children in school.

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*“So you find because of the hard economic hit up which is there, the families fail to make ends meet and end up selling their daughter. As for the boy child, he is left to go and do some work and so you find in schools the paying of the little PTA fees becomes expensive, which forces the child to look for ways.”*

*–Government Official*

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The other factor for consideration involved coverage — ensuring the program would target both rural and urban youth in areas with the highest rates of early pregnancies, gender-based violence, and early marriage.

Respondents from the Agago and Lira districts were confident that such a program was feasible because they have already taken strides to impart SRH information in schools through the Keep It Real project, with training materials provided by Save the Children that covers topics on SRH, gender, and HIV/AIDS prevention. Similarly, a school in the Lira district offers weekly sexuality-education sessions taught by trained teachers on pregnancy prevention, HIV/AIDS, and abstinence. These sessions are discussed with all students starting at primary 3.

With respect to feasibility, respondents noted that the intervention should employ different approaches to reach in-school and out-of-school adolescents and youth. For in-school adolescents and youth, respondents suggested stronger linkages with neighboring health clinics and more robust training of teachers who could easily be employed to educate students on FP/RH matters:

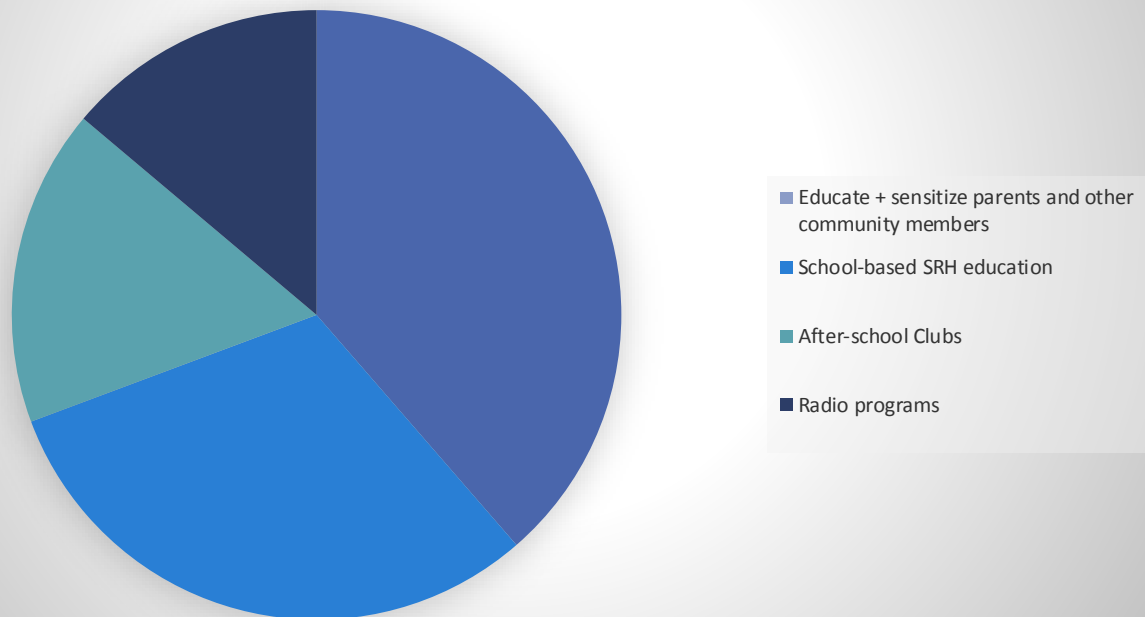
- Invite service providers to provide SRH sessions and counseling in school.
- Form reproductive health clubs led by a student-teacher committee.
- Tailor an all-inclusive and detailed sexual education curriculum for primary and secondary school students.

For out-of-school adolescents and youth, respondents recommend:

- Training students to reach out-of-school adolescents and youth so that they can form community-based youth SRH groups.
- Conduct community outreach activities such as dramas, speeches, music, and dance around the topic of FP/RH to sensitize local stakeholders.
- Initiate dialogue with parents and caregivers.
- Engage religious leaders to promote and educate their congregation on the family planning practices and health needs of youth during church sermons.

Figure 4 showcases respondents' opinions (based on the frequency they were mentioned) on the best ways to reach youth (both in school and out of school) with reproductive health information and services. Of note, respondents were able to select more than one answer for this question.

**Figure 4: The Best Ways to Reach Adolescents and Youth with Reproductive Health Information and Services**



### *Family Planning and Reproductive Health Services*

Respondents were also asked their views on adolescents' and youths' experience requesting FP/RH services from local service providers. There was an overwhelming consensus across stakeholder groups that services are not youth-friendly and that adolescents and youth often experience stigma and discrimination when requesting family planning services, particularly if they are not married.

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*"We still have the negative attitude by the health workers, much as they were trained on provision of friendly youth services, but we have not reached some places young people still have fear to reach the health workers, they fear to be pushed back and they also fear to talk about private parts."*

*–Youth-serving Organization*

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Respondents also noted that local clinics often do not have a wide range of contraceptive options and that health facilities lack private spaces where adolescents and youth can discuss sensitive health issues with their providers. Combined, these experiences of stigma and discrimination from

health care providers, a lack of diversity in contraceptive options, and a lack of safe spaces to discuss sensitive health topics within clinics discourage many adolescents and youth from seeking needed health care services or counseling.

### *Policy*

Respondents provided insights into whether there were any national policies related to adolescent and youth reproductive health or HIV/AIDS and, if so, whether those policies had a positive or negative impact. Many district education officers confirmed that there are no policies that prohibit SRH information from being taught in schools. In fact, sexual education, known as “family and life skills education,” is supposed to be taught in school by teachers, as part of the science curriculum. However, according to Ministry of Education officials, the provision of contraceptives, like condoms, are not allowed in schools.

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*“There is no policy and in fact we are supposed to provide the right information because with our adolescents there are a lot of myths around that and some of them have gotten deep into their minds. So through sexuality education is when we can get this information to them.”*

*–District Health Officer*

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Even though there are guidelines at the policy level that maintain that sexual education should be taught in schools, several respondents noted that meaningful dissemination and enforcement of these policies at the local or district levels is weak.

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*“Sexual reproductive health has not been a priority really because there is no officially designed curriculum for sexual reproductive health. It’s only one year ago that Save the Children made efforts to come out with the draft curriculum on sexuality education, which Ministry of Education incorporated it but it’s not yet disseminated or officially implemented all over except only by Save the Children in some few district with Agago being one of them but also not being handled in all the schools.”*

*–School Inspector*

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Respondents were more divided as to whether the needs and interests of youth are expressed and considered in national FP/RH initiatives or programs.

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*“What I have seen here is that I don’t think leaders really address the needs of the young people, actually I think they discourage young people from accessing those services because they attach some stigma to young girls going to access these services. The services are not tailored towards the younger girls; it’s mainly for the adults who are comfortable accessing them.”*

*–District Community Development Officer*

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Similarly, respondents also noted that although there are no legal or policy barriers that prohibit adolescents and youth from accessing family planning services, the structural barriers noted above (stigma and discrimination, lack of choice in contraceptive methods, and lack of an enabling environment to foster client confidentiality), as well as a lack of information about health services, discourage adolescents and youth from accessing them.

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*“First of all, these policies are made but dissemination is very poor and young people do not have information about these services. And also there is stigma attached to a young person accessing these services. So I think it’s mainly the question of information or dissemination of this information is not very good, the services are not made attractive for them to access and they are not close to them as they would want.” –Youth-serving Organization*

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## CONCLUSIONS AND RECOMMENDATIONS

Results from this assessment demonstrate a clear link between SRH and education. Early school dropout among adolescent girls is a major concern that appears to be fueled by early pregnancy and early marriage. Overwhelmingly, stakeholders interviewed for this assessment supported the idea of an intervention that offers in-school adolescents and youth links to contraceptive information and services. Following is a summary of the key points from the assessment and recommendations for action:

- Early pregnancy and school dropout were seen as the largest potential barriers to a program delivered in a school-based setting, as they would prevent many of the target population from receiving the interventions.
  - Recommendation: Programs seeking to link in-school adolescents and youth to contraceptive information and services should target students during the last years of primary school (Primary level 5- Primary level 7), before dropout rates peak. Working with younger adolescents provides an opportunity to increase their knowledge and skills, as well as their familiarity and comfort with the health system, before they become sexually active.
- Despite legal restrictions on the provision of contraceptives in school, there appeared to be widespread acceptance for establishing links between schools and SRH services.
  - Recommendation: Linkages between community health centers and schools should be strengthened so that students feel more comfortable turning to a trusted service provider for information or services that cannot be delivered at school. Consider training key school staff (such as counselors where available) on the unique SRH

needs of adolescents and establishing opportunities for health care providers to visit school settings.

- Existing programs supported by the education sector focus mainly on improving sexual and reproductive health knowledge; there appears to be a gap in connecting such programs with on-going health sector supported programs to improve access to contraceptive services.
  - Recommendation: Programmatic approaches to link in-school youth to existing health services would fill this gap.
- Participants had concerns that parents and religious leaders may oppose a school-based program that promotes the use of youth-friendly SRH services.
  - Recommendation: More research is needed to understand the perceptions of parents, adolescents, and political and religious leaders on the feasibility and acceptability of such an approach. A similar assessment to the one conducted with key stakeholders should be completed with these populations.
- Current programs addressing adolescent and youth SRH in a school-based setting provide an exciting opportunity for collaboration.
  - Recommendation: Establishing a technical working group of implementing partners on preventing adolescent pregnancy through school-based links will ensure that all partner efforts are complementary and strengthen the sector response to adolescent pregnancy prevention.
- The importance of stakeholder buy-in was a common theme across interviews.
  - Recommendation: Engaging stakeholders such as parents and community members should be part of the development and implementation of any intervention. In addition, it is important that we ensure stakeholders are aware of evidence on the benefits of comprehensive sexuality education and keeping girls in school.

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