UGANDA'S POPULATION STABILSATION REPORT

"The wealth of a nation is not in the stones or minerals in the ground, but in its people, if healthy, educated and employed"
His Excellency, Yoweri Kaguta Museveni

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Population Secretariat
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Acronyms

ANC	Ante-natal Care
ASRH	Adolescent Sexual and Reproductive Health
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organizations
EmOC	Emergency Obstetric Care
EPI	Expanded Programme for Immunization
GDP	Growth Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and malaria
GOU	Government of Uganda
HIV/AIDS	Human Immunno Deficiency Virus
HSSP	Health Sector Strategic Plan
ICPD PoA	International Conference on Population an and Development
ILO	International Labour Organization
IOM	International Organization for Migration
JPP	Joint Population Programme
MDGs	Millennium Development Goals
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
NDP	National Development Plan
NEPAD	New Partnership for African Development
NHP	National Health Policy
NPPAP	National Population Policy Action Plan
PEAP	Poverty Eradication Action Plan
RAPID	Resource for Awareness in Population and Development
RH	Reproductive Health
RHCS	Reproductive Health Commodity Supplies
SRH	Sexual Reproductive Health
UN WOMEN	United Nations Women
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Populations Fund
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	United Nations World Food Programme
WHO	World Health Organization

Executive Summary

Uganda's population doubled in size from 12.6 million in 1980 to 24.4 million in 2002 and at the current growth rate of 3.2%, the population is expected to double again at 49.2 million by 2022- medium variant fertility and up to 130 million in 2050 according to the National Population Policy (NPP). The annual population growth rate is projected to increase from an estimated 3.3% per annum in 2007 to 3.5% per annum in 2011 and then start to decline back to 3.3% per annum in 2017.

HIV/AIDS is also taking stall and has in recent years seriously impacted on the population size and structure. There is currently declining impact probably due to the introduction of ARVs. The population of Uganda is youthful and will continue to be over the years due to the prevailing high fertility.

These population dynamics present both an opportunity and a challenge for achieving sustainable economic and human development, as well as framing the trend towards population stabilization. The result of the high (though declining) fertility and mortality reflects an initial increase in population growth rate; a stage when followed by more rapid and sustained fertility decline, will lead to the onset of the demographic window-bonus. At present, population growth is outstripping the growth in vital services, including education, health, housing, utilities and employment. A burgeoning youth population with ambition and no opportunities increases vulnerability as well as civil unrest.

The rapid and unmanageable population growth is the single-most factor standing in the way of a speedier rate of development in Uganda. For the country to set itself towards a path from a peasant to a transformed nation there needs to be more harmony between the pace of growth in population and that of development. For Uganda, this means: mobilizing leadership to champion the right of individuals to make choices on the factors that affect equity and inclusion for the population and in society; harnessing young people's energies, potential and channeling this productively; enabling couples and women to realize their family planning choices and accelerating the decline in maternal and neo-natal morbidity.

Population issues remain an area of focus in the National Development Plan that informs the national and sectoral development policies, plans and programmes. This is further highlighted in the NPP's overall goal to improve the quality of life of the people of Uganda through policies and programmes that address population trends and patterns, but for Uganda to attain population stabilization with a Total Fertility Rate of 2 remains an issue of major concern.

CHAPTER 1

1.0 Introduction

Uganda's demographic profile is one of the country's most salient development challenges. Uganda's population growth rate is still amongst the highest in the world, at 3.2 per cent per annum with a Total Fertility Rate of nearly seven children per woman. The population, currently estimated at 33 million, is projected to reach 80 million by 2030 and 130 million by 2050. The population nearly doubled in the past 20 years to 29 million in 2005. This has produced a youthful population of about 50% below the age of 18 years.

Unless measures are put in place to check Uganda's fast growing population, which is among the highest in Africa, sustainable development will be undermined. Uganda's national development is being undermined by high food prices, climate change, forest denudation, land degradation, water shortage, declining oil supplies, species extinction and destruction of ecosystems, all attributable to the high fertility and population growth rate. The root of these problems is the ruthless exploitation of Uganda's resources in terms of charcoal burning, over cultivation on the small plots of land, over fishing, misuse of wetlands by the increasing population. Plots of land are divided among children, and due to large family sizes, per capita access to arable land is shrinking with each successive generation. More people are crowded into less space. As space is taken up, it is becoming more valuable, eventually affecting the poorest in the country. In the long run, the effect of population growth has started leading to substandard housing or homelessness.

Big families that result from high fertility increase the economic and emotional burden of parenthood. High fertility and therefore, rapidly growing populations have negative effects on the health and well-being of women children, families and communities, and are key factors in poverty enhancement. With the current population growth rate, Uganda faces many challenges to stabilize its population policies and programs.

High fertility and high population have several challenges for sustainable development and opportunities can only be realized if there is significant investment in social services, which can lead to populations that can afford to purchase industrial products and participate in sustainable development. In an effort to improve the livelihoods of people, the government is opting for industrialization. Many of the industries however, are not environmentally friendly despite environmental impact assessment policies. Government has also prioritized family planning as a key cross cutting factor in the National Development Plan 2010 – 2014. Access to contraceptives allows women to decide the number and spacing of their children and the relationship between contraception and women's status is a dynamic one, with synergistic

improvement in women's educational and economic opportunities and also an important impact on the acceptability and use of contraception.

Uganda has faced significant political upheaval in the second half of the twentieth century. After gaining independence from Britain in 1962, the country experienced two decades of dictatorship accompanied by extreme civil violence. Since 1986, the presidency of Yoweri Kaguta Museveni has brought relative stability and economic growth to the country, but Uganda has also remained involved in internal and regional conflicts. After decades of instability and civil conflict, Uganda has enjoyed relative stability, sustained economic growth, and great improvements in health over the last 20 years. Notable among these have been decreases in infant and child mortality, increased life expectancy, and great strides to reduce the prevalence and spread of HIV/AIDS.

The Government of Uganda is committed to improving the quality of life of her population through, among others achievement of Socio-economic Development and the Millennium Development Goals (MDGs). During the past 20 years remarkable socio-economic progress was made and this progress is reflected in many sectors especially in macro-economic stability, economic growth and rehabilitation of social services and infrastructure. It is therefore important to monitor closely the progress and pace of our efforts in implementation of the development programmes, while identifying achievements as well as challenges that need to be addressed.

Every year the Population Secretariat, in its State of Uganda Population Report, publishes key population concerns that need to be attended to in Uganda's quest to improve the quality of life of its people. The reports elaborate key challenges as well as opportunities at various levels. The reports further highlight the required policy actions that need to be taken in order to catalyze and maximize on the already achieved gains. The State of Uganda Population Reports, therefore, are significant documents and present opportunities to all policy makers and development partners to pay attention to issues that require serious national response. Previous SUPRE(s) analyzed fertility and HIV/AIDS patterns, access to reproductive health, conflict and post conflict situation, socio-cultural practices in relation to gender, culture and human rights in the context of social, health and human development in Uganda.

Population growth becomes a major issue in Uganda's development discourse when the economy is in deep trouble.[1] Although Uganda has devoted an increasing amount of resources to health interventions, funding for reproductive health services as well as general health sector remains inadequate. As such without improving the efficiency of current reproductive health interventions, Uganda is unlikely to meet some of its Millennium Development Goals relating to maternal health and the population will continue growing at alarming rates.

[1] http://www.kashambuzi.com/blog/385.html?task=view

1.1 Background

This report describes the process of population stabilization in Uganda in the context of fulfilling reproductive rights and attaining sustainable development. The report is based on censuses and sample surveys with various sources of information that can be used for understanding population dynamics and illustrates the current projected population and the relation to population stabilization. Cognizant of the fact that Uganda is far from attaining replacement fertility, the report analyses the determinants of fertility as the main factor of population growth in the country and its connection with development variables.

The report is also informed by the national population and development-related policy and program interventions in achieving population stabilization. The Report, based on the analysis from the population projections, policy environment and program interventions, makes recommendations to guide the country in attaining fertility replacement levels that are responsive to human rights and sustainable development.

1.2 Methodology

The report has benefited from the previous population censuses and surveys, as well some consultations with concerned agencies, experts and other stakeholders in the country. Their inputs have been instrumental in making this Report more coherent and dispassionate. The content of this document was substantially based on secondary sources from the National Statistics Office, National Statistical Coordinating Board, and other relevant research agencies.

1.2.1 Population Censuses

Prior to 1900, there was limited information on Uganda's population. Decennial population censuses have been conducted in Uganda since 1911. The 1911, 1921 and 1931 Population Censuses were mainly administrative in nature, and separate enumeration procedures were made for the African and non-African population in the country. The population census results of 1911, 1921 and 1931 revealed populations of 2.5, 2.9 and 3.5 million persons respectively.

The 1948 Population Census was the first scientific census to be carried out in Uganda. This was followed by the 1959 Census. The two censuses enumerated the African Population and the non-African populations separately. The first post independence census was conducted in 1969 followed by those of 1980, 1991 and 2002. The 2002 Population and Housing Census was the most comprehensive census ever conducted in Uganda. The census collected data on the demographic and socio-economic characteristics of the population; household and housing conditions, agriculture; activities of micro and small enterprises; and the community characteristics. Uganda is currently preparing for the 2012 census and this may have a significant impact in the analysis of this report. The report is

therefore, based on the available population censuses and relevant surveys and studies.

1.2.2 Sample Surveys

The Uganda Bureau of Statistics undertakes regular Demographic and Health Surveys. To date, Uganda has carried out four Demographic and Health Surveys in 1988/9, 1995, 2000/1, and 2006. The fifth UHS is underway, results will be released in 2012 but the panel survey already indicates improvement in some of the health related indicators. UDHS provides information on household characteristics, fertility levels and preferences, awareness and use of family planning methods, childhood mortality, maternal and child health, maternal mortality, breastfeeding practices, nutritional status of women and young children, malaria prevention and treatment, women's status, domestic violence, sexual activity, and awareness and behavior regarding AIDS and other sexually transmitted infections in Uganda.

The Ministry of Health carries out HIV surveillance surveys dating back to 1989. In collaboration with the Bureau of Statistics the Ministry of Health carried out a population based HIV/AIDS Sero Behavioral survey in Uganda in 2004. The surveys have been used as a basis for most of the assumptions made especially on fertility, mortality while the sero-behavioural survey provides information on the HIV prevalence.

The UDHS survey is part of global effort supported by the United States government, to monitor and evaluate population, health and nutrition programs in developing countries at intervals of five years. Furthermore, the survey is based on a two-stage cluster sampling design. In the first stage, clusters are the principal sampling unit and at the second stage, 25-30 households are randomly selected from each cluster.

1.3 General Information about Uganda

1.3.1 Location and Size

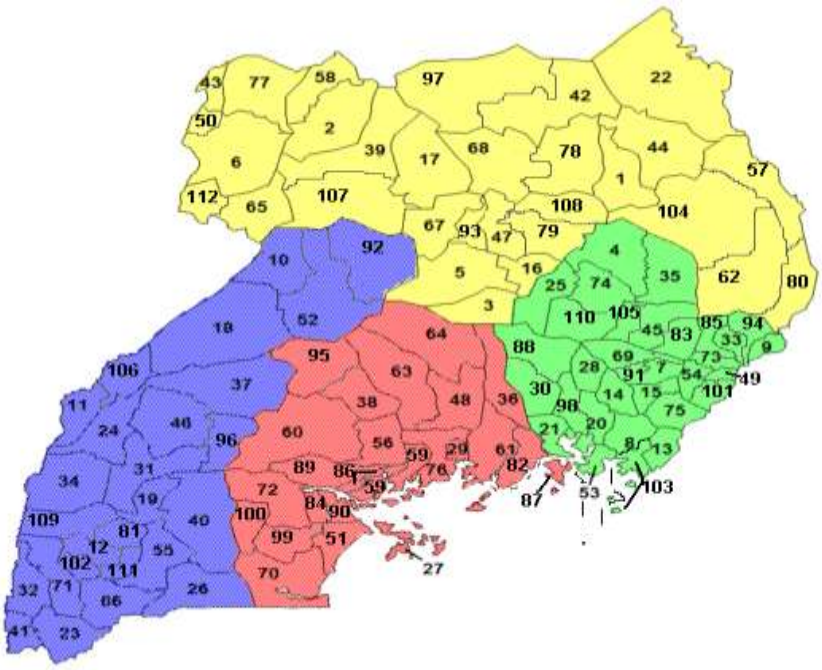
Uganda is a landlocked country in East Africa. It is bordered by Kenya on the east, the north by Sudan, by the Democratic Republic of the Congo on the west, by Rwanda on the southwest and by Tanzania on the south. It has an area of 241,038 square kilometers, of which the land area covers 197,323 square kilometres.

1.3.2 Administration

The country is currently divided into 111 districts and one city (the capital city of Kampala)[2] across four administrative regions. Most districts are named after their main commercial and administrative towns. Each district is further divided into counties and municipalities.[2] The head elected official in a district is the Chairperson of the Local Council V.

The districts are sub divided into lower administrative units. These are counties, sub-counties and parishes. Overtime, the numbers of districts and lower level administrative units have continuously increased (see table 1) with the aim of making administration and delivery of services easier. The total number of districts increased from 56 districts at the time of the 2002 Population and Housing Census to 80 in 2007 and currently to 111 with one Capital City authority. This however, had a negative element in that most of the districts do not have time series data and hence it is not possible to do a district level trend analysis and demographic behavior. In addition to the administrative system, Uganda has a parallel Local Governments System at different levels. These are LC V (District); LC IV (County / Municipality); LC III (Sub – County); LC II (Parish); and LC I (Village). The role of the local governments is to implement and monitor government programmes at the respective levels.

Figure 1: The Map of Uganda

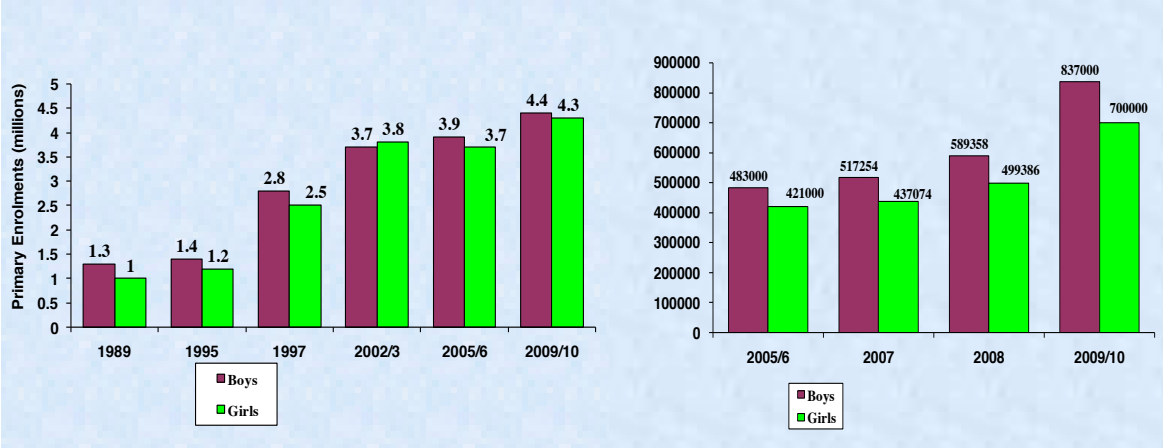


[2] Status of Local Governments: Ministry of Local Government, 2 Aug 2010.

1.3.3 Education

Uganda's education system is both formal and informal. Under the formal system, the four – tier educational model is followed. This has seven years of primary education, four years of ordinary level secondary education, two years of advanced level secondary education and the tertiary level of education. Each level is nationally examined and certificates are awarded. University education is offered by both public and private institutions.

Figure 2: Primary and Secondary School Enrolment in Uganda 1989 – 2009/10



The Universal Primary Education (UPE) programme was introduced in 1997 to offer free education at the primary level while Universal Secondary Education (USE) was introduced in 2007. The government also sponsors about 4,000 students every year through the public universities. The private sponsorship scheme is also operational in the public universities. University education can also be obtained from any of the private universities in the country. In addition, a large number of institutions both private and public also offer tertiary education.
To compliment the formal education, there exists informal education to serve all those persons who did not receive formal education. Under the informal system, a range of practical/hands-on skills are imparted to those who have not gone through or only partially gone through the formal system of education. The majority of participants in the informal system are the young adults and/or drop out and disadvantaged children. The Functional Adult Literacy (FAL) programme in the Ministry of Gender, Labour and Social Development (MOLGSD) targets older people who did not get chance to go through formal training.

1.3. Uganda's economic outlook

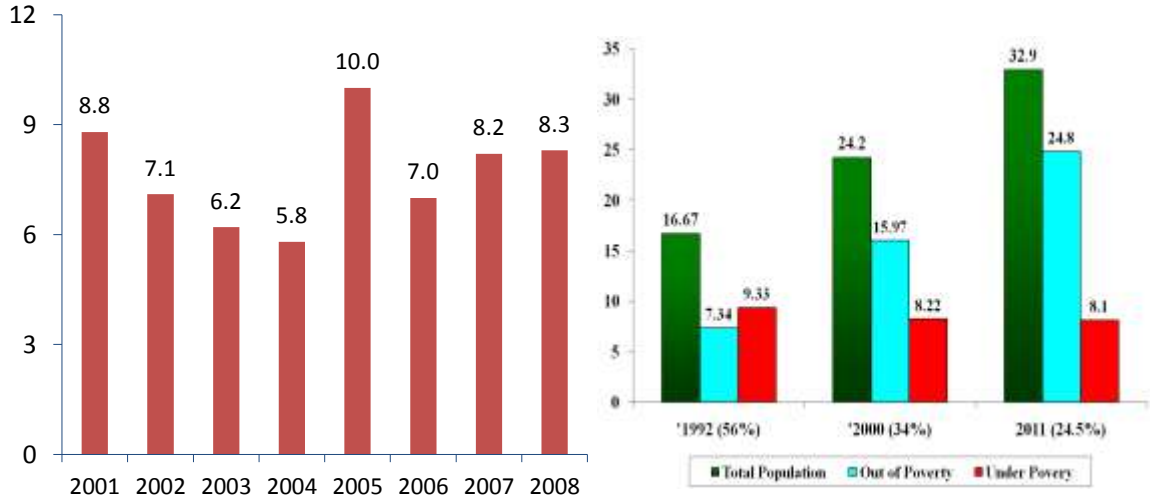
The Government of Uganda is committed to improving the quality of life of her population through, among others achievement of Socio-economic development and the MDGs. The economy has had an impressive growth over the years. Even during the global economic meltdown, the country's real GDP growth rate was 7.1%. The 2009 Human Development Index puts Uganda's GDP per capita at US

$889, lifting Uganda from the lower to the middle rungs/categories of developing countries. However, there are still 31% (2005/6) of the population living below the poverty line.

During the past 20 years, remarkable socio-economic progress was made and this progress is reflected in many sectors especially in macro-economic stability, economic growth and rehabilitation of social services and infrastructure. In early 1980s, Structural Adjustment programs were introduced which led to strong economic growth of GDP. Hence, the period that followed showed a remarkable increase in productivity and output. This was given impetus by macroeconomic stability resulting from the macroeconomic reforms that led to the economy reverting to its high GDP growth rates and low and stable inflation and interest rates from the 1990's to present. According to Annual Health Sector Performance Report 2007–2008, budgeted public health expenditures equaled about US$8.20 per person per year. This level of expenditure needs to be raised for provision of the minimal level of services. More needs to be done to show investment case for reproductive health as a vehicle for household poverty reduction and economic transformation.

The economy of Uganda is primarily based on the agricultural sector, with over 70 percent of the working population being employed by the sector. Agricultural exports account for over 45 percent of the total export earnings with coffee, tobacco and fish continuing to be the main export commodities that bring in foreign exchange. In the last 5 years, the telecommunication sector has been the fastest growing sector of the economy, and this is due to the expansion programs and increase in coverage by the major telecommunication companies in the country which have led to increased numbers of subscribers and providers of the services.

Figure 3: Macro economy trends

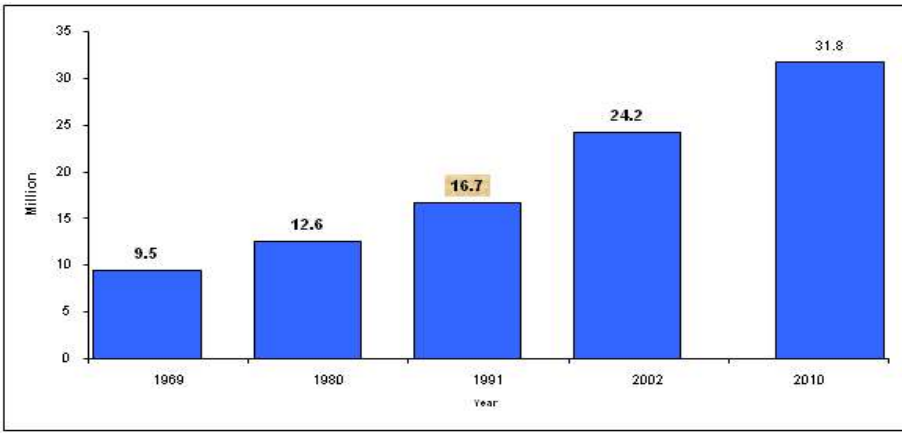


CHAPTER 2

2.1 Uganda's Demographic context

Uganda's demographic profile is one of the country's most salient development challenges. Uganda's population has continued to grow over a period of time. It increased from 9.5 million in 1969 to 24.2 million in 2002 at an average annual growth rate of 3.2 percent between 1991 and 2002. The projected 2010 mid-year population stands at 31.8 million. The population, currently estimated at 33 million, is projected to reach 80 million by 2030 and 130 million by 2050. More than half of Uganda's population (51 percent) are females. This has produced a youthful population of about 50% below the age of 18 years.

Figure 4: Census population, 1969, 1980, 1991 and 2002 and mid year (2010) projection (millions)



Source: Uganda Bureau of Statistics

The total fertility as estimated by the DHS, stood at 6.7[3], largely unchanged over the past twenty years and much higher than in neighboring countries (e.g. Kenya: 4.7; Tanzania: 5.6. Consequently, the population growth rate was about 3.4% per year between 1991 and 2002, which puts Uganda among the countries with the highest population growth rates in the world.

The demographic implications of this high population growth rate can be read from Table 1 below which shows demographic projections for Uganda from the United Nations Population Division based on the medium (and thus most probable) variant of the 2002 revision. According to these projections, Uganda's population is expected to reach 103.2 million people in 2050. This projection is based on considerable fertility decline from presently about 7 to only 2.9 in 2045-2050.

Whether this will be achieved is far from certain and will likely depend on overall economic development in coming decades as well as government efforts to

[3] UDHS 2006.

support a fertility decline. But even with this considerably fertility decline, population growth will still be over 2% per year in 2045-50 and Uganda's population is projected to stabilize at a population of some 200 million only in the 22nd century.

Table 1: Demographic Projections for Uganda 2000-2050

	Population ('000)	Pop. Growth	Population Density	TFR	Dependency Rate	Pop. Aged 15-64	Growth 15-64	Pop. Aged 5-19
2000	23487	3.30%	100	7.10	110	11164	3.16%	9504
2005	27623	3.62%	117	6.78	112	13044	3.67%	11167
2010	32996	3.58%	140	6.37	111	15621	3.88%	13467
2015	39335	3.46%	167	5.93	108	18894	4.06%	16167
2020	46634	3.31%	198	5.43	102	23051	4.00%	19115
2025	54883	3.11%	233	4.87	96	28051	3.86%	22143
2030	63953	2.84%	271	4.27	89	33894	3.64%	25287
2035	73550	2.53%	312	3.70	82	40522	3.38%	28395
2040	83344	2.27%	353	3.24	74	47844	3.12%	31096
2045	93250	2.06%	395	2.90	67	55801	2.79%	33051
2050	103248		438		61	64039		34326

Source: United Nations Population Division

2.2 Sex ratio at birth

Vital registration provides the most appropriate source of information on sex ratio at birth. As noted in chapter 1, the coverage of vital registration in Uganda is still very limited. The UDHS 2006 estimated the sex ratio at birth at 102.6 males per females, and this was assumed to remain so throughout the projection period.

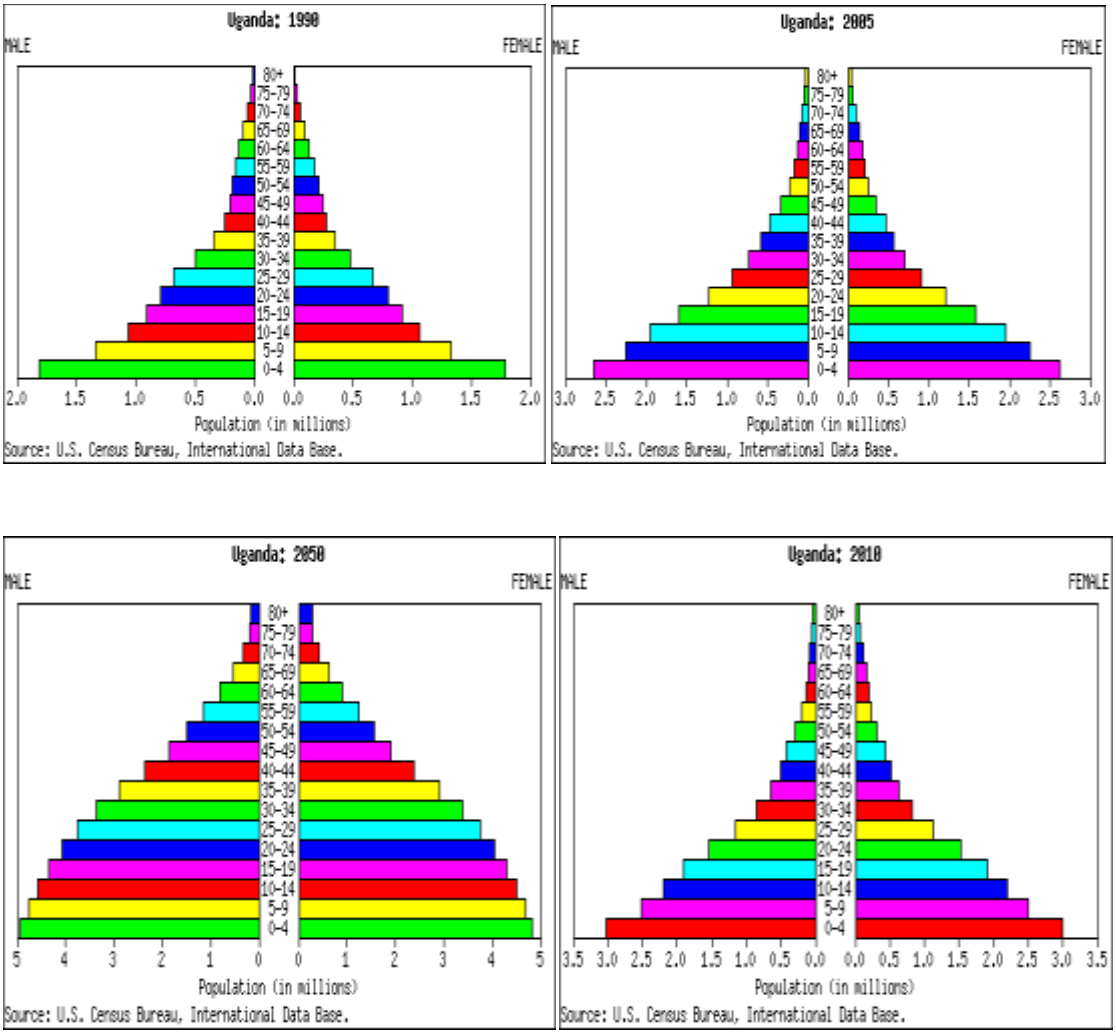
2.3 Age-sex distribution of Uganda's Population

The 2002 Census is the most recent population and Housing census and hence is the source of information on age sex distribution of the population in Uganda. Figure 5 shows the age-sex distribution of the population as reported in the 2002 census (adjusted to mid-year). The population pyramid is typical of a population with high fertility and mortality as depicted in the road base of the pyramid and rapid tapering off with increasing age.

A quick look at the five-year age-sex distribution did not reveal major deviations arising from age errors as five-year age distributions tend to have a smoothing effect on single year age distributions. However, a close examination of the age-sex ratios showed fluctuations that could not be explained by demographic factors and were therefore attributed to the quality of the age-reporting arising

from differential age shifting by sex and hence necessitating graduation of the reported age-sex distribution.

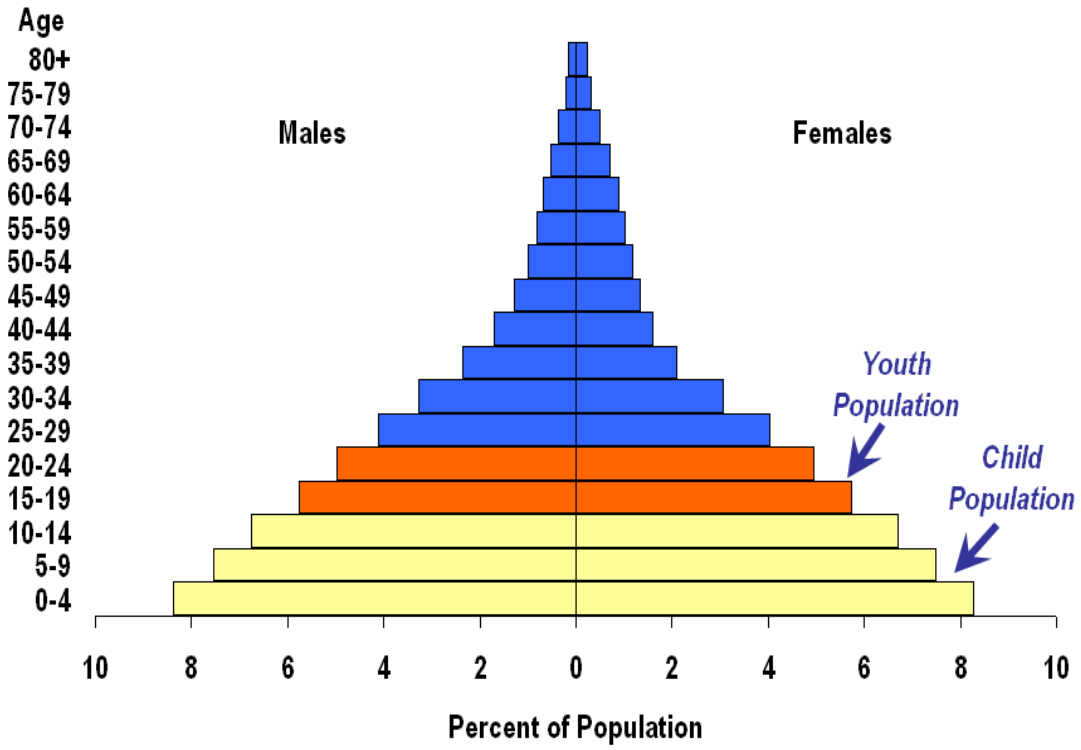
Figure 5: Uganda Population Pyramid (s) for 1990, 2005, 2010 and the prediction for 2050



2.4 Population Structure

About half of the population in Uganda is below 24 years of age. It is a challenge and opportunity of the country. This demographic surge of people entering their productive and reproductive years is great potential for development - if Uganda can invest wisely in the education, health, skills and economic opportunities of youth.

Figure 6: The population structure of Uganda



2.5 Net Migration

Where as the Population and Housing Census has fairly reliable information about migration into Uganda, there is no reliable source of information about migration out of Uganda. It is therefore not possible to ascertain the net effect of migration on the population. In the absence of net migration data, assumptions about net migration were based on estimates by the United Nations for Uganda. The United Nations estimated net migration during the period 1995-2000 as a net loss of 9,000. However, this figure was not broken down by age and sex.

2.6 Demographic Projections

Population projections are essential for planning at the national, regional and district levels in both the private and public sectors. In order for planners and policy makers to efficiently allocate the scarce resources, they need to know the future size and structure of the country's population as well as their characteristics. Planning for any sector of the economy therefore requires information about the future size and structure of the population in the area.

Although demographic information can be obtained from censuses and surveys, they often do not meet all the needs of planners for the following reasons: Censuses are carried out every ten or five years in different countries and because the census, results are often released at least about two years after enumeration, the information from censuses though informative are technically out of date even at the time of being released. This is because, at the very minimum, planners require information about the current size and structure of the population, and not two or three or five years ago. However censuses are expensive exercises to conduct therefore, it is not possible to carry out census every year to meet the planning needs of policy makers.

Table 2: Mid-year population estimates and projections for Uganda, 1992 – 2011

Mid Year Population			
Year	**Urban**	**Rural**	**Total**
1992	1,801,100	15,671,900	17,473,000
1993	1,891,700	16,149,900	18,041,600
1994	1,987,000	16,641,700	18,628,700
1995	2,087,000	17,148,000	19,235,000
1996	2,192,100	17,668,800	19,860,900
1997	2,302,500	18,204,800	20,507,300
1998	2,418,400	18,756,300	21,174,700
1999	2,540,100	19,323,800	21,863,900
2000	2,668,000	19,907,400	22,575,400
2001	2,802,400	20,507,700	23,310,100
2002	2,943,500	21,123,700	24,067,200
2003	3,091,400	21,998,000	25,089,400
2004	3,247,000	22,612,700	25,859,700
2005	3,410,500	23,330,800	26,741,300
2006	3,582,200	24,047,100	27,629,300
2007	3,762,600	24,818,700	28,581,300
2008	4,372,000	25,220,600	29,592,600
2009	4,524,600	26,136,700	30,661,300
2010	4,692,200	27,092,400	31,784,600
2011	4,859,500	28,080,300	32,939,800

Source: Uganda Bureau of Statistics

2.7 Uganda is still predominantly rural

The Rural population (% of total population) in Uganda was reported at 87.02 in 2008, according to the World Bank. The 2002 census reported about 12 percent of the population lived in urban areas. Uganda is one of the world's poorest countries. In spite of high GDP growth rates recorded in recent years, most of the population lives in poverty. Agriculture is the most important sector of the economy, employing over 80% of the work force, with coffee being the main source of foreign trade. The country poses substantial natural resources like

fertile soils, regular rainfalls, small deposits of copper, gold, and recently discovered oil.

Uganda is encouraging rapid rural to urban migration in order to speed up the process of modernization including industrialization. The economic, social and environmental challenges are already enormous posing serious environmental threats, including high levels of water and air pollution and attendant health risks, even with this small percentage (12%) of urban dwellers. There should be adequate plans for jobs, food, transport, housing, schools, health, sanitation and recreation facilities to absorb an influx of poor and functionally illiterate people as being encouraged to reside in towns.

Figure 7: Consequences of rural-urban migration

2.8 Teenage Pregnancy (15-19) years

Uganda has the highest teenage pregnancy rate in sub-Saharan Africa, with half of its girls giving birth before the age of 18. Some girls give birth to healthy children, but for many, pregnancy is unplanned, birth comes too early and the experience is one of fear and pain. Many times girls marry and start their families before ending their own childhood.

The median age for women to marry is below the age of consent (17.8 years) as many experience their first sexual intercourse at 16.6 years, compared to 18.1 for men, according to the 2006 UDHS. New evidence on adolescents reveals that 23% of young women aged 15 – 19 yearshave been in relationships with older men before marriage compared to 4% of young men of the same age[4]. According to the World Health Organisation (WHO), adolescent girls face

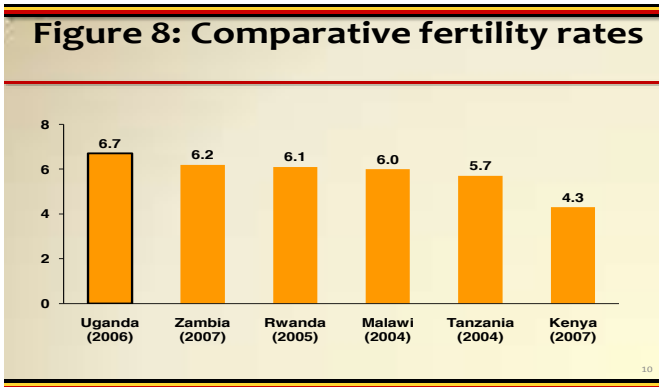
[4] GUTTMACHER Institute (2008): Protecting the Next Generation in Uganda,

health risks during pregnancy and childbirth, accounting for 15% of the global burden of disease for maternal conditions and 13% of all maternal deaths.

In Uganda, adolescent mothers are twice as likely as older mothers to die during childbirth. Only 41% of births are attended by skilled personnel. For poor young mothers, aged 14 and under, the risk is highest because they have the lowest access to prenatal care, hence, more likely to deliver at home than in hospitals, experts say. Ministry of Health data show also that fertility varies markedly with the residence, the education and economic status of the mother. Uneducated mothers living in rural areas have almost twice as many children as women with secondary or higher educations (7.7 children compared with 4.4). The national teenage pregnancy rate of 25% is also high and the leading contributor to high school drop out.

2.9 Fertility

The primary driver of the high population growth rate is the persistently high fertility rate. Census based estimates show fertility levels have remained fairly constant for over 3 decades remained high over the past 3 decades. The TFR was 7.1 in 1969 and 1991, and decreased slightly to 6.9 in 1995 and 2000, and 6.7 by 2006 according to the 2006 UDHS. However, the UDHS of 2006 showed that a decline was beginning to be realized. It was assumed that the decrease in TFR would continue till the end of the projection period. The TFR was therefore assumed to decline from 7.0 in 1991 to 6.7 in 2006, and remain constant until 2010 and then would steadily decline to 6.0 in 2017 and further to 4.87 by 2025 – 2030.



Key factors known to sustain this very high fertility level include: gender inequalities and the generally low status of women; a pro-natalist culture that places very high value on children as security for parents at their old age; children are a source of labour; sex preference by some parents; insufficient access to family planning services and poverty. The education of women is a key determinant for fertility as with other reproductive health variables. According to the 2006 DHS, women with no education have a TFR of 7.8 while the desired number of children for those with primary education is 5.8 compared to 3.8 for

those with secondary education (UBOS 2007). The sexual and reproductive behavior of adolescents and young people together with the very high unmet need for family planning at 41% are some of the additional determinants of high fertility. Figure 7 below shows fertility rates for different countries in the region and indicates that Uganda has the highest fertility rate among neighboring countries that recently participated in the Demographic and Health Survey programme.

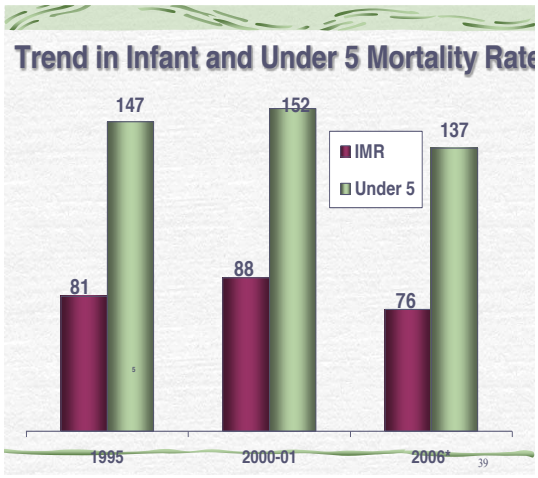
2.10 Mortality

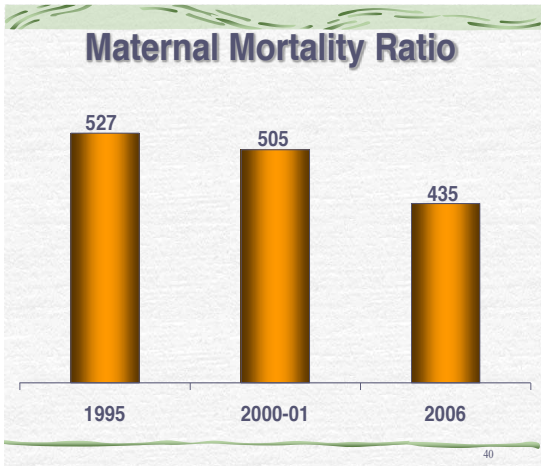
There has been a general improvement in mortality levels. The infant mortality rate declined from 122 to 76 deaths per 1,000 live births between 1991 and 2006 while the under five mortality reduced from 203 to 137 deaths per 1,000 live births over the same period. The 2006 UDHS showed that the Infant Mortality Rate is lower among children in urban areas as well as those born to educated and wealthier mothers. Maternal mortality ratio has also slightly declined form 526 to 507 and further to 435 deaths per 100,000 live births in 1995, 2000 and 2006 respectively.

Life expectancy at birth is an estimate of the average number of years a person is expected to live if a particular pattern of mortality is maintained. The over-all life expectancy at birth from 2002 Census was 50.4 years for both sexes. Males registered a lower life expectancy of 48.8 years compared to their female counterparts at 52 years. There was a gain of 2.3 years in life expectancy between 1991 and 2002 for both sexes.

For purposes of population projections, life expectancy at birth is used as a measure of mortality. The life expectancy at birth is projected to increase from 50.5 for females and 45.7 for males in 1991 to 54 and 53 in 2017 respectively. This was based on the fact that the UDHS 2006 had shown improvement in infant and child mortality. (See figure 8). The sustained mortality decline coupled with accelerated fertility decline will combine to create the onset of the demographic transition which will eventually lead to the demographic bonus.

Figure 9: Trends in childhood and maternal mortality





2.11 Youth & Employment

One of the key challenges of the future for Uganda's youth is youth unemployment. Reversing this trend is a major challenge for any developing countries, more so for Uganda which has an upright population pyramid with a high dependency ratio. According to the state of Uganda population report 2006, over the past two decades, youth have continued to form a broad base of the population. In 2008 World Bank statistics were showing that Uganda's overall unemployment rate stood at 3.2 percent, whilst that of youth (15-24) stood at a whopping 22.3 percent. Investing in young people is not only a social obligation, but makes economic sense. Young people's involvement in planning and in all processes of policy formulation is therefore paramount.

CHAPTER 3

3.1 Demographic Transition

With a population of 33 million, Uganda is one of Africa's largest and fastest-growing countries. Uganda's population will continue to grow because of the large number of people who are either currently at an age when they are having children or who will soon enter that age group. With half of its population age 15 or younger, Uganda stands out as one of the world's youngest age structures. As the world reaches 7 billion, countries at the beginning of their demographic transition represent a relatively small proportion—about 9 percent—of the world's population. However, these countries face similar development challenges.

Despite economic growth in the past decade, many Ugandans live in poverty and confront social and economic inequities. Uganda has entered into its demographic transition by reducing its once-high death rate[5]. As a result of lower mortality but still high fertility, Uganda has developed a very youthful age structure. Fertility and birthrates are very high. The median age is about 15 years old; most Ugandans are still minors. Uganda's current population is just over 30 million, but by 2050 it's expected to be more like 120 million. At that point Uganda — with a land area a bit smaller than Romania — is expected to have more people than Russia.

Over the last ten years, Uganda's GDP growth has actually outpaced population growth by a percentage point or two. If this continues, 2050 Uganda will be a lower-middle income country, albeit a somewhat crowded one. Well, right now Uganda's population density is about 120 people per square kilometer, roughly equal to Poland, and only half that of the United Kingdom. Even if the population quadruples, it will only be a bit denser than Lebanon (392) or the Netherlands (395), about the same as the American state of New Jersey (452) and still less than contemporary Taiwan (636) or Bangladesh (1060). Also, Uganda's very rapid growth means it will have a young population. If they can raise their standards of health and education, they'll be well positioned for the demographic transition in a generation or two.

3.2 Fertility transition in Uganda

Uganda is clearly in a very early stage of a demographic transition to low birth rates and low death rates – death rates have dropped significantly without a corresponding fall in birth rates, resulting in a large increase in population. As a result of lower mortality but still high fertility, Uganda has developed a very youthful age structure. Uganda's population will continue to grow because of the large number of people who are either currently at an age when they are having children or who will soon enter that age group. With half of its population age 15 or younger, Uganda stands out as one of the world's youngest age structures.

[5]Population Reference Bureau 2011 Copyright.

Despite economic growth in the past decade, many Ugandans live in poverty and confront social and economic inequities.

3.3 High unmet need for family planning

Although use of modern contraception (CPR) among married women in Uganda has more than doubled from 7.8% in 1995 to 18.2% in 2000/01[6], the unmet need for family planning has increased, among married women in particular, from 29% to 35%[7] over the same period.

Over 1.4[8] million women in Uganda would like to delay pregnancy, space their children or stop childbearing altogether, but are not currently using any contraceptive method. Uganda's total fertility rate of 6.7 is among the highest in the world[9], yet the *wanted* fertility rate is just 5.3.[10] Women *and* men in Uganda report the lowest "ideal family size" compared to actual fertility in all of sub-Saharan Africa. Nearly 18% of pregnancies in Uganda are unintended, and in many cases are unwanted: an estimated 12% of all pregnancies end in unsafe abortion, and as many as 3000 women die each year in Uganda as a consequence of unintended pregnancy through complications during childbirth or through unsafe abortion[11].

3.4 Reducing the Unmet Need for Family Planning is Critical

More than two-thirds of men and women in Uganda say they would like to delay childbearing or limit their family size. Uganda's high total fertility rate and high population growth rate are due in part to a high unwanted fertility rate of 1.6[12], and are the most significant contributing factors to continuing high levels of poverty and high maternal and infant/child mortality throughout the country. The statistics create a major bottleneck for achieving poverty reduction and realizing the MDGs. This problem has to be addressed more vigorously, especially through interventions that target child spacing to protect the health of mother and child[13].

Uganda's Poverty Eradication Action Plan (PEAP)[14] highlighted improving health outcomes and increasing people's ability to plan the size of their families as key strategies to reduce poverty. PEAP targets included reducing the high unmet need for family planning, thereby reducing the rapidly growing population.

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[6] Married women, any modern method – UDHS 1995 and 2000/01, MOH. CPR for married women any method (including traditional) has increased from 14.8% to 22.8%. CPR for all women/any modern method has increased from 7.4% to 16.5% and CPR for all women/any method (including traditional) has increased from 13.4% to 20.1%.

[7] UDHS 1995 and 2000/01. Unmet need among all women has increased from 22% to 24.4%.

[8] Based on population projections from 2002 Population and Housing Census, and unmet need among all women.

[9] Population Reports, Vol XXVII, No.2, July 1999.

[10] UDHS 2000/01.

[11] Promises to Keep: The Toll of Unintended Pregnancies on Women's Lives in the Developing World, Global Health Council, 2002

[12] *New Survey Findings: The Reproductive Revolution Continues, Population Reports,* Volume XXXI, Number 2, Spring 2003 Series M, Number 17 Special Topics

[13] Budget Speech by the Minister of Finance, Planning and Economic Development, Hon. Gerald M. Ssendaula, June, 2003

[14] Poverty Eradication Action Plan (Draft), MOFPED, March 2004.

High fertility especially when unintentional and unwanted places a heavy burden on women's health, results in high risks to terminate unwanted pregnancies, and significantly affects the health of children as well. Maternal mortality, poor maternal health and large numbers of children in turn have a serious impact on household welfare. Along with poor health, large family size has been identified by communities as one of the major causes of household poverty[15]. Significant economic gains at household level could be achieved by meeting people's expressed desire for better spaced, smaller families.

3.5 Challenges to increasing the use of family planning

Well over two-thirds of Ugandan women and men say they want to space or limit childbearing (71% of women and 67% of men). In fact, a majority (62%) of married women not currently using a family planning method say they intend to do so in future, while 9.7% are still undecided. However, they face many challenges.

3.5.1 Social, cultural, and religious values have a strong influence on reproductive choices for women in Uganda. Early and frequent childbearing and large family size reflect long-standing societal norms among most segments of the population, even though they conflict with the apparent desire reported by the UDHS among individual women and men to space childbearing and to limit family size to a smaller "ideal" number of children. Many women may be discouraged from using family planning by spouses or family members, or by political, religious and community leaders or other community members. Over 14% percent of married women who are not using family planning and don't intend to do so in future say they, their spouse, their church, or others disapprove[16].

3.5.2 Lack of accurate information also plays a key role in limiting use of family planning, and knowledge of a wide range of methods is critical to informed decision-making. While most adults in Uganda (96% of women and 98% of men[17]) have heard about at least one method of contraception, knowledge about a wider range of available family planning choices is limited. Many people also have misconceptions about FP and the effects that contraceptives may have on future fertility, unborn children and women's health[18]. Over 23% of married women who are not currently using family planning and do not intend to do so in future say they don't use contraception due to health concerns or fear of side-effects, and another 5% say they lack information about methods and sources[19]. Nearly 7% of these women say their partner opposes use of contraception, yet few programmes target men with accurate information about family planning.

[15] Second Participatory Poverty Assessment Report (UPPAP), MOFPED, December 2002.
[16] UDHS 2000/01.
[17] UDHS 2006.
[18] "Increasing the Usage of Family Planning: Qualitative Study" Draft Report for PSI Uganda, Steadman Research Services, December 2004.
[19] UDHS 2006.

3.5.3 Lack of access to quality services remains a major challenge in Uganda. Many areas still lack basic health facilities, a significant proportion of health centres lack qualified RH service providers, many providers have not been trained in up-to-date family planning skills, family planning is not fully integrated with other health services, community-based family planning services are not in place in most communities, and family planning commodities and supplies are not consistently available at service delivery points. A significant number of health facilities are operated by the Catholic Church[20] and are unable to offer any level of family planning services apart from natural FP methods, yet alternative channels for providing a full range of family planning services in these locations are not in place.

3.5.4 Prioritization and resource allocation: The high health and development costs of failing to reduce the number of unintended pregnancies through family planning are not well understood by a number of politicians and other opinion-leaders who publicly "de-campaign" family planning and condom use with poorly-informed arguments. This lack of understanding and commitment from leaders and decision-makers at all levels means that family planning has not received the support and resources it requires at national, district and lower levels.

While family planning was highlighted in the PEAP as a priority strategy to reduce poverty and improve health outcomes, this priority was not reflected in national and district budget allocations and programmes, nor is it reflected in donor-funded programmes. HIV/AIDS, malaria and child health (EPI) access a significant proportion of health resources largely through targeted donor funds[21], while family planning and reproductive health in general received little or no dedicated funding at national or lower levels.

3.6 Family Planning in Uganda

Family planning was introduced in Uganda in 1959. Recently, there has been an urgent focus to revitalize family planning in order to achieve critical benefits at individual, household, community and national levels. If services are not revitalized immediately to reduce the country's high unmet need for family planning, it is unlikely that Uganda will be able to meet its health outcome goals nor will it be able to meet its national poverty-reduction (PEAP) or development (MDG) goals.

3.6.2 Family planning investment is vital

Rapid population growth is like a double-edge sword. For Uganda to benefit from the population explosion there must be an investment in the population, education, training, health and skills. Sufficient jobs to generate the higher level

[20] Catholic-run facilities: 27% of hospitals and 9% of lower-level health centres.
[21] GFATM, PEPFAR, and GAVI among others

of per capita income and a well-educated labour force to attract the needed investments necessary for economic growth will also play a crucial role.

Population size is not the issue because the population is guaranteed to grow. Variables such as age, structure, spread and type of the population are more important as they determine the quality of the population. If Uganda's population were already healthy, well-educated and had good jobs, then it might be able to deal more effectively with rapid growth. However, given the challenges Uganda faces to development, slowing population may be able to help the country advance economically.

The Uganda National house hold survey, 2010 indicated that almost two out of every 10 children were conceived against the parents' will. Over 40%of women conceive more children than they want because they have no access to family planning. If every woman in need of contraception got access to it, Uganda's fertility would decrease by 30% and bring the average household from seven to four children per woman.

3.6.3 Girl child education contribution to demographic transition

Demographic transition is a function of many factors. Economic empowerment of women and especially girls' education have been singled out as crucial factors in the transition. Yet young girls in Uganda continue to drop out of school at a high rate and are married off early. Dropout is high due in part to lack of school meals. Despite a resolution by NEPAD urging African governments to provide school meals using locally produced food that puts money into peasants' pockets, the Uganda government has been unable or unwilling to help.

This is how an educated woman reduces fertility. Because she stays at school longer, she marries late. She seeks medical care for herself and her children sooner and houses and feeds herself and children better than an uneducated woman, so her children have a good chance of surviving to adulthood. Also because she has pension she does not depend on children in her old age. Therefore she produces fewer children that are more evenly spaced. Her fertility rate drops and she contributes to the country's demographic transition (Workshop report {July 28 2005} on Women's Economic Empowerment UNFPA). The government is urged to reconsider favorably the provision of lunches to keep girls in school longer because there are demographic dividends.

CHAPTER 4:

4.1 Policy and programmes

In Uganda, population issues have been high on the country's agenda for addressing Sexual Reproductive Health and Rights. This commitment is reflected and demonstrated by the several policies, implementation frameworks and action plans that address the major population and development issues (Table 3). Debates and public discussion whether a high population is a blessing for Uganda, or a curse, are getting intense within Government corridors. Members of Parliament and Ministry of Finance officials are questioning the impact of a high population, saying it is a dampener on the country's meager resources. Research institutions are tasked to provide empirical evidence on the likely impact of an increase in spending on infrastructure and sexual reproductive health initiatives, in order to understand the strengths and weaknesses of a high population.

Figure 10: Interlinkages between population and economic development

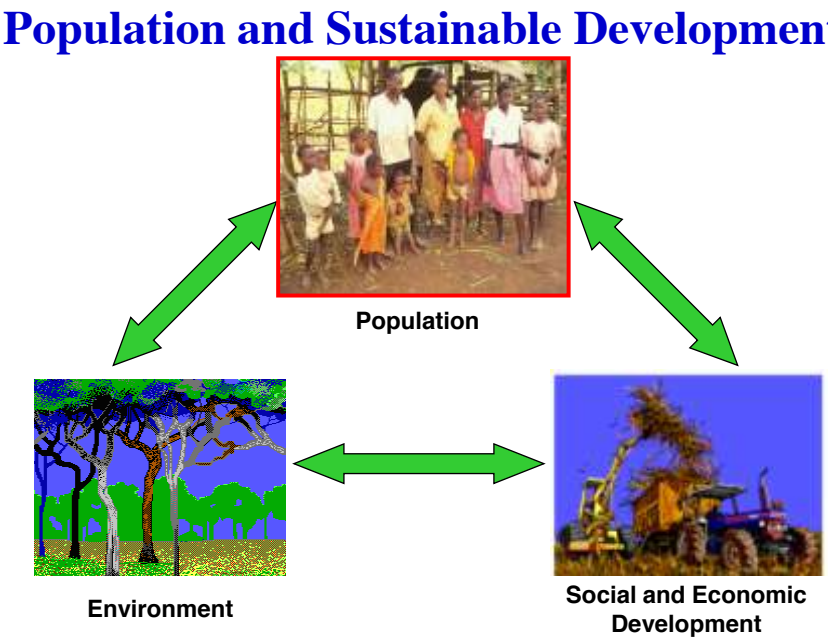

Table 3: Policy documents that articulate government's commitment to population and development

Year of Adoption	Policies and Plans	Goals and Objectives
National Policy and Planning Context		
1997, 2000 &	Poverty Eradication Action Plan (PEAP)	This has been the national planning framework for over the last decade (1997-2007/08). It aimed at providing an overarching framework to guide public action to eradicate

2004		poverty through increasing people's incomes, improving human development and reducing powerlessness.
2010	National Development Plan (NDP)	The Vision is a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years.
Policies and Plans		
1999 2010	National Health Policy	The policy derived guidance from the national health sector reform programme and national poverty eradication programme. Goal: Attainment of a good standard of health by all people in Uganda in order to promote a healthy and productive life. Objective: to reduce mortality, morbidity and fertility
1995 & 2008	National Population Policy	First promulgated in 1995 aimed at improving the quality of life of the people of Uganda and transformation of society. After thirteen years the policy was reviewed to accommodate new and emerging challenges leading to the current 2008 policy. The current policy retained the same goal of improving the quality of life of people. It highlights a number of objectives among which is the promotion of improving the health status of the population
2001	National Reproductive Health Policy Guidelines for Reproductive Health Services.	Goal: improve SRH and quality of life of everyone in the country. Objective: guide planning and implementation, monitoring and evaluation of quality integrated gender sensitive RH services; standardize the delivery of RH services and ensure optimum and efficient use of resources for the sustainability of RH services.
Strategic Plans		
2000, 2005 & 2010	National Health Sector Strategic Plan I & II and National Health Sector Strategic Investment Plan III	Was first developed in 2000 to operationalize the 1999 NHP. The HSSP I laid a foundation for health development in the country. In 2005, the HSSP I was reviewed to the current HSSP II and retained the NHP goal. Both HSSP I & II aimed at reducing morbidity and mortality from the major causes of ill-health and premature death. The current HSSP II is guided by 4 main programme objectives, namely: effective, equitable and responsive health care delivery system; strengthening the integrated support systems, reforming and enforcing the legal and regulatory framework and ensuring an evidence-based policy, programme and planning in health development.
2000	RH Division 5-year Strategic Framework-2000-2004	Goal: Contribute to the improvement of quality of life of the people of Uganda. Objective: Reduce MMR by 30% from 506 to 354/100,000 live births, increase Contraceptive Prevalence Rate from 15% to 30%, increase deliveries supervised by skilled health workers from 38% to 50%, increase ANC attendance to at least 4 visits per pregnancy with the first visit in the first trimester, to increase Tetanus coverage among pregnant mothers receiving at least 2 dozes from 50% to 80% and incorporate gender concerns among RH programmes.
2007	Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda	Goal: To accelerate the reduction of maternal and neonatal morbidity and mortality in Uganda. Objectives: increase the availability, accessibility, utilization and quality of skilled care during pregnancy, child birth and post-natal at all levels of the health care delivery system, promote and support appropriate health seeking behaviour among pregnant women, their families and the community, and strengthen family planning information and service provision for women, men, couples who want to space or limit their childbearing thus

		preventing unwanted and/or untimely pregnancies that increase the risk of a maternal death.

4.1.1 The Poverty Eradication Action Plan (PEAP)

Through the Poverty Eradication Action Plan (PEAP), which was the overall national development framework between 1997 and 2008/9, the government reaffirmed its commitment to achieving the MDGs and prioritized improving health outcomes under the Human Development Pillar (MoFPED, 2004). PEAP acknowledged the fact that a healthy population is a necessary condition for development and poverty reduction. The PEAP set priorities including increasing spending on preventive care such as family planning commodities, procurement of malaria commodities such as insecticide-treated nets, as well as recruitment and deployment of health workers, provision of free essential drugs and supplies for all the pregnant women, and strengthening family planning, delivery and EmOC services in all health facilities.

4.1.2 The National Development Plan (NDP)

Family planning is among the main objectives of the recently launched five-year National Development Plan (NDP) 2009/10 – 2013/14 which has replaced the PEAP as a priority for reducing maternal mortality and alleviating poverty. Through the NDP, government pledges to reduce maternal mortality to 131/100,000 live births by 2015 and increase CPR to 50% from the current 24% (Republic of Uganda, 2010). Based on economic forecasts, the GDP is expected to increase to 7.2% with the nominal per capita income increasing from 506 in 2008/9 to 850 over the NDP period.

4.1.3 The National Health Policy and NHSSP

Within the overall national development framework, addressing health issues in the country is guided by the National Health Policy (NHP) developed in 1999 (MoH, 1999) and reviewed (MOH Policy 2010). Family planning is a key priority area being addressed in an integrated manner through the Uganda Minimum Health Care package[22] (UNMHCP) along with focus on essential Ante-natal and Emergency obstetric care[23], ASRH, VAW[24] and improving nutrition for pregnant and lactating mothers, among others (MoH, 1999). The 2010 NHP puts emphasis

[22] *The Uganda Minimum Health care Package (UNMHCP) comprise interventions that address the major causes of the burden of disease and is the cardinal reference in determining the allocation of public funds and other essential inputs. Government allocates the greater proportion of its budget to the package in such a manner that health spending gradually matches the magnitude of priorities within the burden of disease (MoH, 1999).*

[23] Emergency obstetric care addresses the major direct causes of maternal death which are responsible for about 80% of maternal deaths. These are haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour.

[24] *Promote and support agencies and organizations that work to reduce domestic violence, female genital mutilation and other forms of VAW.*

on investing in people's heath, focusing on promotion of people's health and rights, disease prevention and early diagnosis and treatment of disease.

The NHP is operationalized in a five-year National Health Sector Strategic Plan (NHSSP) I & II and the current HSIP III. One of the overriding priorities of HSSP II was the fulfillment of the health sector's contribution to the PEAP and MDG goals of reducing maternal mortality and morbidity; reducing fertility; malnutrition; the burden of HIV/AIDS, among others. The HSSP II prioritized addressing life-threatening health problems, particularly pregnancy and birth-related deaths and childhood killer diseases. HSSP II worked on principles of integrated service delivery, increased efficiency in resource allocation and use of resources, community participation and empowerment, and focus on maximizing service outputs, health outcomes and client satisfaction.

4.1.4 The National Reproductive Health Policy

Further commitment to address quality population is clearly articulated in a number of policy documents including the National Reproductive Health Policy; the Sexual and Reproductive Health Care Minimum Package; the National Reproductive Health Policy Guidelines for Reproductive Health Services (MoH, 2006); Guidelines for Gender Mainstreaming in Reproductive Health and the Strategy to Improve Reproductive Health in Uganda 2005-2010 etc.

To further consolidate the strategies for addressing population issues identified in all the above policies and guidelines, in 2007 the Ministry of Health developed a Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (Republic of Uganda, 2007). The roadmap's vision is "to have women in Uganda go through pregnancy, child birth and postpartum period safely and their babies born alive and healthy". The Roadmap underlines the importance of family planning in reducing maternal deaths and illnesses. The roadmap sets priorities and strategies including: promotion and improvement of the legal framework and policy environment for effective formulation and implementation of maternal health programmes; ensuring availability, accessibility and utilization of quality maternal and newborn health services; strengthening human resource capacity; advocating for increased allocation and distribution of resources; strengthening coordination and management of maternal and newborn care services; and empowering communities to participate in care, as well as strengthening monitoring and evaluation mechanisms for better decision making and service delivery.

4.2 The National Population Policy

The National Population Policy (NPP) 2008 is in harmony with the former Uganda's over-arching development framework, the Poverty Eradication Action Plan (PEAP). It defines the critical issues that must be tackled in order to ensure a quality population that enhances the country's development goals and objectives. The National Population Policy takes into account Uganda's past and present, and remains cognizant of Uganda's commitments to international and

regional conventions, declarations and covenants such as the International Conference on Population and Development programme of Action (ICPD-PoA), 4th World Women's Conference, Millennium Development Goals (MDGs) and New Partnership for African Development (NEPAD).

The National Population Policy (2008) recognizes that all couples and individuals have the basic right to decide freely and responsibly the number and the spacing of their children, and to have access to information and education in order to make an informed choice; and the means to do so. It stipulates the promotion and expansion of comprehensive family planning services, facilitating individuals and couples wishing to practice family planning with the means to do so, and enhancing the role of men in the promotion and utilization of family planning. The policy underlines empowerment of women, provision of higher education and capacity to make informed decisions as crucial in positively influencing women's reproductive health. It recognizes that health, in particular reproductive health, is a basic human right, and specifically points out the importance of RH commodity security and increased budgetary allocation for reproductive health.

4.2.1 The National Population Policy Action Plan

The purpose of the NPPAP is to coordinate the implementation of the NPP and contribute to the realization of Uganda's vision on sustainable human development by:

- Identifying and integrating programmes and actions addressing population issues into national, sectoral and departmental plans;
- Facilitating the implementation of the policy at national, district and community levels by making the national policy objectives operational; and
- Serving as a tool that will guide the implementation and coordination of the National Population Policy.

The NPPAP links population issues with broader development concerns, like poverty eradication, health (including Reproductive Health and HIV/AIDS), education, housing, agriculture, environment, gender, labour and employment, among other social issues which should be explicitly addressed by public policy so as to positively impact on the quality of life.

The NPPAP translates the goal, objectives and strategies of the NPP into focused and measurable intervention programmes and activities, where stakeholders identify easily with activities relevant to their sectors. The national population agenda is articulated in five thematic areas, namely;

- Population and development,
- Sexual and reproductive health;
- Gender and family welfare;
- Advocacy and communication; and
- Institutional framework and coordination.

In each thematic area, crosscutting issues namely research, gender, advocacy, and poverty are identified so that they are not compromised in the course of implementing the policy at all levels.

The National Population Action Plan is prepared within the framework of the NDP in addressing issues of limited human development and disempowerment. Actions to improve human development focus on improving the quality and retention at primary and post primary education levels, reducing infant, child and maternal mortality rates and increasing peoples control over the size of their families by ensuring that family planning services are accessible to all, and ensuring households responsibly participate in increasing protection against HIV/AIDS.

4.2.2 NPP Implementation Framework

There is a well established policy implementation mechanism with the Population Secretariat taking the lead role and responsibility for ensuring a quality population. Population Secretariat collaborates with several stakeholders, including sectoral ministries, government agencies, development partners, CSOs, religious and cultural institutions on policy development, advocacy and awareness creation on the population issues outlined in the NPP and NPPAP.

For effective implementation and coordination of the NPP, the specific roles of major stakeholders such as; line ministries, local governments, civil society institutions, as well as individuals and households, have been identified within their mandates.

The National Population Council in collaboration with the Prime Minister's Office and the National Planning Authority will be responsible for ensuring that stakeholders comply with the Action Plan through relevant and timely interventions. The Council will organise quarterly review meetings of the forum to monitor the progress and adherence to the sector plans. It will also sanction a mid-tern and final (end of five years) evaluation of the NPP implementation by an independent body or as will be deemed appropriate. This will guide the future direction of the implementation process of the Policy.

4.2.3 The Joint Population Programme (JPP)

The Joint Programme on Population (JPP) is a four year partnership between the Government of Uganda, CSOs and 10 UN agencies which include; World Health Organization (WHO), International Labour Organization (ILO),United Nations World Food Programme (WFP), International Organization for Migration (IOM), United Nations Joint Programme on AIDS (UNAIDS), United Nations Women (UN WOMEN), United Nations Populations Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Human Settlements Programme

(UN-HABITAT), and United Nations High Commissioner for Refugees (UNHCR).

The JPP is referred to as "investing in population" aiming to accelerate efforts towards turning Uganda's youth population into a skilled and motivated labour force capable of propelling the nation into a prosperous economy. The programme will help tap opportunities presented by Uganda's currently youthful population, where 69.3% are under the age of 24 years while aiming at placing necessary conditions to enable the country benefit from the potential young people.

As discussed in chapter 1, Uganda's Population is mostly made up of children who have to depend on fewer working adults. This means that a large proportion of the national income is spent on social services like education, health, and housing leaving a small fraction for families to save and invest. The JPP believes that with family planning, good education especially for the girl-child, the country will be able to transform the high fertility and mortality rates into low fertility and mortality rates, a process referred to as "demographic transition" hence resulting into a population with a more group of people working thus deducing to economic growth, a phenomenon known as "demographic bonus", where everyone should benefit.

4.3 Do Population Policy Commitments translate into quality population?

While there are a number of policies, guidelines and service standards to address the high fertility in the country, the apparent weak implementation and limited coverage of these policies has led to persistent high fertility, morbidity and increasing poverty. The 1995 NPP which by far offered the most comprehensive discussion on the causes of high fertility and infant and maternal mortality and morbidity, did not articulate concrete actions to address gender related barriers to better quality of life. Male involvement is now highlighted in the 2008 NPP as a cause of poor social status of women resulting in failure to fully exercise their reproductive rights, thus high fertility and increased maternal deaths but no particular attention is paid to it as a priority area of focus.

The discussion on reproductive health has largely focused on gender as a "women-only-issue" with no comprehensive focus on men and their involvement in maternal and reproductive health, given the fact that men are central in household decision making, particularly on issues of access to, control and distribution of resources, movement outside the home, as well as control over one's sexual life. The 1995 NPP also offered little discussion on the role of the community in population issues; yet population challenges are rampant in poor and rural communities. Community mobilization and empowerment are pertinent to improved quality of the population. The 2008 has wide focus on male involvement in reproductive health issues and the NPPA clearly demonstrates the urgent need for Population Secretariat to liaise closely with the MOGLSD in community mobilization and empowerment.

Uganda's RH commodities have been relentlessly starved of funding. Direct contraceptive funding from UNFPA and USAID represented about two-thirds of the total government budget for contraceptives, government covering only 14% of the national contraceptive need. What is worse is that even this small government contribution was not fully forthcoming. For instance, government had allocated Uganda shillings 1.5 billion per year to reproductive health commodities since 2005/06, but much of this money was either not disbursed or diverted[25]. For instance, spending on contraceptives has been between 2- 6% of allocated funds! The MoH had estimated a 30% gap between contraceptive need and actual availability, raising the question of whether policy implementation depends too much on the interests or commitment of stakeholders. It was not until 2009/2010 that the government funding for RHCS was prioritized, with increasing funding in financial year 2010/2011 (see table 4 below).

Table 4: Government funds available for RH Commodities

Item	**Funds**
MOH Funds Under Letter of Credit (From 2008/09 FY)	454,882,539 (UGX)
MOH Funds FY 2009/10	1,498,798,489 (UGX)
MOH funds FY 2010/2011	1.5 billion (UGX)
MOH funds FY 2010/2011 (Mobilized by NMS)	900,000,000 (UGX)
Total Available funds Now (MOH Funds)	4,353,681,028 (UGX) **=1.917,921 USD**
Funds Anticipated from MOH in the next 4 financial Years	6 Billion (UGX) **=2,643,171 USD**
World Bank Loan for 5 years	**18,949,654.74 (USD)**
Total Available for 5 years	**23,510,746 (USD)**

4.4 Financing the Population programmes

Budgeting in Uganda has been guided by the PEAP, Uganda's National Development Framework and Medium-Term Planning Tool since 1997 to 2009 and currently, the NDP. The sources of financing for the Population Secretariat and the Population Program include the national budget (central government budget) that includes GoU and donor budget support and project funding.

The government budget includes both government funds and donor budget support and is the most preferred mode of funding because it is flexible and government has the control to allocate resources to agreed priorities. There is a well-established finance management and monitoring mechanism which reinforces a similarly well established accounting system in ensuring expenditure

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Population Action international, 2009: Maternal health Supplies in Uganda by Elizabeth Leahy Madsen, Jennifer Bergeson-Lockwood and Jessica Bernstein

is made against agreed work plans and outputs. While there are a number of donors supporting the population program, UNFPA is the main development partner. Inadequate budgetary allocation has been and is a major obstacle to improving the quality of Uganda's population.

4.5 What needs to be done?

Most sectors, especially health and education still argue their planning and budgeting proposals from a needs/cost perspective and therefore do not factor in, the investment case: returns on every dollar spent on reproductive health, savings accruing and potential lost earnings that could be saved which weaken the case during budget negotiations. There is need to empower health and education sectors to make the case for investment in reproductive health and create a mechanism during planning and budgeting process for this dialogue with Ministry of Finance officials. The Ministries of Finance should appreciate that budget allocation for sexual and reproductive health is not a cost, but an investment. With a total fertility rate of 6.7 children per woman and an average economic growth rate of 7% over the last decade, there should be an ideal balance between the two that can allow a balanced investment in economic and social sectors to meet the needs of a growing population.

4.5.1 Investing in Reproductive Health

Potentials for investing in reproductive health exist within each country in the planning and budgeting processes. Over the last 2 years, Uganda went through the process of developing a five-year National Development Plan (2009/10 – 2014/15), a successor document to the Poverty Eradication Action Plan I & II (2000/1 – 2008/9). Sexual and reproductive health has been integrated within this document, with clear set targets. For instance, the NDP targets to increase the CPR from 24% to 50% within 5 years and reduce Total Fertility Rate from 6.7 to 6.0. There are other sexual & reproductive health indicators included in this document as well as in sectoral policies and strategic plans.

Recognizing the role of reproductive health to national development, in Financial Year 2008/9, Parliament of Uganda refused to approve the Ministry of Health budget until the Ministry could clearly show the proportion of the budget earmarked/allocated for sexual and reproductive health. Similarly, parliament also refused to approve a World Bank loan amounting to USD $ 130 million for health systems strengthening, until there was specific allocation for sexual and reproductive health component. The loan was approved with reproductive health taking US $30 million, the balance going for health systems strengthening.

The development of Medium Term Expenditure Framework presents another opportunity for integrating SRH in the national planning and budgeting process. However these instruments not withstanding, there are challenges in planning for, budgeting and utilizing resources allocated for sexual and reproductive health. Often times there are competing priorities/needs in a developing country

with very limited income and resource base. The questions that policy makers, planners and economist have to battle with are:

- Do we focus our budget on drivers of economic transformation such as investment in infrastructure that creates jobs and investment, and then in turn raise the income that can be invested into other sectors?
- Should we invest in social sectors before we can do the infrastructure investment or should we do in both? Which of these options make sound economic decision? Countries like China focused on infrastructure for a long time and then only recently moved to social investment when their economies have grown. Is this the way forward or what is the right balance?
- Sometimes even when the budget allocation is made for sexual and reproductive health, absorption capacity is limited and at the end of the year funds are returned to the treasury due to non absorption. There are also cases of fungibility in some instances.

The Ministry of Health underscores the critical role of RHCS in attaining better reproductive health status and sustaining services, as stated in the Strategy to Improve Reproductive Health in Uganda (2005-10), and the National Family Planning Advocacy Strategy. The second Health Sector Strategic Plan (HSSP II) targets an increase in contraceptive prevalence rate (CPR) to 40% from the current 23%; full availability of condoms (100%); eliminate drug stock-outs, including RH commodities in 80% of health units; and provide emergency contraceptives in 60% of health units. In spite of these and other policy commitments and promises, stock-outs of all drugs, including RH commodities, occurs regularly.

4.5.2 Making the Economic Case for investing in RH

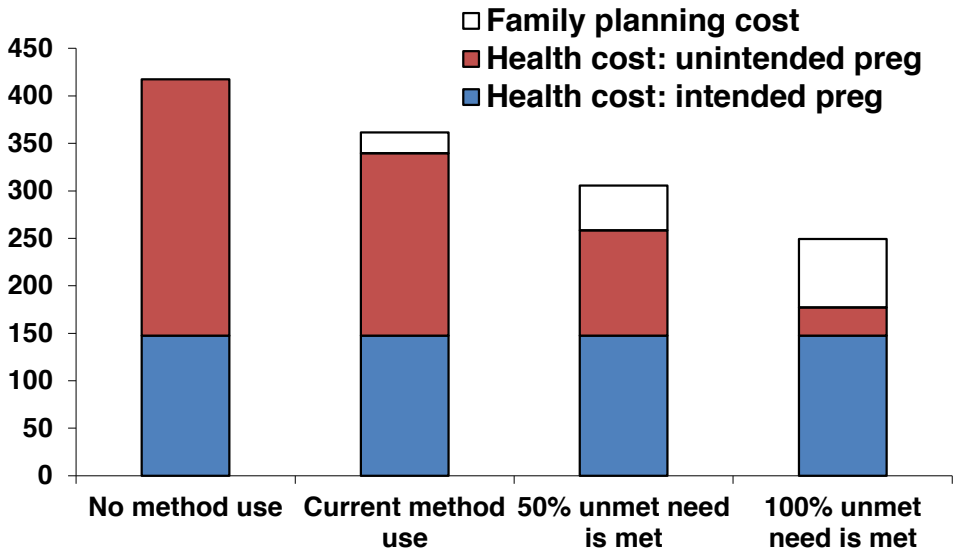
In general, there is paucity of evidence that links SRH with investments. However, in Uganda there are currently a few studies that have shown potentials for investing in sexual and reproductive health, in particular, family planning. These are:

1. Adding It Up Study[26] done by the Economic Policy Research Centre which shows that investing by addressing the current 41% unmet need for family planning as one of the reproductive health elements reduces maternal death by 33%. We also know it has potential to reduce infant mortality by two times if birth were spaced for more than 2 years with significant returns to the children, household, community and nation. For every US $1 invested in family planning, there would be US $3 return. So if Uganda invested US $108 in family planning commodity procurement (which is the estimated cost) and therefore address all the current unmet needs for family planning, Uganda would save $112 million dollars annually in health care costs associated with

[26] GUTTMACHER INSTITUTE, Adding it Up: The costs and benefits of investing in family planning and maternal and newborn health

management of complications of unintended pregnancies. This would add to earnings by saving potential earnings that would be lost through lives lost and lives lived with disability, equivalent to UGX 120 billion or 0.4% of GDP. These savings could be invested back into health care to achieve the Abuja target for health sector budget allocation of 15% or even get re-invested in other economic sectors.

Figure 11: Fulfilling the unmet need for FP would save women's lives and contribute to economic investment



2. Resources for Awareness in Population & Development (RAPID) Projections – this projection has been done for Uganda, jointly with the National Population Secretariat and it examines the link between fertility, population growth rate and its impact on different sectors and the overall national economy. Assuming a slower population growth rate scenario (which can be achieved by a combination of strategic investment in economic and social sectors (e.g. addressing unmet need for family planning & girl child education) and assuming economic growth rates at constants of 7% or 10%, the projection gives Uganda options for attaining middle income status within a single generation (30 years time frame).