The Republic of Uganda
MINISTRY OF HEALTH

THE THIRD NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN (FP-CIP III)

2025/26 - 2029/30

With Support from:
UNFPA through, Marie Stopes Uganda (MSUG)

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PREFACE

The Third National Family Planning Costed Implementation Plan (FP-CIP III) builds upon the solid foundation laid by its predecessors to deliver a more resilient, government-owned, and quality-centered program. Guided by the lessons from FP-CIP II, this plan redefines Uganda's approach to family planning by embedding it within the broader RMNCAH continuum of care and ensuring sustainability through domestic financing and institutional accountability.

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FP-CIP III represents more than a roadmap, it is a collective commitment to equity, efficiency, and long-term impact. Its implementation will drive the modern contraceptive prevalence rate (mCPR) and reduce the unmet need for family planning among all women. These goals will be achieved through four strategic pillars: strategic health communication for behavioral change, governance and accountability, integration for equitable service delivery and sustainable FP financing and commodity security.

The success of FP-CIP III depends on active participation from key sectors, government ministries, local governments, development partners, civil society, and the private sector. Each stakeholder has a role to play in ensuring that family planning becomes an integral part of every health interaction, community dialogue, and budgetary decision.

I commend the leadership and technical guidance of the FP-CIP III Evidence Task Force and acknowledge the dedication of all who contributed to this process. Together, we can build a self-sustaining, equitable, and quality-driven family planning program that contributes to the realization of Universal Health Coverage and the aspirations of Vision 2040.

Prof. Charles Olaro
Director General, Health Services

ACKNOWLEDGEMENT

The successful development of the Third National Family Planning Costed Implementation Plan (FP-CIP III, 2025/26–2029/30) is a result of extensive collaboration, commitment, and shared vision among a wide range of stakeholders. On behalf of the Ministry of Health, I extend sincere appreciation to the FP-CIP III Evidence Task Force for their leadership and technical direction throughout the process.

We recognize with gratitude the invaluable contribution of our development partners, particularly the United Nations Population Fund (UNFPA) for financial support, Avenir Health through the Track20 project for the technical support, Marie Stopes Uganda, and Clinton Health Access Initiative (CHAI) for their assistance and coordination support.

Special appreciation goes to the representatives from government ministries, district health teams, civil society organizations, academia, and the private sector who participated in consultations and provided technical inputs to ensure the plan reflects Uganda's priorities and context. Their expertise and commitment have shaped a comprehensive and actionable plan for the next five years.

The Ministry of Health reaffirms its commitment to leading the implementation of this plan through a coordinated, multi-sectoral approach. Let us all continue to work together to accelerate access to quality, equitable, and sustainable family planning services for all Ugandans.

Dr. Richard Mugahi
Commissioner, Reproductive and Child Health

EXECUTIVE SUMMARY

The Third National Family Planning Costed Implementation Plan (FP-CIP III) 2025/26–2029/30 outlines Uganda's renewed commitment to building a sustainable, government-led, and resilient family planning (FP) program. While previous CIP cycles expanded contraceptive access and strengthened the policy environment, progress remains fragile due to financing gaps, inequitable service delivery, and weak multi-sectoral coordination. The FP-CIP III responds to these gaps with a transformative, systems-oriented approach anchored in resilience, integration, and domestic ownership.

The plan's overarching goals are to increase modern contraceptive prevalence to 37.8% among all women and 47.8% among married women, and to reduce unmet need to 13.5% by 2030. These goals will be achieved through four strategic pillars: (1) Strategic Health Communication for Behaviour Change, which strengthens community-led communication, counters misinformation, and promotes age-appropriate, rights-based self-care; (2) Governance and Accountability, which integrates FP into multi-sectoral planning, strengthens partner coordination, improves data systems, institutionalizes FP in government plans, and expands the FP workforce; (3) Integration for Equitable Service Delivery, which elevates service quality through mentorship, scale-up of high-impact practices, improved supply chain management, strengthened community systems, and alignment of partners for equity; and (4) Sustainable FP Financing and Commodity Security, which prioritizes domestic financing, includes FP benefits package in UHC schemes, strengthens supply chain resilience, and embeds FP into national and district budgeting structures.

The FP-CIP III emphasizes measurable, sustainable outcomes by embedding FP within routine health services, national development planning, and existing government accountability platforms. By shifting from donor reliance to predictable domestic financing and multisectoral ownership, this plan positions family planning as a core driver of human capital development, economic productivity, and Uganda's broader Vision 2040 aspirations.

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Uganda's Family Planning (FP) program is deeply anchored in the country's long-term development vision, Vision 2040, which aspires to transform Uganda from a peasant society into a modern and prosperous nation within 30 years. Central to this vision is the recognition that population dynamics directly influence economic growth, human capital development, and social transformation. The Government of Uganda (GoU) acknowledges that effective family planning is not merely a health intervention but a strategic enabler for sustainable development, helping the country reduce its population growth rate from 3.2% to 2.4% and harness the demographic dividend. By empowering individuals and couples to plan their families, FP contributes to improved maternal and child health (key intervention that has reduced maternal deaths by 30.3% in Uganda), gender equality, education outcomes, and poverty reduction, all of which are critical to achieving the aspirations of Vision 2040 (Ahmed et al., 2025).

In alignment with this national vision, the Fourth National Development Plan (NDP IV) and the Ministry of Health (MoH) Strategic Plan 2025/26–2030/31 underscore FP as a core priority. Achieving these priorities requires sustained political commitment, cross-sector collaboration, and strategic investment in high-impact FP interventions. Family planning is therefore positioned not just as a health service but as a development accelerator, linking population management to economic growth, environmental sustainability, and social wellbeing.

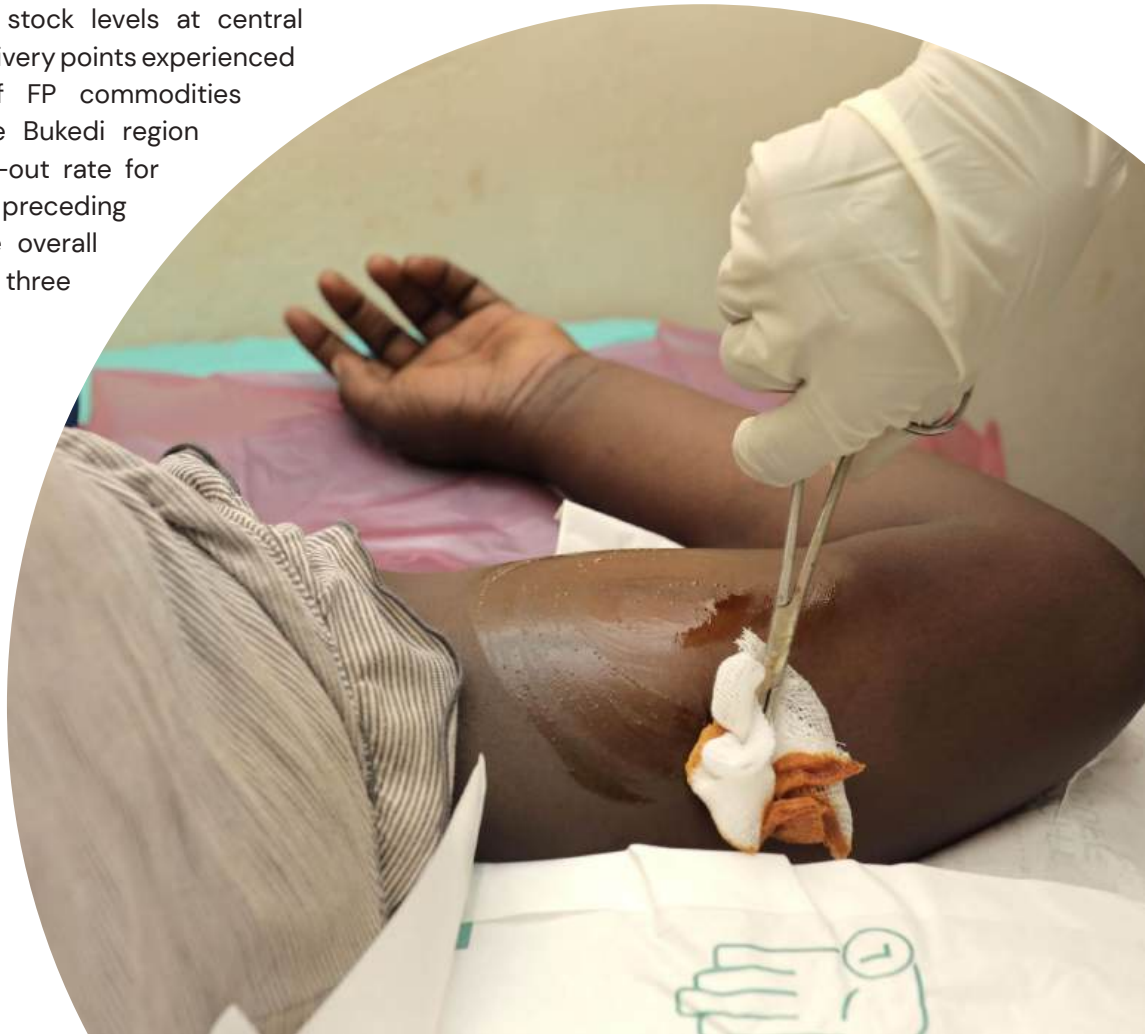
Over the past decade, Uganda has made commendable strides in improving reproductive health outcomes. With strong support from development partners, the country has implemented two successive Family Planning Costed Implementation Plans (FP-CIPs), which provided clear roadmaps for expanding access to and use of FP services. The FP-CIP I (2015–2020) laid the groundwork by defining national FP priorities, mobilizing resources, and strengthening policy frameworks. Its evaluation highlighted key successes such as increased contraceptive uptake, expanded service delivery points, and enhanced coordination mechanisms. However, it also revealed persistent challenges, geographic inequities, limited community engagement, weak data systems, and heavy donor dependence, that threatened sustainability.

Building on the insights from the initial plan, the FP-CIP II (2020/21–2024/25) was designed to adopt a more programmatic and technical focus, emphasizing integration, equity, and system strengthening. It aimed to reposition family planning as a multisectoral development catalyst, aligning with Uganda's Vision 2040 and the Sustainable Development Goals. The plan prioritized scaling up High-Impact Practices (HIPs), such as postpartum and post-abortion family planning, and the Total Market Approach (TMA) to enhance domestic resource mobilization and reduce long-standing donor dependency. Furthermore, FP-CIP II sought to promote regional balance through targeted interventions, strengthen commodity security, and improve evidence-based programming via better data management and coordination mechanisms among partners, ensuring accountability for national demographic goals.

Micro-Level Challenges

At the operational and frontline levels, the evaluation revealed a cascade of challenges that directly undermined service quality and client trust. Despite healthy stock levels at central warehouses, service delivery points experienced chronic stock-outs of FP commodities and supplies, with the Bukedi region reporting a 96% stock-out rate for any method in the preceding three months and the overall availability of at least three modern methods at primary facilities dropping from 82% to 76% (PMA,2022). This commodity insecurity was compounded by persistently poor quality of client counselling, as reflected in the Method Information Index Plus (MII+) stagnating at just 45%, meaning most women did not receive comprehensive information on side effects, method switching, or other options, a gap that fuels method discontinuation.

Frontline health facilities also suffered from critical understaffing, leading to unacceptable waiting times of three to five hours and rushed provider-client interactions that further eroded care quality. For clients, while services themselves are free, the prohibitive cost of transport to reach facilities created a significant financial barrier, particularly for the poorest women. Deeply entrenched socio-cultural norms and gender barriers compounded these access issues, with women often resorting to using contraception secretly due to male opposition and fear of gender-based violence, while persistent myths that family planning causes infertility were reinforced by religious and cultural leaders.



Community outreaches and provider training programs, though vital, remained heavily reliant on donor funding, leading to abrupt cessation when support ended, and high staff turnover meant that skills from one-off training events were quickly lost. Finally, at the facility level, health workers struggled to use DHIS2 data for operational decisions, lacked routine performance feedback, and depended on district staff for basic report generation, severely limiting their ability to engage in continuous quality improvement.

Macro-Level Challenges

At the systemic, policy, and structural levels, the evaluation uncovered foundational failures that rendered the program's progress fragile and unsustainable. The most critical macro-level challenge was overwhelming donor dependency coupled with unsustainable domestic financing: the Government of Uganda's average annual contribution of roughly $2 million represented only a fraction of the total commodity need, which stood at over $22 million in 2025 alone, while USAID funding declined sharply and UNFPA became the lead donor, leaving the entire system vulnerable to external funding shifts and a persistent multi-million-dollar financing gap.

The intended multi-sectoral collaboration remained largely theoretical, as the National FP Steering Committee met irregularly with minimal involvement from key ministries such as Gender, Finance and Education, while district-level coordination committees were largely non-existent, resulting in fragmented planning and partners working in isolation. A paradoxical breakdown in the supply chain meant that despite ample stocks at central warehouses, facilities faced chronic shortages, a classic last-mile failure pointing to inefficient distribution, weak facility-level forecasting, and inadequate transport funding.

The absence of functional District Costed Implementation Plans (DCIPs) was particularly striking, with many district officials unaware of their existence, meaning family planning had no distinct budget line item at the local level and districts remained entirely dependent on partners. Consequently, the program failed to meet its core impact targets: the modern contraceptive prevalence rate for all women reached only 33.8% against a 39.6% target, unmet need remained high at 19.9% compared to a 10% target, and teenage pregnancy stagnated at 24% against a 15% target.

Equity-focused programming for youth and marginalized groups remained limited, with post-abortion FP uptake among adolescents stuck at just 2.6% and no systematic scale-up of gender-transformative interventions to engage men and shift harmful norms. Finally, although national-level data use was strong, the entire data system was fragmented and donor-dependent, with implementing partners providing essential analytical support that ceased when funding ended, leaving districts unable to generate forward-looking intelligence and locking the program into retrospective reporting rather than proactive strategy.

Against this backdrop, the Family Planning Costed Implementation Plan III (FP-CIP III, 2025/26–2029/30) has been conceived to consolidate the gains of FP CIP II while addressing systemic weaknesses that continue to impede universal access and sustainability. Its development is driven by three key imperatives;

First, the demographic necessity:

Uganda's population growth rate remains high above NDP IV targets, calling for accelerated shift from a high fertility population to a more manageable, healthier and productive workforce thus harnessing the demographic dividend.

Second, the health system integration mandate:

As Uganda moves toward a fully integrated health service delivery model, FP must be seamlessly embedded into all service delivery points, ensuring continuity of care and efficient resource utilization.

Third, the need for fiscal resilience:

With declining external funding, Uganda must build a financially self-sustaining FP program through predictable domestic financing, service integration and promoting performance-based financing.

CHAPTER TWO

SITUATION ANALYSIS

Uganda's family planning landscape has evolved significantly over the past decade, driven by strong policy commitment and structured implementation through the two-Family Planning Costed Implementation Plans (FP-CIP I and II).

However, despite measurable gains, the FP ecosystem remains fragile, characterized by funding volatility, inequitable service delivery, and limited multi-sectoral engagement. The situational analysis below synthesizes the performance and lessons from FP-CIP II across five thematic areas, multi-sectoral collaboration, policy and governance, service delivery, financing, and data systems, to inform the strategic direction of FP-CIP III (2025/26–2029/30).

2.1 MULTI-SECTORAL COLLABORATION AND GOVERNANCE

Implementation under FP-CIP II revealed a persistent gap between the strategic recognition of multi-sectoral action and its operationalization. While the National FP Steering Committee was reactivated, its meetings were irregular, and participation from pivotal ministries such as Gender, Education, and Finance remained limited, constraining the policy coherence needed to address the socio-economic determinants of fertility. At the subnational level, district coordination committees were largely inactive, hampered by unclear mandates and a reliance on external partner funding and agenda-setting. This undermined local government ownership and the systematic integration of FP into District Development Plans and broader RMNCAH activities. The resultant governance model was fragmented, with partners often driving implementation in parallel to—rather than through—strengthened public sector systems.

2.2 POLICY ENVIRONMENT AND ENABLING FRAMEWORKS

The period saw substantive progress in developing supportive policy instruments. Notable achievements include the development of National Self-Care Guidelines, revised Post-Abortion

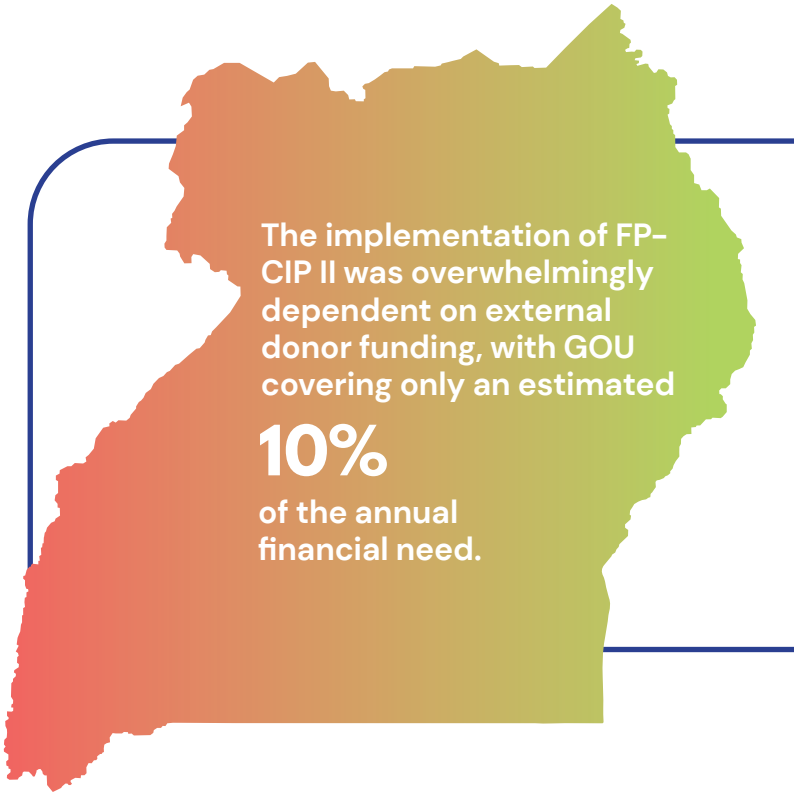
Care guidelines, and the advancement of the Total Market Approach (TMA). The TMA made significant strides in fostering public-private collaboration, securing regulatory approvals for private-sector provision of injectables through accredited pharmacies, and broadening method choice. Simultaneously, the institutionalization of self-care guidelines began decentralizing access and empowering users. However, a critical implementation gap persisted in translating these national policies into consistent action at subnational levels. Integration of FP priorities into sectoral and local government plans was uneven, and policy enforcement remained weak, indicating a disconnect between framework development and operational reality.

2.3 SERVICE DELIVERY AND ACCESS

Service delivery expansion was a clear achievement of FP-CIP II, evidenced by growth in the number of contraceptive users and facilities providing Long-Acting Reversible Contraceptives (LARCs). The deliberate scale-up of High-Impact Practices (HIPs), such as immediate Postpartum Family Planning (iPPFP) and Post-Abortion Family Planning (PAFP), contributed to this progress. However, significant gaps in quality and equity undermine these gains. Counselling remains inconsistent, stock-outs of commodities periodically disrupt service continuity, and access to a full range of methods—particularly LARCs, varies dramatically by region. Furthermore, adolescent-responsive services are under-developed, failing to meet the specific needs of a demographic that accounts for a substantial portion of first antenatal care visits. These gaps highlight that while access has widened, the health system has not yet fully integrated FP as a standard, quality-assured component of care across all service points, from antenatal clinics to postnatal and adolescent health services.

2.4 FINANCING AND SUSTAINABILITY

Financing remains the most acute vulnerability of Uganda's FP program. The implementation of FP-CIP II was overwhelmingly dependent on external donor funding, which covered only an estimated 10% of the annual financial need. This reliance created volatility and hindered long-term planning. At the district level, this dynamic was mirrored in the development of costed FP plans that often-reflected external priorities rather than locally-owned strategies embedded within government budgeting and Universal Health Coverage (UHC) frameworks. The heavy donor dependence starkly contradicts the core principle of fiscal resilience and exposes the program to sustainability risks. The absence of predictable, adequate domestic financing for FP commodities and services prevents its full integration as a fundamental component of primary healthcare and UHC, leaving the system ill-prepared for transitions in external support.



2.5 DATA, EVIDENCE, AND ACCOUNTABILITY SYSTEMS

Improvements were made in routine FP data reporting through the DHIS2 platform. However, the system's potential for driving improvement was not fully realized. Data streams from community, facility, and logistics systems remained siloed, and an FP-specific electronic dashboard (DataPro) was not scaled nationally or sub-nationally. Accountability mechanisms were largely confined to partner-driven review meetings, with weak feedback loops to district management teams for corrective action. Consequently, data was not optimally used for real-time decision-making, performance tracking, or fostering accountability at the operational level. This represents a missed opportunity to leverage information as a tool for system learning and integrated planning within the broader RMNCAH data ecosystem.

2.6 IMPLEMENTATION OF THE TOTAL MARKET APPROACH (TMA)

The Total Market Approach 2020/21-2025/26 strategy elaborated how the multi-sectoral approach, especially with increased involvement from the private sector, played a role in addressing fertility concerns and also increased access to quality comprehensive FP services and information. Some achievements and progress were registered as follows.

- **Secured authorization for the provision of injectable contraceptives through accredited pharmacies - potentially expanding access to injectables and stimulating private-sector investment.**
- **Supported the finalization of the Last Mile Assurance (LMA) guideline, ensuring integration of critical components such as leakage mitigation for national-level implementation.**
- **Supported the introduction of other FP products into the private sector market, broadening method choice and engaging new market players.**
- **Some insurance companies have expanded their maternal health service packages to include FP though still largely restricted to short-term methods.**
- **By bringing stakeholders together, about $2 million for private-sector FP system strengthening was mobilized. Key contributors include the Gates Foundation, CIFF, EKN, FCDO, UNFPA, and pharmaceutical companies.**

2.7 REGIONAL DISPARITIES IN FPCIP IMPLEMENTATION

2.7.1 Community Outreaches

Uganda's performance on integrated SRH/FP outreaches steadily improved over the five-year FP-CIP II implementation period, rising from 65% in 2020/21 to 83% in 2024/25, demonstrating strengthened outreach capacity and expanded community access to services. However, the table below shows clear regional disparities in both trends and consistency of implementation. Regions such as Kigezi, Karamoja, Lango, and Teso generally maintained strong performance across multiple years, often reaching or surpassing their annual outreach targets, reflecting effective local coordination and strong district-level engagement.

In contrast, Kampala, Acholi, and West Nile repeatedly fell below target, with several years marked by red and yellow performance ratings. These persistent gaps suggest operational challenges such as urban congestion (Kampala), post-conflict mobility constraints (Acholi), and logistical barriers. Overall, while national coverage advanced, the table highlights the need for targeted support to consistently underperforming regions to ensure equitable community access to FP and other SRH services.

2.7.2 Contraceptive Commodity Availability at Service Points.

Commodity security remained the cornerstone of ensuring uninterrupted access to FP services under the CIP II framework. The evaluation of contraceptive security highlighted the progress and challenges in quantification, procurement, and distribution processes.

Table 1: Shows integrated outreaches conducted by region

Region	Jul 20-Jun 21	Jul 21-Jun 22	Jul 22-Jun 23	Jul 23-Jun 24	Jul 24-Jun 25	Trend
Acholi	61%	63%	67%	71%	69%	
Ankole	89%	51%	90%	93%	95%	
Bugisu	76%	79%	73%	79%	65%	
Bukedi	83%	85%	82%	84%	87%	
Bunyoro	22%	84%	77%	81%	93%	
Busoga	74%	77%	72%	83%	75%	
Kampala	65%	59%	64%	43%	79%	
Karamoja	72%	84%	80%	83%	81%	
Kigezi	90%	102%	81%	94%	94%	
Lango	80%	76%	72%	78%	75%	
North Buganda	81%	73%	79%	92%	80%	
South Buganda	100%	88%	63%	91%	92%	
Teso	78%	80%	81%	86%	84%	
Tooro	75%	83%	76%	81%	90%	
West Nile	76%	85%	80%	92%	81%	
Total	65%	75%	74%	83%	83%	

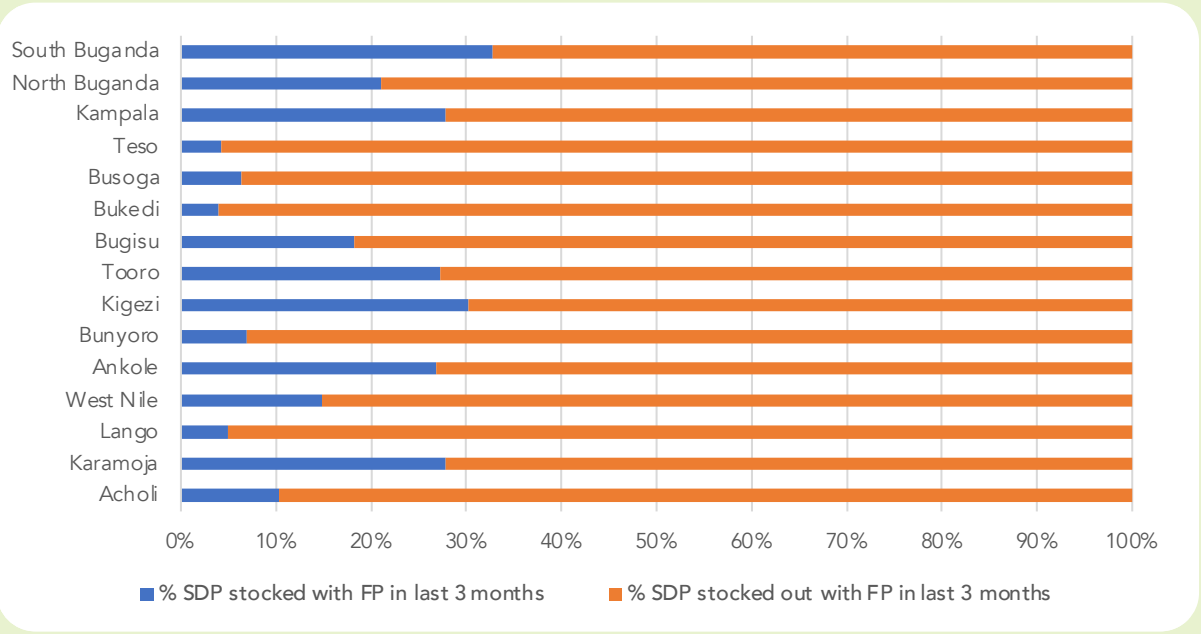
Implementation levels	<=70	71-84	>=85

Source: DHIS2

Where district and facility involvement in the FP commodity supply chain was found to be structured but ultimately a constrained process. Facilities actively using consumption data from registers to forecast and quantify demand, all of which contribute to the national quantified need.

Despite the health stock status at national, a snapshot of stock availability at service delivery points revealed significant stock-out of commodities spanning from regional to primary level facilities.

Figure 12: Shows FP stock availability by region (SDP Survey, 2023)



Regional disparities were evident, with Bukedi region recording the highest stock-out rate of any method in the past three months at 96.0%. Stock-outs were also more prevalent in rural facilities (83.2%) compared to urban facilities (74.3%), and were highest among facilities under government management (84.7%). Commodities stock outs at service delivery points continue to be a chronic problem despite availability at central level, potentially pointing to supply chain and last mile challenges.

2.7.3 Access to Post-Partum Family Planning

The country experienced a modest improvement in the uptake of immediate postpartum family planning (iPPFP)- uptake of FP within the first 48hours following delivery, between 2020 and 2025. While overall progress in PPFP can be evident, there was still a significant gap in ensuring that contraception begins immediately after childbirth, a critical intervention for preventing closely spaced pregnancies and improving maternal and newborn health outcomes.

During the implementation period of the Costed Implementation Plan (CIP II), access to immediate postpartum family planning improved from 0.8% in FY2020/21 to 2.3% currently. Regional variations were observed, with the highest uptake in the Lango sub-region (5.1%), while the lowest uptake was reported in West Nile (0.6%), indicating the need for targeted interventions to address regional disparities and strengthen postpartum family planning services nationwide.

Table 2: Immediate Post-Partum FP (iPPFP)

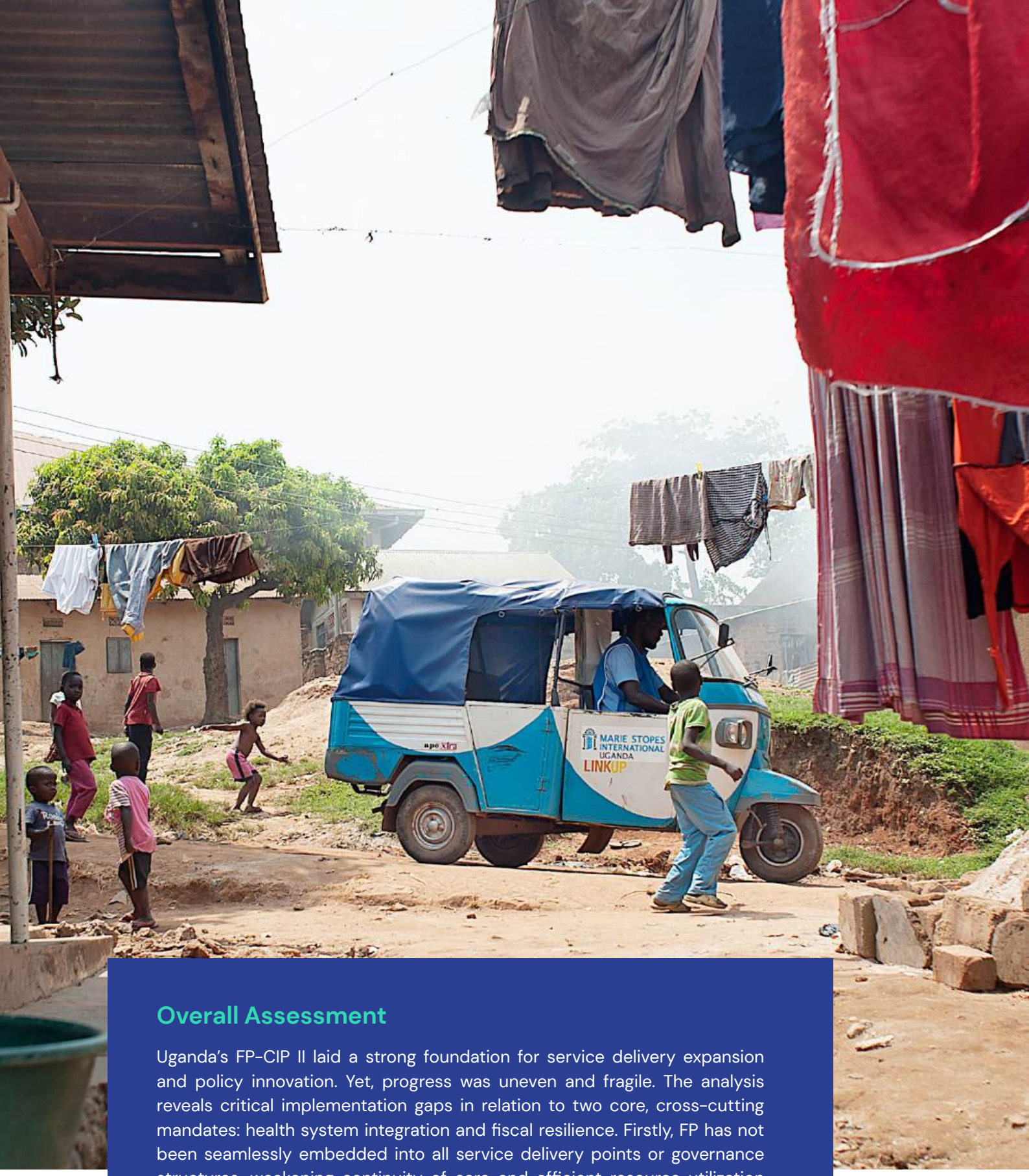
REGION	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25	TREND
Acholi	1.2%	1.5%	1.1%	1.0%	0.9%	
Ankole	1.0%	1.1%	0.9%	2.0%	3.2%	
Bugisu	0.7%	0.7%	0.7%	1.6%	3.2%	
Bukedi	0.3%	0.5%	0.9%	1.1%	2.8%	
Bunyoro	0.6%	1.1%	1.3%	1.2%	1.7%	
Busoga	1.5%	2.7%	1.9%	2.4%	3.1%	
Kampala	0.2%	0.4%	5.0%	4.7%	2.9%	
Karamoja	0.2%	0.3%	0.6%	0.8%	1.5%	
Kigezi	1.7%	1.5%	1.4%	2.2%	2.3%	
Lango	1.5%	4.4%	3.4%	3.6%	5.1%	
North Buganda	1.1%	0.8%	0.5%	0.5%	0.8%	
South Buganda	0.4%	0.7%	0.8%	0.8%	1.8%	
Teso	0.4%	0.4%	0.5%	0.5%	1.1%	
Tooro	0.8%	0.8%	0.9%	1.9%	2.2%	
West Nile	0.1%	0.2%	0.7%	0.8%	0.6%	
Grand Total	**0.8%**	**1.1%**	**1.3%**	**1.6%**	**2.3%**	

2.7.4 Access to Post Abortion Family Planning

Overall, unlike iPPFP, Post Abortion FP uptake improved greatly from 7.1% to 10.6% between FY20/21 and FY24/25 as shown table 13 below. Uptake of PAFP remained extremely low in Bunyoro and Teso while significant strides have been observed in South Buganda, Bukedi, Busoga and Kampala.

Table 3: Trends in Post Abortion FP Uptake

REGION	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25	TREND
Acholi	5.1%	7.1%	5.7%	7.2%	9.6%	
Ankole	7.3%	8.5%	12.9%	14.9%	9.9%	
Bugisu	9.6%	10.6%	14.6%	16.5%	16.6%	
Bukedi	8.8%	11.8%	9.2%	13.7%	20.7%	
Bunyoro	3.9%	4.7%	3.9%	3.5%	2.6%	
Busoga	6.3%	10.8%	9.4%	13.7%	16.2%	
Kampala	16.3%	16.4%	14.7%	16.4%	19.3%	
Karamoja	3.3%	3.8%	3.1%	3.8%	5.0%	
Kigezi	4.4%	7.3%	6.4%	5.5%	5.2%	
Lango	6.5%	11.7%	9.3%	9.2%	13.2%	
North Buganda	8.5%	10.7%	9.7%	8.9%	8.4%	
South Buganda	13.0%	15.0%	16.9%	16.7%	16.6%	
Teso	2.1%	2.9%	2.2%	2.5%	2.9%	
Tooro	5.1%	6.7%	8.1%	6.1%	4.5%	
West Nile	3.6%	3.4%	4.2%	3.3%	4.0%	
Grand Total	**0.8%**	**9.0%**	**8.9%**	**9.7%**	**10.6%**	



Overall Assessment

Uganda's FP-CIP II laid a strong foundation for service delivery expansion and policy innovation. Yet, progress was uneven and fragile. The analysis reveals critical implementation gaps in relation to two core, cross-cutting mandates: health system integration and fiscal resilience. Firstly, FP has not been seamlessly embedded into all service delivery points or governance structures, weakening continuity of care and efficient resource utilization within the evolving integrated health model. Secondly, the over-reliance on external funding has stifled the development of a financially self-sustaining program, jeopardizing the gains made and highlighting an urgent need for a transition toward predictable domestic financing and smarter, performance-based resource allocation.

CHAPTER THREE

DEVELOPMENT OF THE FP CIP III, 2025/26–2030/31

3.1 BACKGROUND OF THE PROCESS

The development of the FP-CIP III was a participatory and evidence-driven process built upon the findings of the end-term evaluation of FP-CIP II. The evaluation systematically reviewed the implementation of the 2020/21–2024/25 plan using a mixed-methods approach that combined document analysis, national and subnational consultations, and quantitative data reviews. It examined the plan's relevance, effectiveness, and efficiency, identifying key achievements such as improvements in contraceptive access and policy development, while also highlighting challenges around financing, data use, and equity. The insights from this evaluation provided the empirical foundation for shaping FP-CIP III, ensuring that the new plan would not only consolidate previous gains but also address systemic weaknesses that hindered progress toward national reproductive health goals.

Following the evaluation, the FP-CIP III development process involved extensive stakeholder engagement coordinated by the Ministry of Health through the National FP-CIP Evidence Task Force. Consultative workshops and technical working groups brought together diverse actors, including government ministries, development partners, district health teams, civil society, and private sector representatives, to co-create priorities and strategic directions for the next five years. This inclusive process ensured alignment with Uganda's Vision 2040, and the National Development Plan IV. Modeling of FP-CIP III targets involved translating evaluation findings into measurable outcomes and indicators, setting ambitious yet achievable targets for modern contraceptive prevalence and unmet need. The costing exercise was carried out collaboratively with health financing experts, applying standardized micro-costing methodologies to estimate resource needs and ensure fiscal realism. The resulting FP-CIP III is therefore both technically sound and financially feasible, providing a clear roadmap for a sustainable, government-led FP program anchored in evidence, inclusivity, and accountability.

3.2 GUIDING PRINCIPLES OF FP-CIP III

The FP-CIP III is guided by a core set of principles designed to transform Uganda's FP program into an equitable, sustainable, and resilient system. Grounded in the lessons from FP-CIP II and aligned with national development goals, these principles, Equity, Sustainability, Integration, Accountability

& Transparency, and Rights-Based & Person-Centered Care, collectively ensure the plan addresses critical gaps, prioritizes underserved populations, and fosters a government-led, responsive framework for achieving universal access to quality family planning services.

Equity will be a central, cross-cutting principle, mandating the deliberate prioritization of underserved regions and populations. This requires targeted resource allocation, tailored programming, and continuous monitoring to close persistent gaps in access, particularly for adolescents, rural communities, and regions that have historically fallen behind.

Sustainability will guide the transition from donor dependence to a resilient, government-led FP program. This involves strengthening domestic financing, integrating FP into essential health services and national budgets, and building robust, locally-owned systems for supply chain management and human resources.

Integration ensures that FP services are systematically embedded within broader sexual and reproductive health (SRH), maternal, child, and adolescent health platforms. This principle maximizes efficiency, improves the user experience, and leverages existing community and health system structures for greater impact.

Accountability & Transparency will be operationalized through strong governance, a clear results framework, and participatory monitoring. Regular reviews of disaggregated data, active feedback mechanisms from communities and clients, and transparent reporting will ensure resources are used effectively and programs remain responsive.

Rights-Based & Person-Centered Care affirms that all individuals have the right to make informed reproductive choices free from coercion or discrimination. Services will be designed to be respectful, non-judgmental, confidential, and responsive to the diverse needs of all users, especially adolescents and youth.

3.3 FP-CIP III STRATEGIC FRAMEWORK (2025/26–2029/30)

3.3.1 Vision and Goals

Uganda's FP-CIP III builds on the achievements and lessons of FP-CIP II. Its vision articulates Uganda's long-term aspiration for a healthy, productive population capable of driving sustainable economic transformation.

3.3.2 Vision

Improved quality of life of Ugandans by enhancing their productivity.

3.4 METHODOLOGY FOR SETTING PROGRAM GOALS FOR FP-CIP III

Goal setting is an important aspect of strategic planning and key to maintaining government accountability. Our goals are right-sized to generate political will and provide a framework for annual monitoring. The Goals are ambitious enough, but achievable, requiring additional effort – hence monitoring will provide helpful information to help the FP program improve and grow. These goals further create an environment where the government will have to improve programs and coverage, and for accountability networks can push the government to deliver on the commitments made in the FP CIP III.

For the FP-CIP III, a benchmarking approach was taken, setting mCPR goals, and the Unmet need based on continuing the FPET trend to 2030 and taking the median estimates. Achieving these goals will require at least maintaining the current growth trend through the five-year plan period.

3.5 PROGRAMMATIC GOALS

Three programmatic goals are provided under realistic scenario.

Increase national mCPR (All Women) from

33.8% in 2025 **to** **37.8%** by 2030

through improving access to sexual and reproductive health and rights information and services.

Increase national mCPR (Married Women) from

42.4% in 2025 **to** **47.8%** by 2030

through improving access to sexual and reproductive health and rights information and services.

Reduce the unmet need for modern contraception from

19.9% in 2025 **to** **13.5%** by 2030

Achieving these goals requires deliberate investment in high-quality FP service delivery, sustainable financing mechanisms, and strengthened accountability systems. These goals also contribute to addressing regional disparities in FP access, particularly in high-fertility, low-access regions.

3.6 RATIONALE FOR THE GOALS

Adopting a rights-based approach that transcends marital status, all women of reproductive age should have universal access to a full range of high-quality contraceptive methods, ensuring their autonomy and informed choice. This vision aligns directly with the FP2030 global partnership, which envisions a future where voluntary modern contraceptive use is realized for everyone who desires it, supported by individual agency, responsive and sustainable health systems offering a wide method mix, and an enabling policy environment.

3.7 FP-CIP III PROGRAMMATIC GOALS AND TARGETS (2025-2030)

Table 4: FP CIP III Programmatic Goals and Targets (2025-2030)

PROGRAMMATIC GOAL	BASELINE (2025)	TARGET (2030)	RATIONALE FOR THE GOAL
1. Increase the modern Contraceptive Prevalence Rate (mCPR) for all women of reproductive age.	33.8%	37.8%	This goal aims to accelerate progress toward the demographic dividend by committing to ambitious, inclusive growth. The target is set to surpass historic trends, reflecting a new commitment to reaching all women with quality, rights-based services.
2. Increase the modern Contraceptive Prevalence Rate (mCPR) for married women/in-union.	42.4%	47.8%	This goal capitalizes on the established contraceptive use among married women to intensify impact. It shifts focus from access alone to improving quality, choice, and continuation to accelerate fertility transition and improve family health.
3. Reduce the unmet need for modern FP methods among all women of reproductive age.	19.9%	13.5%	This goal directly targets unmet need as the clearest measure of program success, focusing on transforming contraceptive desire into actual use. It aims to address barriers through quality, availability, and supportive services to create a true enabling environment for choice

3.8 COMMODITIES NEED FOR THE FP-CIP III (2025-2030)

The commodities needed for both the public and private sector for the tenure of the FP-CIP III are presented below.

Table 5: FP Commodity Needs for Public and PNFP facilities

PUBLIC AND PNFP SECTOR Quantities						
Product	**Unit**	**FY 25/26**	**FY 26/27**	**FY27/28**	**FY28/29**	**FY29/30**
Pills (POPs)	cycles	599,833	626,226	653,645	682,127	682,127
Pills (COCs)	cycles	2,399,332	2,504,903	2,614,579	2,728,509	2,728,509
Pills (ECPs)	blister pack	1,773,738	1,841,015	1,910,702	1,982,883	1,979,335
Injectables (DMPA-IM)	vial	1,464,066	1,528,485	1,595,409	1,664,929	1,664,929
Injectables (DMPA-SC)	vial	4,392,199	4,585,456	4,786,228	4,994,788	4,994,788
IUDs-Copper	each	33,362	34,830	36,355	37,939	37,939
IUD-hormonal	each	13,565	14,162	14,782	15,426	15,426
Implants (5-year)	each	107,095	111,807	116,702	121,787	121,787
Implants (3-year)	each	383,665	400,546	418,084	436,302	436,302
Cycle beads	each	10,743	11,215	11,706	12,216	12,216
Female condoms	each	526,169	549,321	573,373	598,357	598,357
Male Condoms	each	11,049,557	11,535,738	12,040,824	12,565,504	12,565,504

CHAPTER FOUR

IMPLEMENTATION FRAMEWORK FOR FP-CIP III

4.1 FP-CIP III STRATEGIC PILLARS

Pillar 01

Strategic Health Communication for Behaviour Change

Building upon Uganda's National Family Planning Advocacy Strategy 2020-2025 and evidence from FP-CIP II, Pillar 1 implements a high-impact, multi-layered Social and Behaviour Change Communication (SBCC) campaign. This strategic communication initiative is the central engine for addressing the key drivers of poor outcomes in Uganda's family planning landscape: deeply entrenched myths and misinformation, pervasive fear of side effects, high method discontinuation rates, and restrictive social and gender norms. By directly targeting these barriers through community, digital, and evidence-based channels, the pillar aims to transform knowledge into positive, sustained health-seeking behaviour.

1.1 Amplified Media & Community Campaign: Equipping Trusted Messengers for Local Dialogue

The large-scale media campaign is designed to create a unified, national narrative that empowers and amplifies local action. It utilizes mass media, particularly radio, which has extensive reach, to broadcast dramas, discussions, and testimonials that model positive behaviours and challenge social norms. This campaign provides the "air cover" for grassroots activities.

The community-led mobilization component is the critical ground force. It strengthens the capacity of Community Health Workers (CHWs), and Civil Society Organizations (CSOs) to serve as trusted, frontline communicators. Crucially, they will be equipped with standardized, visually engaging CHW materials and facilitation toolkits, including flip charts, discussion guides, and myth-busting cue cards, that are culturally resonant and translated into local languages. These materials are not for distribution alone but are designed to facilitate structured dialogues in community gatherings, male-engagement

sessions, and women's groups. This approach bridges the gap between passive knowledge and active use by allowing communities to voice and address their specific concerns, such as fears about infertility or religious opposition, in a safe, facilitated space.

1.2 Dynamic Digital Campaign: Co-Creating with Youths for Normative Shift

Recognizing that adolescents and youths are primary digital consumers, this sub-pillar executes a targeted digital campaign on platforms like WhatsApp, Instagram, and TikTok. Moving beyond one-way messaging, the campaign employs a strategy of co-creation with youth influencers and content creators to develop relatable content, short videos, interactive polls, and live Q&A sessions with health providers. This content directly addresses drivers of poor outcomes among youth: stigma, privacy concerns, and misinformation. The digital campaign will normalize conversations about method choice, side-effect management, and sexual reproductive health rights, while integrating direct links to youth-friendly service finders, telemedicine consultations, and CHEW outreach schedules. This creates a seamless journey from digital awareness to tangible service access.

1.3 Focused Myth-Busting & CHEW Materials for Side-Effect Management

A core driver of low uptake and high discontinuation is misinformation and unpreparedness for side effects. The campaign directly names and counters the most pervasive myths with clear, scientifically accurate information delivered across all channels. Parallel to this, a major focus is on managing fear and expectations around side effects. CHW materials and digital content will include clear, actionable guidance on common side effects, their duration, and management strategies. This empowers users to persist with methods or seek timely switching, rather than abandoning use altogether. This sub-pillar champions "full, free, and informed choice" by ensuring individuals understand the range of methods available, leading to better method-match and higher satisfaction.

1.4 Network of Champions & Gender-Inclusive Advocacy for Norm Change

To alter the restrictive social fabric, the pillar builds a visible network of champions. This includes training cultural and religious leaders, male role models, and local politicians to publicly endorse family planning as a pro-health, pro-family, and pro-development intervention. Women's Networks will be fostered for peer support and collective action, while Men's Action Groups will be engaged to promote shared responsibility in reproductive health and challenge norms around masculinity and fertility. These advocates, equipped with key messages and advocacy tools, work within their spheres of influence to reshape community norms and reduce stigma.

1.5 Integration and Monitoring for Impact

The SBCC campaign is not a standalone initiative; it is fully integrated with service delivery, outreach, and training. Messages about method availability will align with commodity supply chains, and CHWs will be trained to reinforce campaign messages during client consultations. A robust monitoring framework tracks shifts in key indicators, myth belief, intention to use, perception of side effects, and gender-equitable attitudes, using digital analytics, community feedback, and periodic surveys. This real-time data allows for agile adaptation of the media campaign, digital content, and CHEW materials, ensuring the strategy remains responsive, evidence-based, and directly contributes to closing the equity gap and increasing contraceptive prevalence across Uganda.

In summary, Pillar 1 confronts the fundamental drivers of poor FP outcomes through a synergistic strategy: a national media campaign setting the agenda, a youth-centric digital campaign driving normative change, empowered CHWs with targeted materials facilitating critical local dialogue, and a diverse champion network reshaping the social environment. This comprehensive SBCC approach is designed to build a sustainable, supportive ecosystem for informed voluntary choice.

Table 6: Key Interventions under Strategic health communication for Behavioural Change

THEME	STRATEGIC OBJECTIVE	KEY INTERVENTIONS	KEY OUTPUTS	KEY OUTCOMES	TARGET
1. **Amplified Media & Community Campaign**	To create a unified national narrative and empower trusted community messengers to bridge the gap between knowledge and practice.	1. Implement a large-scale national media campaign (radio dramas, discussions, testimonials). 2. Equip Community Health Workers (CHWs) and CSOs with standardized, culturally resonant facilitation toolkits (flip charts, guides, cue cards). 3. Facilitate structured community dialogues, male-engagement sessions, and women's groups.	1. Aired radio/TV spots and programs 2. Developed and distributed CHW/CSO toolkits in local languages. 3. Number of community dialogues and mobilization sessions held. 4. Trained CHWs and CSOs on SBCC facilitation.	1. Increased salience of FP as a national priority. 2. Enhanced knowledge and self-efficacy among CHWs as communicators. 3. Communities actively discuss and address specific FP myths and concerns. 4. Improved community norms supporting FP.	**Nationally** (Media Campaign) **All Regions** (Community Mobilization, with intensified focus on selected low-performing districts from FP-CIP II).
2. **Equip Community Health Workers (CHWs) and CSOs with standardized, culturally resonant facilitation toolkits (flip charts, guides, cue cards).**	To directly counter misinformation and build user confidence by managing expectations, thereby reducing fear-driven discontinuation.	1. Develop and disseminate clear, factual content that names and addresses top myths (e.g., infertility, cancer). 2. Integrate actionable guidance on side-effect management into all CHW materials and digital content. 3. Champion "full, free, and informed choice" messaging across all channels.	1. Myth-busting and side-effect management content packages produced for multiple channels. 2. CHWs regularly providing side-effect counselling. 3. Tracked reach and engagement with myth-correction content.	1. Decreased belief in common FP myths. 2. Increased knowledge of side-effect management and method diversity. 3. Higher user confidence and self-efficacy in managing methods. 4. Reduced method discontinuation due to fear or side effects.	**Nationally** (Mass Media) **All Regions** (Integrated into service delivery).
3. **Facilitate structured community dialogues, male-engagement sessions, and women's groups.**	To co-create normative change among adolescents and youth, reducing stigma and creating a digital pathway to services.	1. Partner with youth influencers to co-create relatable content (testimonials, Q&As, explainer videos) for WhatsApp, Instagram, TikTok. 2. Host live interactive sessions with health providers. 3. Integrate direct links to youth-friendly service finders, telemedicine, and outreach schedules.	1. Portfolio of co-created digital content published. 2. Number of live Q&A/ engagement sessions held. 3. Metrics on digital engagement, reach, and click-through to service information.	1. Increased positive discourse about FP among youth peer networks. 2. Reduced stigma and increased perception of FP as normal and positive. 3. Increased intention to use FP services among youth. 4. Higher uptake of linked digital-to-physical services.	**Nationally** (Digital Platforms) **All Regions,** with content tailored for urban/peri-urban youth.

THEME	STRATEGIC OBJECTIVE	KEY INTERVENTIONS	KEY OUTPUTS	KEY OUTCOMES	TARGET
4. Improved community norms supporting FP.	To reshape restrictive social and gender norms by leveraging influential voices and peer support networks.	1. Recruit, train, and deploy a diverse cohort of champions (cultural/religious leaders, male role models, politicians, satisfied users). 2. Establish and support Women's Networks for peer support. 3. Establish Men's Action Groups to promote shared responsibility.	1. Number of champions trained and publicly advocating. 2. Number of active Women's Networks and Men's Action Groups. 3. Public endorsements and statements by leaders. 4. Advocacy events and community dialogues led by champions.	1. Increased public endorsement of FP by local leaders. 2. Strengthened peer support systems for women. 3. Improved male engagement and support for FP. 4. Measurable shift towards more gender-equitable attitudes in communities.	**National Level FP Champions** **All Regions,** with champion recruitment focused at sub-national and district levels.
5. Integration & Monitoring for Impact	To ensure message-service alignment and enable data-driven, agile adaptation of the SBCC campaign.	1. Integrate SBCC messages with service delivery, outreach, and training components. 2. Train CHWs to reinforce campaign messages during consultations. 3. Implement a robust monitoring framework using digital analytics, community feedback, and surveys.	1. Functional coordination mechanism between SBCC and service delivery teams. 2. CHWs trained on integrated messaging. 3. Regular monitoring reports and dashboards on KPIs (myth belief, intention, attitudes). 4. Documentation of adaptive changes made to campaign.	1. Coherent user experience from message to service. 2. Increased ability to track campaign performance and impact. 3. Agile, evidence-based refinement of materials and strategies. 4. Contribution to increased contraceptive prevalence and equity.	**Nationally** (System Integration) **All implementing districts** (Monitoring and adaptation).

Pillar 02

Governance, Advocacy and Accountability

This pillar establishes the essential enabling environment for effective and sustainable family planning service delivery. It focuses on strengthening the leadership, financial, data, and accountability systems that underpin the entire health system. By ensuring policies are backed by budgets, performance is transparently tracked, and leaders are held accountable, this pillar addresses the root systemic bottlenecks that hinder quality service provision. It transforms governance from a passive structure into an active driver of results, ensuring the gains from demand generation and service delivery are sustained and scaled.

2.1 Institutionalizing Leadership and Policy Integration

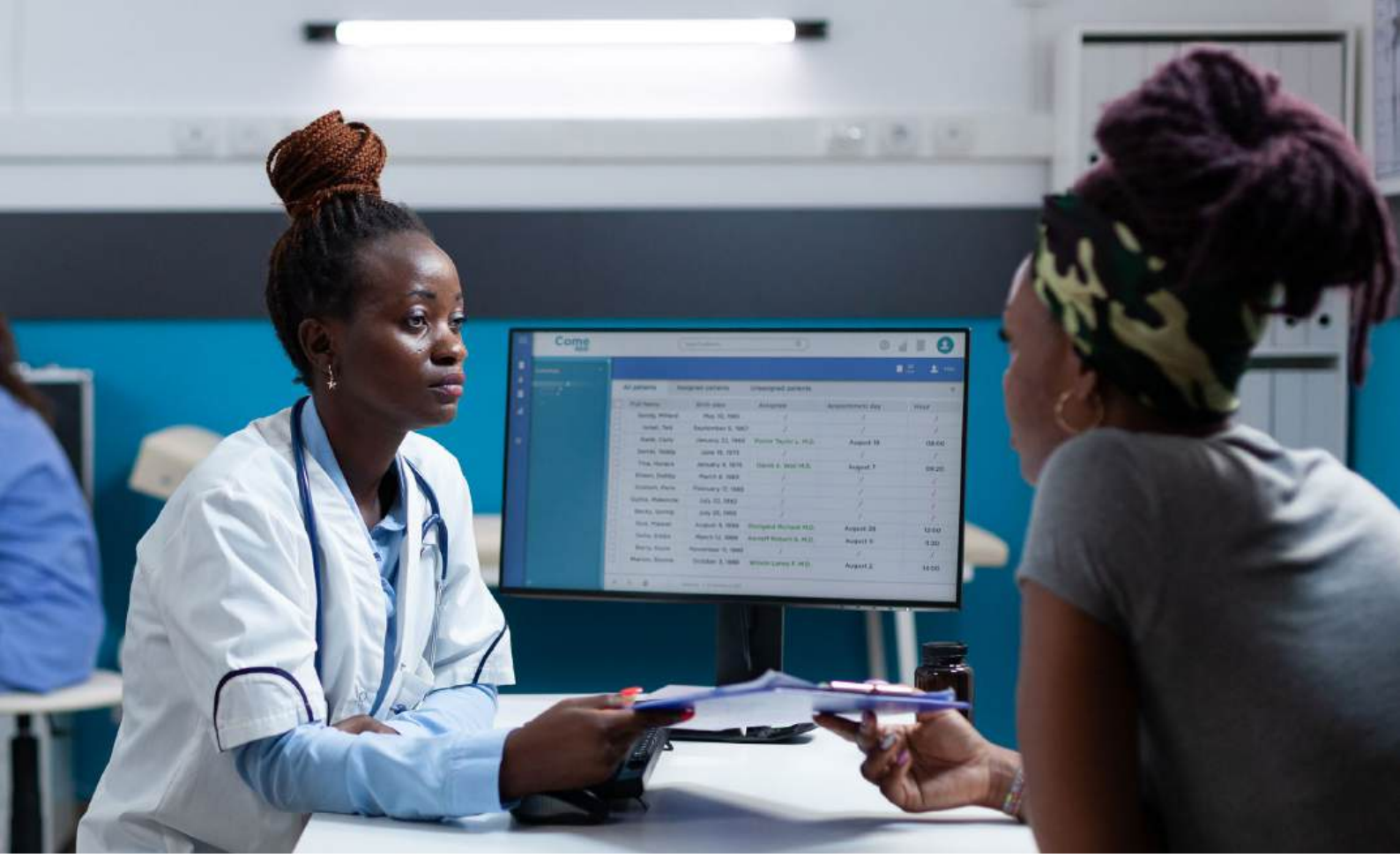
This sub-pillar systematically embeds FP as a cross-government priority beyond the health sector. It involves reactivating and formalizing the National Family Planning Steering Committee with mandated participation from key ministries; Health, Finance, Local Government, Gender, and Education, to drive coordinated policy and resource mobilization. This leadership is cascaded to districts by integrating FP objectives and accountability measures into the core mandates of District Health Management Teams and local development committees. Key activities include developing integration guidelines, conducting leadership orientations, and revising planning templates. The expected output is a functional multi-sectoral governance structure with FP explicitly reflected in district and sectoral plans and budgets. This will lead to the key outcome of improved policy coherence, increased domestic resource allocation for FP, and stronger local ownership, directly tackling the bottleneck of fragmented planning and weak political commitment.

2.2 Securing and Tracking Sustainable Domestic Financing

This sub-pillar addresses the chronic bottleneck of unpredictable and unclear funding for FP. It focuses on securing long-term domestic investment by advocating for and technically supporting the creation of explicit, protected FP budget lines within national and district health budgets under the Universal Health Coverage framework. Concurrently, it establishes transparent tracking mechanisms, such as integrated budget codes and public expenditure reviews, to monitor the flow and utilization of FP funds. Key inputs include budget advocacy kits, training for planning officers, and the development of a public-facing expenditure dashboard. The primary output will be verifiable FP budget lines in financial documents and regular published expenditure reports. The targeted outcome is increased and more efficient domestic financing for FP, reduced donor dependency, and greater fiscal accountability, ensuring commodity security and program activities are reliably funded.

2.3 Enhancing Data Systems for Performance Monitoring

This intervention transforms data from a passive reporting exercise into an active management tool by fully functionalizing the FP DataPro dashboard within the national DHIS2. It involves customizing the platform to provide real-time, district-specific analytics on critical indicators, from commodity stock levels and service uptake to equity measures like adolescent access. Activities include system customization, training for data managers and users, and enforcing strict data completeness and timeliness protocols. The key output is an operational, user-friendly dashboard providing actionable insights at all administrative levels. This will lead to the outcome



of a data-driven culture where managers can identify stock imbalances, service inequalities, or quality gaps in real time, directly addressing the bottleneck of delayed or poor-quality information that hinders proactive decision-making.

2.4 Establishing Data-Driven Accountability Mechanisms

This sub-pillar creates a structured cycle of accountability by institutionalizing regular, evidence-based performance reviews. It integrates FP performance metrics into the established agendas of bi-annual multi-sectoral reviews and quarterly District Joint Performance Meetings. These forums will mandate the use of the FP DataPro dashboard to review scorecards, identify persistent bottlenecks (e.g., specific facilities with chronic stockouts or low postpartum FP uptake), and assign concrete corrective actions with clear timelines and responsible parties. Key activities involve developing review protocols and training facilitators. The output will be a schedule of minuted review meetings with associated action trackers. The intended outcome is a strengthened culture of accountability where leaders are answerable for FP results, leading to faster resolution of systemic problems and improved program performance across all districts.

2.5 Strengthening Human Resource Planning and Competency

This sub-pillar ensures the human resource foundation for quality service delivery is solid. It tackles the bottlenecks of staff shortages, misdistribution, and skill gaps by integrating FP into national and district human resource plans, ensuring future staffing strategies align with service needs. It also scales up competency-based training and continuous mentorship for health workers, with a focus on rights-based counselling, LARC provision, and adolescent-friendly service delivery. Inputs include revised HR planning guidelines, standardized training curricula, and a roster of trainers and mentors. The outputs will be HR plans with explicit FP staffing targets and a cohort of health workers who have received updated, hands-on training. The ultimate outcome is an adequate, equitably distributed, and highly competent workforce capable of delivering the high-quality, respectful care essential for achieving FP-CIP III's goals.

Table 7: Key interventions under Governance, Advocacy and Accountability

THEME	STRATEGIC OBJECTIVE	KEY INTERVENTIONS	KEY OUTPUTS	KEY OUTCOMES	TARGET
1. **Institutionalizing Leadership in Multi-Sectoral Platforms**	To embed FP as a cross-government priority and ensure coordinated policy and budget integration at all levels.	1. Mandate inclusion of FP objectives and budget lines in sectoral and district development plans. 2. Reactivate and formalize the National FP Steering Committee with multi-sectoral representation. 3. Reactivate and formalize the District FP Steering Committee with multi-sectoral representation.	1. FP explicitly included in annual work plans and budgets of key ministries and districts. 2. Functional National FP Steering Committee with defined TORs and meeting schedule. 3. Functional District-level FP steering committee with defined TORs and meeting schedule.	1. Improved multi-sectoral coordination and ownership of FP outcomes. 2. Increased and predictable domestic budget allocation for FP. 3. Strengthened district-level leadership and accountability for FP performance.	**Nationally** (All relevant sectors) and **All Districts**
2. **Strengthening Public Financial Management and Transparency**	To secure sustainable domestic financing and enhance transparency in FP resource allocation and expenditure.	1. Advocate for explicit FP budget lines under UHC frameworks at national and district levels. 2. Establish and operationalize a public tracking mechanism for FP expenditures. 3. Conduct regular expenditure reviews and audits.	1. FP budget lines created and reflected in national and district budget documents. 2. Publicly accessible dashboard or reports on FP fund disbursement and utilization. 3. Annual FP expenditure review reports published.	1. Increased domestic funding for FP. 2. Greater transparency and reduced fund leakage. 3. Improved efficiency and accountability in FP spending.	**National** Ministry of Finance and District Local Governments in **all regions.**
3. **Enhancing Data Systems for Performance Monitoring and Accountability**	To enable real-time, data-driven decision-making through a fully functionalized and scaled FP performance dashboard.	1. Fully integrate and scale the FP DataPro dashboard within DHIS2. 2. Customize dashboard to provide district-specific analytics on supply, service delivery, self-care, and equity indicators.	1. Fully operational FP DataPro dashboard accessible at national, regional, and district levels.	1. Improved availability and use of real-time FP data for management.	**Nationally** integrated; roll-out and capacity building focused on **all districts.**

THEME	STRATEGIC OBJECTIVE	KEY INTERVENTIONS	KEY OUTPUTS	KEY OUTCOMES	TARGET
4. Establishing Data-Driven Review and Accountability Mechanisms	To institutionalize routine, multi-sectoral performance reviews that drive corrective action and hold leaders accountable.	1. Integrate FP metrics into agendas of bi-annual multi-sectoral reviews and quarterly District Joint Performance Meetings. 2. Use FP DataPro analytics to identify bottlenecks and guide resource allocation. 3. Develop and track action plans from review meetings.	1. FP included as a standing agenda item in multi-sectoral and district review meetings. 2. Performance scorecards and bottleneck analysis reports regularly produced. 3. Documented corrective actions and follow-up reports.	1. Strengthened culture of accountability for FP results. 2. Timely identification and resolution of systemic bottlenecks. 3. Improved linkage between data review, planning, and corrective action.	**National** multi-sectoral platforms and District-level review committees in **all implementing districts.**
5. Strengthening Human Resources and Service Delivery Capacity	To ensure the health workforce is planned, trained, and supported to deliver high-quality, rights-based FP services.	1. Integrate FP into national and district human resource plans. 2. Scale up competency-based training and mentorship for health workers on rights-based counselling and service provision. 3. Integrate FP into pre-service education curricula for relevant cadres.	1. Number of health workers trained and mentored in FP service delivery. 2. Revised pre-service training modules for health professions.	1. Adequate and competent FP service providers available at all levels. 2. Improved quality of care and adherence to rights-based standards. 3. Sustained workforce capacity through institutionalized training.	**National** HRH units and District Health Offices; training targeting facilities in **all regions,** prioritized by need.

Pillar 03

Integration for Equitable Service Delivery

This pillar translates policy into equitable practice by ensuring quality, rights-based family planning services reach all populations, with a deliberate focus on underserved groups like adolescents, postpartum women, and those in hard-to-reach communities. It moves beyond standalone interventions to scale two complementary strategies: systematically embedding FP into all service delivery points and delivering targeted outreach to priority groups, all under a strengthened national quality assurance framework. This integrated approach directly tackles the bottleneck of fragmented, low-quality services that fail to meet diverse client needs.

3.1 Scaling Up Youth-Responsive and Gender-Sensitive Services

This sub-pillar addresses the critical bottleneck of stigma and inaccessibility that prevents adolescents and youth from seeking care. It mandates all relevant health facilities to operationalize national standards for adolescent-friendly services, moving beyond designated "corners" to integrate principles of confidentiality, respect, and non-judgmental communication across all service points, including antenatal, postnatal, and HIV clinics. Key inputs include updated service delivery protocols, provider training modules on adolescent development and gender sensitivity, and community engagement materials. The primary output will be facilities assessed and certified as youth-responsive, with providers demonstrating competency in tailored counselling. This will lead to the key outcome of increased service utilization and satisfaction among young people, ensuring their right to confidential, dignified care is fulfilled. Course correction will rely on routine client feedback and supervision reports to identify and retrain facilities where stigma persists.

3.2 Expanding Access through Targeted Outreach and Integrated High-Impact Practices

This sub-pillar tackles the dual bottlenecks of geographical inaccessibility and missed opportunities within the health system. It expands reach through planned, integrated outreaches to underserved communities and out-of-school youth, co-locating FP with other essential services. Simultaneously, it systematically scales up evidence-based High-Impact Practices (HIPs), specifically immediate postpartum FP (iPPFP) and post-abortion FP (PAFP), by integrating them into routine maternity and PAC protocols. Inputs involve mobile outreach kits, revised clinical guidelines for HIPs, and commodity kits for postpartum LARCs. Outputs include a schedule of completed outreaches and an increased number of facilities providing iPPFP/PAFP as standard care. The targeted outcome is a significant increase in modern contraceptive prevalence among postpartum women and a reduction in unmet need in remote areas. Bottlenecks like commodity shortages at outreach sites or reluctance among maternity staff will be addressed through real-time logistics tracking and targeted mentorship.

3.3 Institutionalizing Quality through Competency and Mentorship

This sub-pillar confronts the persistent bottleneck of variable service quality and skill decay after training. It shifts from unsustainable, project-driven workshops to a government-led, institutionalized system for continuous quality improvement. This involves establishing a national framework for competency-based assessment and embedding regular, integrated supportive supervision and on-the-job mentorship for providers, with a special focus on skills for LARC, iPPFP, and PAFP provision. Key inputs are standardized clinical checklists, a cadre of trained national and district mentors, and a digital skills registry. The output is a functional mentorship and supervision schedule with documented provider competency assessments. The intended outcome is a sustained improvement in service quality, adherence to rights-based standards, and higher client satisfaction across all facilities. Course corrections will be data-driven, using mentorship reports to identify common skill gaps and adapt training curricula in real time.

Table 8: Strategic Interventions under Integration for Equitable service delivery

THEME	STRATEGIC OBJECTIVE	KEY INTERVENTIONS	KEY OUTPUTS	KEY OUTCOMES	TARGET
1. **Scaling Up Youth-Responsive & Gender-Sensitive Services**	To eliminate stigma and ensure confidential, dignified FP access for adolescents, youth, and other priority groups.	1. Operationalize adolescent-friendly service standards across all relevant service points (ANC, PNC, HIV, FP). 2. Train all providers in adolescent development, rights-based counselling, and non-judgmental communication.	1. Number of facilities assessed and certified as youth-responsive. 2. Number of providers trained and competency-assessed in youth-friendly service delivery.	1. Increased service utilization and satisfaction among adolescents and youth. 2. Reduced client-reported stigma and fear of judgment. 3. Improved provider attitudes and skills in serving young people.	All high-volume health centres & hospitals nationally.
2. **Expanding Access via Targeted Outreach & Integrated HIPs**	To increase FP coverage by reaching underserved populations and embedding services into high-contact maternal health moments.	1. Conduct integrated mobile outreaches to remote communities and out-of-school youth. 2. Systematically scale up Immediate Postpartum FP (iPPFP) and Post-Abortion FP (PAFP) by revising service protocols and ensuring commodity availability. 3. Co-locate FP services with all service delivery points.	1. Schedule and reports of completed integrated outreaches. 2. Number of facilities providing iPPFP and PAFP as standard care. 3. Number of service points with co-located FP counselling and provision.	1. Increased modern contraceptive prevalence among postpartum women. 2. Reduced unmet need for FP in hard-to-reach communities. 3. Higher uptake of FP at critical points of contact with the health system.	**Outreaches:** All regions with a target of >95% coverage. **HIPs:** All regional referral & general hospitals, scaling to high-volume HCIVs & HCIIIs.
3. **Institutionalizing Quality via Competency & Mentorship**	To sustain high-quality, rights-based FP service delivery through a government-led system of continuous clinical improvement.	1. Establish a national competency-based assessment and mentorship framework for FP providers. 2. Implement integrated supportive supervision with standardized clinical checklists. 3. Maintain a digital registry of provider skills and mentorship outcomes.	1. Functional national mentorship framework and trained mentor cadre. 2. Regular supportive supervision visits conducted with completed checklists. 3. Digital skills registry for FP providers operational.	1. Sustained improvement in clinical skills (especially for LARCs, iPPFP, PAFP). 2. Consistent adherence to national quality and rights-based standards. 3. Increased client satisfaction and method continuation rates.	**National rollout** of the framework; mentorship & supervision focused on all facilities providing FP services, prioritized by performance.

Pillar 04

Sustainable FP Financing and Commodity Security

This pillar secures the long-term viability of Uganda's FP program by tackling two interconnected systemic weaknesses: unpredictable funding and fragile supply chains. It shifts financing from donor-dependent projects to embedded government budgets and national health financing mechanisms while leveraging digital tools to create a transparent, resilient commodity pipeline from central warehouses to the last-mile point. The focus is on building domestic ownership and a data-driven system that prevents stockouts and ensures every budgeted dollar translates into an available method for clients.

4.1 Integrating FP into Mainstream Government Budgets

This sub-pillar addresses the bottleneck of FP being treated as a vertical, externally funded program vulnerable to shifting priorities. It works to institutionalize FP as a core, shared responsibility by advocating for and technically supporting the creation of embedded, predictable budget lines within the planned expenditures of key ministries (Health, Gender, Finance) and, crucially, within District Local Government budgets. Inputs include investment cases, standardized budget-coding guidelines, and advocacy engagements with parliamentary committees and district planners. The key output will be verifiable FP budget lines in Ministerial Policy Statements and District Development Plans. The targeted outcome is increased and more reliable annual domestic allocations for FP, reducing program vulnerability. Course correction will involve tracking actual disbursements against budgets and re-engaging sectors or districts where funding is consistently under-executed.

4.2 Leveraging National Financing Mechanisms for FP Services

This intervention tackles the bottleneck of limited and fragmented payment for services, which disincentivizes quality provision. It secures sustainable funding streams by explicitly embedding a comprehensive FP service package within national health financing architectures. Key activities include policy dialogue to include FP in the National Health Insurance Scheme (NHIS) benefit package, designing FP-specific indicators within existing Results-Based Financing (RBF) schemes, and guiding districts to allocate a portion of their conditional grants (e.g., Uganda Intergovernmental Fiscal Transfer Program funds) to FP. Outputs include revised NHIS/RBF policy documents and tracked district grant utilization for FP. The outcome is a diversified, results-oriented financing flow that directly rewards facilities for providing quality FP services, including to adolescents and postpartum women. Bottlenecks, such as delays in NHIS rollout, will be addressed by simultaneously strengthening the RBF and grant pathways.

4.3 Securing Domestic Financing for Commodities and Supply Chain

This foundational sub-pillar confronts the critical bottleneck of ad-hoc, insufficient government funding for procuring essential contraceptives, which creates total system dependency. It involves sustained, evidence-based advocacy with the Ministry of Finance and Parliament to secure adequate, timely, and predictable annual domestic allocations for FP commodity procurement, aligned with the national quantification report. Inputs are multi-year costed procurement plans and advocacy briefs. The primary output is an increased percentage of the national contraceptive commodity need funded through the government budget. The

key outcome is enhanced long-term commodity security and a reduced risk of stock-outs at the central level, moving Uganda toward self-reliance. Course corrections will involve public expenditure tracking and mobilizing civil society to hold government accountable for funding shortfalls.

4.4 Enhancing Last-Mile Visibility and Management with Digital Tools

This sub-pillar addresses the unclear "last mile" where stockouts most frequently occur due to poor visibility and reactive management. It strengthens commodity security by fully operationalizing and integrating digital logistics systems. The intervention focuses on ensuring the Logistics Management Information System (LMIS) data automatically populates dashboards within DHIS2/FP DataPro, providing District Health Teams with real-time, facility-level stock visibility. Inputs include system integration, training for data managers, and provision of tablets/smartphones for reporting. Outputs are functional digital dashboards with automated low-stock alerts and high data completeness rates. The outcome is proactive supply chain management, where districts can pre-empt stockouts through timely redistribution and targeted resupply, drastically reducing facility-level stock-out rates. Bottlenecks like poor internet connectivity will be mitigated with offline-reporting capabilities and scheduled data syncs.

4.5 Building District Capacity for Supply Chain Management

This sub-pillar tackles the human resource bottleneck of weak district-level capacity in supply chain oversight, which undermines even well-funded systems. It builds the skills of District Health Teams and facility staff in accurate commodity quantification, forecasting, and using digital dashboards for decision-making. Activities include hands-on training workshops, development of simplified forecasting tools, and strengthening mechanisms for private-sector reporting into the public system. Key outputs are trained district medicine management supervisors and improved accuracy in quarterly commodity orders. The intended outcome is a resilient, data-driven supply chain ecosystem managed by competent local teams, ensuring efficient commodity flow and minimizing wastage. Course correction will involve mentoring visits and using order accuracy as a performance metric in district reviews.

Table 9: Strategic Interventions under Sustainable FP Financing and Commodity Security

THEME	STRATEGIC OBJECTIVE	KEY INTERVENTIONS	KEY OUTPUTS	KEY OUTCOMES	TARGET
1. **Integrating FP into Mainstream Government Budgets**	To institutionalize FP as a predictable, domestically funded priority within core government planning and budgeting cycles.	1. Advocate for and support the creation of embedded FP budget lines in Ministry (Health, Gender, Finance) and District Local Government annual work plans and budgets. 2. Develop and disseminate standardized budget-coding and planning guidelines.	1. FP budget lines reflected in Ministerial Policy Statements and District Development Plans. 2. Number of districts with verified FP allocations in their approved budgets.	1. Increased and more reliable annual domestic budget allocations for FP. 2. Reduced program vulnerability to shifts in external funding.	National (Key Ministries) and All Implementing Districts (District Local Governments).
2. **Leveraging National Financing Mechanisms for FP Services**	To secure sustainable, diversified funding streams that incentivize and pay for quality FP service delivery.	1. Advocate for inclusion of a comprehensive FP package in the National Health Insurance Scheme (NHIS) benefit package. 2. Integrate FP-specific indicators into existing Results-Based Financing (RBF) schemes. 3. Guide districts to allocate a portion of conditional grants (e.g., UGF) to FP activities.	1. Revised NHIS/RBF policy documents including FP. 2. Tracked reports on district grant utilization for FP services and outreach.	1. Diversified, predictable financing for FP service provision. 2. Increased provider motivation and accountability for quality through performance-based payments.	National (NHIS, RBF design).
3. **Securing Domestic Financing for Commodities**	To ensure adequate, timely, and predictable government funding for the procurement of FP commodities.	1. Conduct sustained advocacy with Ministry of Finance and Parliament using costed national procurement plans. 2. Track and publicly report on government disbursements for commodities.	1. Increased annual government budget allocation for FP commodity procurement. 2. Published annual public expenditure tracking reports for FP commodities.	1. Enhanced long-term central-level commodity security and reduced donor dependency. 2. Improved transparency and accountability in commodity financing.	National (Ministry of Finance, Parliament).
4. **Enhancing Last-Mile Visibility with Digital Tools**	To enable proactive, data-driven supply chain management to prevent stockouts at service delivery points.	1. Fully operationalize and integrate the LMIS with the DHIS2/FP DataPro dashboard for real-time stock visibility. 2. 2. Implement automated low-stock alerts and train managers on dashboard use.	1. Functional, integrated digital dashboard providing facility-level stock data. 2. High data completeness and timeliness rates from health facilities.	1. Proactive identification and resolution of stock imbalances. 2. Significant reduction in stock-out rates at the last mile.	All supported health facilities nationally

4.2 SPECIFIC REGIONAL FOCUS TO INCREASE SERVICE DELIVERY AND ACCESS

4.2.1 Achieving Universal Outreach Coverage

To surpass the critical benchmark of 95% outreach coverage across all regions, a nationally coordinated, regionally tailored strategy will be implemented. While intensified, data-driven support will be provided to historically underperforming regions like Kampala, Acholi, and West Nile, the program will concurrently strengthen and standardize outreach micro-planning, community mobilization, and partner coordination mechanisms in every region. This ensures no region falls below the coverage target, addressing urban density, post-conflict sensitivities, and logistical barriers with equal rigor to achieve uniform national saturation.

4.2.2 Reducing commodity Stock-Outs

To address the critical and widespread challenge of stock-outs that undermines access in all regions, a nationwide emergency initiative will be launched. This intervention will not prioritize specific regions but will instead implement a uniform, system-wide strengthening of the contraceptive supply chain. The strategy focuses on three simultaneous actions: (1) rolling out dynamic, consumption-based forecasting tools to every health facility; (2) establishing a rapid-response redistribution mechanism managed at the district level to swiftly move commodities from overstocked to understocked facilities within and between regions; and (3) instituting a publicly visible, real-time stock-out dashboard to drive accountability. The goal is to achieve and sustain a national stock-out rate of under 5% at the last mile, ensuring reliable contraceptive availability is the standard, across the entire country.

4.2.3 A National Drive for Immediate Postpartum Family Planning (iPPFP)

Recognizing that iPPFP uptake is unacceptably low and a missed opportunity in every region, this sub-pillar launches a nationwide scale-up campaign. The approach moves beyond identifying low-performing regions to implementing a mandatory, standardized service package for all maternity units. This includes: (1) revising national maternity protocols to mandate iPPFP counselling and provision as a non-negotiable component of delivery and postnatal care; (2) conducting mass competency-based training for all maternity staff across all regional and general hospitals, followed by lower-level facilities; and (3) ensuring "iPPFP kits" containing essential commodities like postpartum implants and IUDs are permanently available in every labour ward. The objective is to transform iPPFP from a sporadic intervention into a routine, expected element of maternal healthcare, dramatically increasing uptake uniformly across all regions.

4.2.4 Universal Integration of Post-Abortion Family Planning (PAFP)

To address the systemic failure to provide PAFP services consistently, this intervention mandates the universal integration of PAFP into all post-abortion care (PAC) services as a standard of care, regardless of region. The strategy involves: (1) instituting a national "PAC/PAFP Linkage" protocol that makes PAFP counselling and method provision a mandatory step before PAC discharge; (2) launching a nationwide de-stigmatization and training program for all PAC providers to build skills and commitment; and (3) integrating PAFP commodities into essential PAC supply kits at all service points. By making PAFP an automatic, non-discretionary part of the PAC clinical pathway, this intervention seeks to eliminate regional performance disparities and ensure that every woman receiving PAC has immediate, respectful access to contraceptive care.

CHAPTER FIVE

PERFORMANCE MONITORING AND EVALUATION

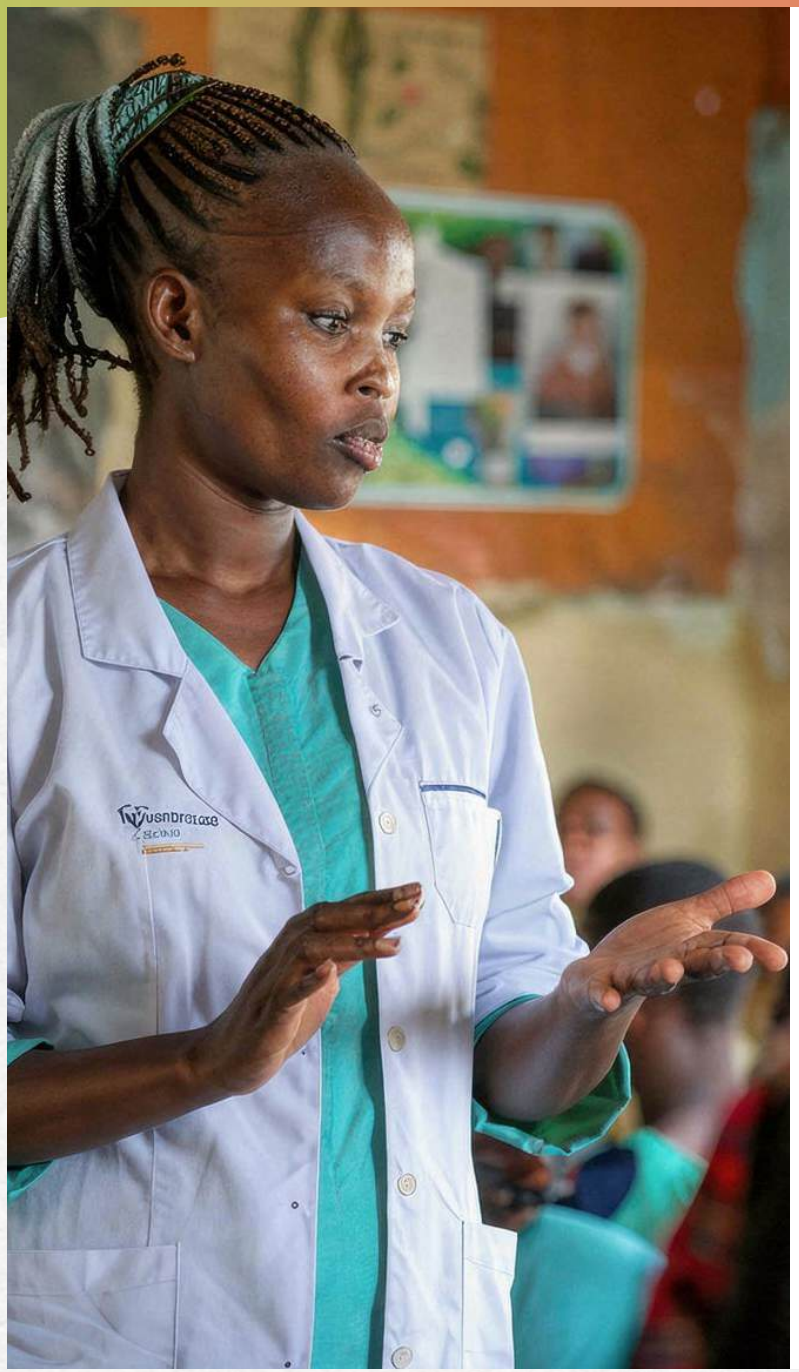
5.1 FP-CIP III IMPLEMENTATION PLAN

The FPCIP III outlines a coordinated, multi-sectoral strategy to accelerate progress toward Uganda's FP goals. This implementation plan translates the four strategic pillars, (1) Strategic Health Communication for Behaviour Change, (2) Governance, Advocacy and Accountability, (3) Integration for Equitable Service Delivery, and (4) Sustainable FP Financing and Commodity Security, into actionable interventions. The plan specifies key activities, responsible actors, timelines, and performance indicators to ensure accountability and measurable impact. By aligning government ministries, development partners, civil society, and private sector actors, this framework aims to increase contraceptive prevalence, reduce unmet need, and ensure that every individual can exercise their right to free and informed reproductive health choices.

Table 10: FPCIP III Implementation Plan

PILLAR	STRATEGIC OBJECTIVE	KEY ACTIVITIES	LEAD ACTORS	SUPPORT ACTORS	FY 2025/26	FY 2026/27	FY 2027/28	FY 2028/29	FY 2029/30
Pillar 1: Strategic Health Communication for Behaviour Change	Increased awareness and acceptance of FP services among individuals, couples, and communities.	1.1 Equip CHWs and CSOs with standardized toolkits to facilitate community dialogues and radio discussions on FP.	MOH Health Promotion, DLGs	CSOs, CHW Networks, Media Houses	X	X	X	X	X
		1.2 Co-create digital content with youth influencers on WhatsApp, Instagram, and TikTok to normalize FP conversations.	MOH, Youth NGOs	Influencers, NITA-U	X	X	X	X	X
		1.3 Develop and disseminate myth-busting materials that directly address misconceptions (e.g., infertility, cancer).	MOH Health Promotion	CSOs, Religious Leaders	X	X	X		
		1.4 Recruit and train a diverse network of champions (religious leaders, male role models, satisfied users) to publicly endorse FP.	MOH, DLGs	Cultural Institutions, Faith-Based Orgs	X	X	X	X	X
		1.5 Establish Women's Networks and Men's Action Groups to foster peer support and shared responsibility.	MOH, Community Dev't	CSOs, Local Councils	X	X	X	X	
Pillar 2: Governance, Advocacy and Accountability	To strengthen leadership, data systems, and accountability mechanisms for coordinated and transparent FP service delivery	2.1 Reactivate and formalize the National FP Steering Committee with mandated participation from key ministries.	MOH	MoFPED, MoGLSD, MoES, NPA	X	X	X	X	
		2.2 Embed FP objectives and budgets into District Development Plans and Health Sector Strategic Plans.	MOH, MoFPED	NPA, DLGs	X	X	X	X	X
		2.3 Fully functionalize the FP DataPro dashboard within DHIS2 for real-time, district-level analytics.	MOH (HMIS), Partners	MoFPED, UBOS, DLGs	X	X			
		2.4 Integrate FP performance metrics into bi-annual multi-sectoral reviews and quarterly District Joint Performance Meetings.	MOH, DLGs	MoFPED, OPM, CSOs	X	X	X	X	X
		2.5 Advocate for and support the inclusion of FP budget lines within national and district health budgets under UHC.	MOH, MoFPED	Parliament (Health Committee), CSOs	X	X	X	X	X

PILLAR	STRATEGIC OBJECTIVE	KEY ACTIVITIES	LEAD ACTORS	SUPPORT ACTORS	FY 2025/26	FY 2026/27	FY 2027/28	FY 2028/29	FY 2029/30
Pillar 3: Integration for Equitable Service Delivery	To ensure quality, rights-based FP services are accessible to all, with a focus on underserved populations and high-impact moments.	3.1 Systematically integrate FP counselling and method provision into all service points.	MOH (RH/ CHD)	DLGs, Implementing Partners	X	X	X	X	X
		3.2 Conduct integrated outreaches to reach youth and out-of-school adolescents and marginalized populations in underserved communities.	DLGs, MOH	CSOs, Community Leaders	X	X	X	X	
		3.3 Institutionalize and scale up iPPFP and PAFP at all appropriate service points.	MOH (RH/ CHD)	Training Institutions, Hospitals	X	X	X	X	X
		3.4 Establish a government-led framework for competency-based assessment and on-the-job mentorship for providers.	MOH (HRS)	Training Institutions, CSOs	X	X	X		
Pillar 4: Sustainable FP Financing and Commodity Security	To secure predictable domestic funding and a resilient supply chain ensuring last-mile commodity availability.	4.1 Advocate for and institutionalize FP as a core budget line within national and district government budgets.	MOH, MoFPED	CSOs, Parliament	X	X	X	X	X
		4.2 Explicitly include a comprehensive FP service package within National Health Insurance benefit packages.	MOH, MoFPED	Uganda Health Benefits Package Technical Working Group	X	X	X		
		4.3 Integrate FP outreach and demand generation into multi-sectoral programs (e.g., Parish Development Model).	MOH, MoLG	MGLSD, OPM	X	X	X	X	X
		4.4 Fully operationalize digital LMIS (e.g., OSSR portal) for real-time stock visibility and automated low-stock alerts.	MOH (NMS, HMIS)	MoFPED, DLGs, Partners	X	X	X		
		4.5 Build district capacity in commodity quantification, forecasting, and supply chain oversight.	MOH (NMS), DLGs	Partners, Private Sector	X	X	X	X	X
		4.6 Strengthen private sector engagement by training and accrediting private pharmacies/ clinics for FP service provision.	MOH, Uganda Private Health Partners	Private Pharma Associations, UPDF	X	X	X	X	



5.2 MONITORING AND EVALUATION FRAMEWORK FOR FP-CIP III

Table 11: Monitoring and Evaluation Framework for FPCIP III (2025/26-2029/30)

INPUTS	OUTPUTS
1. CHWs and CSOs equipped with standardized SBCC toolkits (flip charts, myth-busting cue cards) in local languages	1. 30,000 CHWs trained on SBCC facilitation and side-effect management
2. DHIS2 fully integrates FP DataPro dashboard with real-time, district-level analytics	2. FP DataPro dashboard operational nationally with monthly reports
3. VHTs trained to provide community FP dialogues, myth-busting, and referrals	3. 2,000 community dialogue sessions held quarterly; 500,000 myth-busting materials distributed
4. Maternity staff trained on immediate postpartum FP (iPPFP) and post-abortion FP (PAFP) as standard care	4. All HCIIIs, HCIVs, and hospitals provide iPPFP and PAFP services routinely
5. National multi-platform SBCC campaign (radio, TV, digital) produced and disseminated	5. 5 million youth reached annually through co-created digital content (WhatsApp, Instagram, TikTok)
6. Digital LMIS (OSSR portal) operationalized with automated low-stock alerts	6. 96% of health facilities report LMIS data monthly; stock visibility at all levels
7. District supply chain staff trained in quantification, forecasting, and redistribution	7. All districts have trained medicine management supervisors; rapid-response redistribution mechanism functional
8. Private pharmacies/clinics accredited for FP service provision and reporting	8. 1,000 private facilities accredited and reporting FP services into HMIS
9. All HCIIIs and above staff trained on LARC provision, rights-based counselling, and mentorship	9. 2,500 providers mentored annually on LARC, iPPFP, and PAFP through competency-based framework
10. FP integrated into national and district budgets under UHC framework	10. FP budget lines reflected in Ministerial Policy Statements and District Development Plans (all 146 districts)

5.3 RESULTS FRAMEWORK FOR FPCIP III (FY 2025/26 – FY 2029/30)

GOAL **To increase contraceptive prevalence and reduce unmet need for FP among women and girls in Uganda through a multi-sectoral, rights-based, and sustainable approach.**

Table 12: FPCIP III Results Framework

Pillar	Goal	Outcome	Key Performance Indicators	Baseline (2025)	Target (FY 2029/30)	Data Source	Frequency
Programmatic Core Indicators	Increased contraceptive use and protection among women of reproductive age.	Increased prevalence of modern contraceptive use (All Women).	Modern Contraceptive Prevalence Rate for All Women (mCPR).	33.8%	37.8%	FP Estimation Tool (FPET)	Annual
		Increased prevalence of modern contraceptive use (Married Women).	Modern Contraceptive Prevalence Rate for All Women (mCPR).	42.4%	47.8%	FP Estimation Tool (FPET)	Annual
		Reduced unmet need for family planning.	Unmet Need for Family Planning – All Women.	19.9%	13.5%	FP Estimation Tool (FPET)	Annual
		Increased demand Satisfied by Modern Method	Demand Satisfied by Modern Method – All Women.	63.1%	75.0%	FP Estimation Tool (FPET)	Annual
		Increased Couple Years of Protection - CYP	Couple-Years of Protection (CYP)	4,096,513 (2024)	6,000,000	HMIS (DHIS2)	Annual
		Increased number of new FP users	Estimated Number of total FP users.	4,290,000	5,000,000	FP Estimation Tool (FPET)	Annual

Process Level Indicators

Pillar	Outcome	Outputs	Key Performance Indicators	Baseline (2025)	Target (FY 2029/30)	Data Source	Frequency
Pillar 1: Strategic Health Communication for Behaviour Change	**Outcome 1.1:** Increased awareness and acceptance of FP services among individuals, couples, and communities.	**Output 1.1.1:** Community Health Workers (CHWs) and CSOs equipped with standardized SBCC toolkits.	Number of CHWs trained on SBCC toolkits.	TBD (2024)	30,000	Training Reports	Annually
		Output 1.1.2: Community dialogues and radio discussions on FP conducted regularly.	Number of community dialogue sessions held quarterly.	TBD (2024)	2,000 per year	Community Health Reports	Quarterly
		Output 1.1.3: Digital FP content co-created and disseminated through youth platforms.	Number of youths reached through digital campaigns (impressions).	TBD (2024)	5,000,000	Digital Analytics Reports	Quarterly
		Output 1.1.4: Myth-busting materials developed and disseminated.	Number of myth-busting materials distributed.	TBD (2024)	500,000	Distribution Logs	Annually
		Output 1.1.5: Network of FP champions (religious leaders, male role models, satisfied users) established and active.	Number of active champions in the network.	TBD (2024)	2,000	Champion Network Registry	Annually
		Output 1.1.6: Women's Networks and Men's Action Groups formed and functional.	Number of peer support groups formed.	TBD (2024)	1,500	Group Registration Records	Annually
Pillar 2: Governance, Advocacy and Accountability	**Outcome 2.1:** Strengthened leadership, coordination, and accountability for FP service delivery at national and sub-national levels.	**Output 2.1.1:** National FP Steering Committee reactivated and functional.	Number of FP Steering Committee meetings held annually.	TBD (2024)	4 per year	Meeting Minutes	Annually
		Output 2.1.2: FP activities and budgets embedded into District Development Plans and Health Sector Strategic Plans.	Number of City and Local governments with budget lines integrating FP.	TBD (2024)	146 (all districts)	LGs Budget Documents	Annually
		Output 2.1.3: FP DataPro dashboard fully functionalized within DHIS2 and rolled out at all sub national levels	FP DataPro dashboard operational and updated monthly.	No (2024)	Yes	DHIS2 Platform	Continuous
		Output 2.1.4: FP performance metrics integrated into multi-sectoral review meetings.	Percentage of LGs Joint Performance Meetings with FP data reviewed.	TBD (2024)	100%	Meeting Reports	Quarterly

Process Level Indicators

Pillar	Outcome	Outputs	Key Performance Indicators	Baseline (2025)	Target (FY 2029/30)	Data Source	Frequency
Pillar 3: Integration for Equitable Service Delivery	**Outcome 3.1:** Increased access to and utilization of quality, rights-based FP services, particularly among underserved populations.	**Output 3.1.1:** Health facilities equipped to provide youth-friendly FP services.	Number of health facilities offering youth-friendly FP services, integrated into all service delivery points.	TBD (2024)	2,500	Facility Assessment Reports	Annually
		Output 3.1.2: Integrated outreaches conducted.	Proportion of planned integrated outreaches conducted annually.	3.20%	40%	HMIS Data	Quarterly
		Output 3.1.3: Immediate Postpartum FP (iPPFP) and Post-Abortion FP (PAFP) services institutionalized and scaled.	% postpaturm mothers received FP within 48hrs after delivery	8.50%	60%	HMIS Data	Annually
			% postabortion women received FP within 2 weeks after abortion	TBD (2024)	2,500 per year	HMIS Data	Annually
		Output 3.1.4: Competency-based assessment and mentorship framework established.	Number of providers mentored annually on LARC, iPPFP, and PAFP.	8.50%	60%	iHRIS/ and Mentorship Logs	Annually
Pillar 4: Sustainable FP Financing and Commodity Security	**Outcome 4.1:** Sustainable domestic financing and resilient supply chain ensuring last-mile commodity availability.	**Output 4.1.1:** FP commodities funded through predictable domestic budget allocations.	Percentage of FP commodity and supplies need funded domestically.	TBD (2024)	60%	NMS Procurement Records	Annually
		Output 4.1.2: FP services included in National Health Insurance benefit package.	FP services included in NHIS benefits package.	No (2024)	Yes	NHIS Policy Document	Once (by 2028)
		Output 4.1.3: Increased availability of methods at Primary SDPs	% of Primary SDPs with 3+ methods available	76% (2023)	95%	SDP survey	Bi-annual
		Output 4.1.4: Increased availability of methods at Secondary/Tertiary SDPs	% of Secondary/Tertiary SDPs with 5+ methods available	93% (2023)	100%	SDP survey	Bi-annual
		Output 4.1.5: PDM activities integrated with FP services	No. of PDM activities integrating FP messaging	TBD (2024)	5,000	PDM Implementation Reports	Annually
		Output 4.1.6: Digital LMIS (e.g., OSSR portal) fully operationalized.	Percentage of health facilities reporting LMIS data monthly.	TBD (2024)	95%	DHIS2 LMIS Module	Monthly
		Output 4.1.7: District capacity in supply chain management strengthened.	Number of district staff trained in commodity quantification and forecasting.	TBD (2024)	500	Training Reports	Annually
		Output 4.1.8: Private sector accredited and reporting FP services.	Number of private pharmacies/ clinics accredited for FP service provision.	TBD (2024)	1,000	Private Sector Registry	Annually

CHAPTER SIX

COSTING OF FP-CIP III

6.1 COSTING OF THE 3RD NATIONAL FP IMPLEMENTATION PLAN (2025/26 – 2029/30)

To establish the resource requirements for the National FPCIP III, the financial costs of implementing the interventions set out under each of the four pillars of the plan, were estimated from the payer perspective from FY 2025/26 to FY 2029/30. The payer perspective considered the costs that would be incurred by the Government of Uganda and partners in the roll out and implementation of the plan. The costs for family planning commodities, supplies and equipment were computed by the Ministry of Health Quantification Planning and Procurement Unit (QPPU), as part of the National Annual Quantification of Essential Medicines and Supplies. The costs of for the public and private sector are displayed in the appendices.

6.2 CONSIDERATIONS AND ASSUMPTIONS FOR THE COSTING OF ACTIVITIES

- The costing was cognizant of the existing FP service delivery framework and its integrated nature. Costs for salaries, infrastructure, vehicle purchase, Information and Communication Technology, were therefore excluded.
- The costing exercise focused on the interventions agreed upon by the stakeholders consulted during the development of the plan
- The costing of the activities was informed by a number of sources such as from Ministry of Health Integrated Workplans, partner data.
- The locations, coverage, target audience, frequency and timeline of activities were informed by key persons in the MoH and partners that have implemented similar activities.
- The prices for the activity inputs were obtained from the Public Procurement and Disposal of Public Assets Authority (PPDA) price list for 2022.
- Adjustments for inflation made to estimate prices beyond 2025, at an average rate of 3.8% and assumed to hold for the foreseeable future.
- Items that were not on the PPDA list were costed using market prices, taking into account differences in activity location. These were also adjusted for inflation for the years beyond 2025.
- Costs were calculated in Uganda shillings and the totals converted to United States Dollars at annual average exchange rate of USD 1 = UGX 3,600, based on Bank of Uganda data.
- Demographic data was sourced from the Uganda Bureau of Statistics Census and population projections.
- Costs for the acquisition of Unstructured Supplementary Service Data (USSD) codes were secured from the Uganda Communications Commission.
- Costs for Short Message Service (SMS) were obtained from MTN Uganda and Airtel Uganda.

6.3 METHODOLOGY

The costing of activities was conducted using a micro-costing approach, and the analysis done in a Microsoft Excel-based model. The micro-costing methodology involved the identification inputs for each activity, their unit prices and applying them to the target audiences, locations, coverage and timelines intended for each intervention under each pillar of the plan.

The pillars that were costed are;

Pillar 1: Strategic Health Communication for Behaviour Change

Pillar 2: Governance and Accountability

Pillar 3: Integration for Equitable Service Delivery

Pillar 4: Sustainable FP Financing and Commodity Security

6.4 COST OF INTERVENTIONS IN THE NATIONAL FP IMPLEMENTATION PLAN III

The cost of implementing interventions in the plan was estimated by adding the total costs of the activities in four pillars over the five years of implementation. The estimated total cost of interventions from FY 2025/26 to FY 2029/30 is UGX 265,320,529,500 or USD 73,700,147, with the average annual cost being UGX 53,064,105,900 or USD 14,740,029. The annual costs are estimated to be highest in FY 2025/26, at UGX 66,672,196,500 or USD 18,520,055. The high costs are due to the various interventions to set up or roll out the plan, that are only required and captured in the initial year. The annual activity costs are estimated to be lowest in FY 2029/30 at UGX 46,292,576,000 or USD 12,859,049, as the many of the activities would have been implemented in the previous years, thereby reducing the coverage in the final year. The estimated activity costs of the FPCIP III are displayed in the table that follows.

Table 13: Estimated Activity Costs of the National FPCIP III (UGX '000)

PILLAR	FY 2025/26	FY 2026/27	FY 2027/28	FY 2028/29	FY 2029/30	TOTALS
Strategic Health Communication for Behaviour Change	24,437,871	13,316,241	13,806,947	11,608,041	10,240,240	73,409,340
Governance and Accountability	5,176,420	4,507,770	4,691,770	4,461,770	4,599,770	23,437,500
Integration for Equitable Service Delivery	25,581,835	23,276,780	23,373,180	20,733,460	20,733,460	113,698,715
Sustainable FP Financing and Commodity Security	11,476,071	10,890,246	10,890,246	10,799,306	10,719,106	54,774,975
Total estimated cost	**66,672,197**	**51,991,037**	**52,762,143**	**47,602,577**	**46,292,576**	**265,320,530**

From the analysis, the pillar with the highest estimated cost across the five years of the plan is Integration for Equitable Service Delivery, taking up 43%, followed by the Strategic Health Communication for Behaviour Change pillar at 28% of the overall costs. The Governance and Accountability pillar takes up the least costs at 9% of the overall costs. The low costs for this pillar are due to the fact the interventions and activities therein are few, with limited target audiences, coverage and less repetition over the years, in comparison to the other pillars. The estimated activity costs for the plan in USD, as well as the percentage share of costs by pillar are displayed in the table 6.

Table 14: Estimated Activity Costs of the National FPCIP III in USD

PILLAR	FY 2025/26	FY 2026/27	FY 2027/28	FY 2028/29	FY 2029/30	PERCENTAGE
Strategic Health Communication for Behaviour Change	6,788,297	3,698,956	3,835,263	3,224,456	2,844,511	28%
Governance and Accountability	1,437,894	1,252,158	1,303,269	1,239,381	1,277,714	9%
Integration for Equitable Service Delivery	7,106,065	6,465,772	6,492,550	5,759,294	5,759,294	43%
Sustainable FP Financing and Commodity Security	3,187,798	3,025,068	3,025,068	2,999,807	2,977,529	21%
Total estimated cost	**18,520,055**	**14,441,955**	**14,656,151**	**13,222,938**	**12,859,049**	**100%**

The activity costs were also analyzed by the broad categories or components across all the pillars, to identify the cost drivers in the initial year of the plan. The broad categories include Advocacy & engagement of various entities, Sensitization on FP for non-providers, Training Workshops including VHTs and CHEWs, Mentorships & District support, Mass Media campaigns, Printing and Dissemination activities, Resource Tracking, partner mapping, policy frameworks, Outreaches, Supervision, Reviews and Monitoring. The activity costs of the FPCIP III by broad category or component in FY 2025/26 are summarized in the table 7.

Table 15: Costs of the FPCIP III by broad components FY 2025/26

ACTIVITY	COSTS (UGX)	COSTS (USD)	PERCENTAGES
Advocacy & engagement of various entities	2,397,708,500	666,030	3.6%
Sensitization on FP (non-providers)	7,891,275,000	2,192,021	11.8%
Training Workshops incl. VHTs and CHEWs	15,980,941,000	4,439,150	24.0%
Mentorships & District support	13,878,541,000	3,855,150	20.8%
Mass Media	11,581,240,000	3,217,011	17.4%
Printing & Dissemination activities	733,796,000	203,832	1.1%
Resource Tracking, partner mapping, policy frameworks	1,996,780,000	554,661	3.0%
Supervision, Review, M&E	2,873,755,000	798,265	4.3%
Total	**66,672,196,500**	**18,520,055**	**100%**

The activity costs were also analyzed by the broad cost categories in FY 2025/26, to identify the cost drivers of the plan. The cost drivers are FP Training Workshops incl. VHTs and CHEWs, Mentorships & District support and Mass Media campaigns accounting for 24.0%, 20.8% and 17.4% respectively, of the costs in the initial year of the plan. The high costs were attributed to having various target audiences, and wide coverage (country-wide) of the activities. The costs for the Printing and Dissemination activities are lowest at 1.1% of the costs in FY 2025/26. The low proportion of this component is due to the fact that these will be one-off costs.

6.5 UNIT COSTS OF IMPLEMENTATION

The estimated average cost of delivering family planning interventions to one Women of Reproductive Age in the FP-CIPII will be USD 1.4 or UGX 5,071. If the costs FP commodities were added to the intervention costs, the unit cost per WRA would be USD 2.64 or UGX 9,612. Although the costing excluded salary and infrastructure costs that are integrated, their addition would still leave the per unit costs below those of similar countries that average at USD 4.5 or UGX 16,200.

6.6 CONCLUSION

The cost estimates give an indication of the financial resource requirements for the roll-out and implementation of interventions in the 3rd National Family Planning Costed Implementation Plan from FY 2025/26 to FY 2029/30. The UGX 265,320,529,500 or USD 73,700,147 can be mobilized through collaboration among MoH, other MDAs, Local Governments, Development Partners, private sector, Civil Society Organizations. Virtual pooling efforts will also help increase visibility of funding and avoid duplication of efforts, especially among partners.

MoH and partners should utilize the cost estimates to inform planning, budgeting and resource mobilization for the implementation of the plan. In light of the shrinking funding landscape, the efficient use of resources e.g. reducing wastage of time, absenteeism, commodity expiries, non-functional/ unused equipment will go a long way in freeing up some funds. Resource allocation should take into account the geographical disparities in performance of High Impact Practices and prioritize areas where there is most need to ensure efficiency and equity.

Given Uganda's young population structure, high annual growth rate and the benefits of FP in terms of quality of the population (health, education and development), advocacy efforts for increased investments should be relentless and evidence-based, to ensure the achievement of the National FPCIP III targets and FP2030 goals.

CHAPTER SEVEN

MULTISECTORAL INSTITUTIONAL FRAMEWORK FOR FP-CIP III (2025/26–2029/30)

The successful implementation of FPCIP III requires a cohesive, multi-tiered governance structure that ensures coordinated leadership, accountability, and resource alignment across all sectors. This framework clarifies roles, coordination mechanisms, and reporting lines to facilitate integrated planning, implementation, and monitoring of family planning interventions nationwide.

7.1. NATIONAL LEVEL COORDINATION

Table 16: Multisectoral coordination at National Level

BODY	COMPOSITION	KEY FUNCTIONS	MEETING FREQUENCY
National FP Multi-Sectoral Steering Committee	• Chair: Ministry of Health (MoH) • Co-chair: Office of the Prime Minister (OPM) • Members: Ministry of Finance (MoFPED), Ministry of Gender, Ministry of Education & Sports, Ministry of Water & Environment, NEMA, UBOS, Development Partners, CSOs, Private Sector Representatives, Youth Networks	• Provide strategic direction and policy oversight • Review annual performance and approve work plans • Advocate for domestic resource mobilization • Ensure alignment with NDP IV, Vision 2040, and SDGs	Bi-Annual
FP Technical Working Group (TWG)	• Chair: MoH (Reproductive Health Division) • Members: Representatives from all relevant ministries, district health teams, UN agencies (UNFPA, WHO), implementing partners, academia, professional councils	• Develop and review technical guidelines and tools • Support capacity building and mentorship programs • Analyze data and recommend program adjustments • Oversee integration of FP into RMNCAH and climate adaptation plans	Quarterly
FP Secretariat (MoH)	• Headed by Commissioner for Reproductive and Child Health • Supported by FP program managers, M&E officers	• Day-to-day coordination of FPCIP III activities • Prepare progress reports for Steering Committee • Manage communication between national and sub-national levels • Facilitate partner mapping and resource tracking	Continuous
District FP Multi sectoral Coordination Committee	• Chair: District Health Officer (DHO) • Members: District Planner, Gender Officer, Education Officer, Environment Officer, CSOs, Private Providers, VHT Coordinators, Youth Council Representatives	• Integrate FP into District Development Plans and climate adaptation budgets • Conduct quarterly joint supportive supervision and review meetings • Ensure commodity security and data reporting through DHIS2/FP DataPro • Mobilize local resources (e.g., through PDM) for FP activities	Reports to District Council and National FP Secretariat
Health Sub-District / Facility Teams	• In-charges of health facilities, FP focal persons, biostatisticians, VHT supervisors	• Implement FP service delivery, mentorship, and outreach activities • Ensure quality data entry and use for decision-making • Participate in integrated mobile outreaches and community dialogues	Reports to District Health Office

7.2. SUB-NATIONAL (DISTRICT) LEVEL COORDINATION

Table 17: Multisectoral coordination at Subnational level

BODY	COMPOSITION	KEY FUNCTIONS	REPORTING LINE
District FP Multi sectoral Coordination Committee	• Chair: District Health Officer (DHO) • Members: District Planner, Gender Officer, Education Officer, Environment Officer, CSOs, Private Providers, VHT Coordinators, Youth Council Representatives	• Integrate FP into District Development Plans and climate adaptation budgets • Conduct quarterly joint supportive supervision and review meetings • Ensure commodity security and data reporting through DHIS2/FP DataPro • Mobilize local resources (e.g., through PDM) for FP activities	Reports to District Council and National FP Secretariat
Health Sub-District / Facility Teams	• In-charges of health facilities, FP focal persons, biostatisticians, VHT supervisors	• Implement FP service delivery, mentorship, and outreach activities • Ensure quality data entry and use for decision-making • Participate in integrated mobile outreaches and community dialogues	Reports to District Health Office

7.3. COMMUNITY LEVEL COORDINATION

Table 18: Community Level FP Coordination

BODY	COMPOSITION	KEY FUNCTIONS	REPORTING LINE
Parish Development Model (PDM) Committees	• Parish Chiefs, VHTs, Community FP Champions, Women & Youth Group Leaders	• Integrate FP messaging into parish development activities • Refer clients to health facilities and outreaches • Mobilize communities for FP dialogues and male engagement sessions	Linked to District FP Coordination Committee
Village Health Teams (VHTs) & FP Champions	• Trained community health workers, male champions, satisfied FP users, religious/ cultural leaders	• Conduct household visits and myth-busting dialogues • Distribute IEC materials and provide referral slips • Collect community-level data and report through DHIS2 community platform	Supervised by Health Facility In-charges

7.4. CROSS-SECTORAL ENGAGEMENT MECHANISM

Table 19: Cross-Sectoral FP Engagement mechanisms

SECTOR	ROLE IN FPCIP III	KEY CONTRIBUTION
Ministry of Finance (MoFPED)	• Integrate FP into national and district budgets • Advocate for FP inclusion in NHIS benefit package • Track climate financing for FP	Domestic resource mobilization, public financial management
Ministry of Education & Sports	• Support youth FP clubs in schools • Integrate SRH/FP into life skills education • Engage teachers and school health programs	Youth and adolescent engagement
Ministry of Gender, Labour & Social Development	• Promote gender-responsive FP services • Leverage women's groups and men's action groups • Integrate FP into social protection programs	Gender mainstreaming, community mobilization
Private Sector	• Accredited clinics and pharmacies providing FP services • Participate in Total Market Approach (TMA) • Report data into HMIS	Service expansion, market shaping, supply chain strengthening
Development Partners & CSOs	• Technical and financial support • Implementation of targeted interventions • Advocacy and accountability monitoring	Capacity building, innovation, oversight

7.5. ACCOUNTABILITY & REVIEW PLATFORMS

Table 20: FP Accountability and Review Platforms

SECTOR	ROLE IN FPCIP III	KEY CONTRIBUTION
Bi-Annual Multi-Sectoral FP Review Meetings	National	Review progress against targets, share lessons, adjust strategies
District Joint Performance Reviews	Sub-national	Monitor FP indicators, commodity stocks, and equity gaps
Annual FP Performance Scorecards	National & District	Publicly disseminate progress on mCPR, unmet need, financing, and equity
Community Feedback Mechanisms	Community	Gather client and community insights to improve service quality and relevance

APPENDICES

Appendix 1: Estimated commodities costs for the Public Sector in USD

Product	FY 25/26	FY 26/27	FY27/28	FY28/29	FY29/30
Pills (POPs)	85,239	88,990	92,886	96,934	96,934
Pills (COCs)	306,862	320,364	334,391	348,962	348,962
Injectables (DMPA-IM)	650,696	679,327	709,071	739,969	739,969
Injectables (DMPA-SC)	2,074,094	2,165,354	2,260,163	2,358,650	2,358,650
IUDs	11,560	12,069	12,597	13,146	13,146
HIUD	5,426	5,665	5,913	6,171	6,171
Implants (5-year)	643,649	671,969	701,391	731,954	731,954
Implants (3-year)	2,119,750	2,213,019	2,309,915	2,410,570	2,410,570
Emergency Contraceptives	156,847	163,151	169,688	176,468	176,271
FP Condoms (pieces)	399,855.86	417,449.52	435,727.33	454,714.18	454,714.18
Total	**6,453,979.86**	**6,737,357.52**	**7,031,743.33**	**7,337,537.18**	**7,337,340.18**

Source: Ministry of Health National Annual Quantification

Appendix 2: Estimated Commodities costs for the Private Sector in USD

PRODUCT	FY 2025/26	FY 2026/27	FY 2027/28	FY 2028/29	FY 2029/30
Pills (POPs)	94,710	98,878	103,207	107,704	107,704
Pills (COCs)	340,958	355,960	371,545	387,736	387,736
Injectables (DMPA-IM)	520,557	543,461	567,257	591,975	591,975
Injectables (DMPA-SC)	1,659,275	1,732,283	1,808,130	1,886,920	1,886,920
IUDs	9,458	9,874	10,307	10,756	10,756
HIUD	543	566	591	617	617
Implants (5-year)	266,655	278,387	290,576	303,238	303,238
Implants (3-year)	1,141,404	1,191,626	1,243,800	1,297,999	1,297,999
Emergency Contraceptives	499,436	518,025	537,271	557,199	556,083
Cycle beads	15,899	16,599	17,325	18,080	18,080
Female condoms	263,085	274,660	286,686	299,179	299,179
Total	4,811,979	5,020,320	5,236,697	5,461,403	5,460,287

Source: Ministry of Health National Annual Quantification

Appendix 3: Estimated Equipment costs for All Sectors in USD

PRODUCT	FY 2025/26	FY 2026/27	FY 2027/28	FY 2028/29	FY 2029/30
Implant insertion/removal kits	2,766,916	3,358,931	4,087,395	4,984,688	6,091,023
IUD kit (include IUDs)	2,585,547	3,102,657	3,723,188	4,467,825	5,361,391
Pregnancy Test Kits	592,013	677,153	779,316	902,335	1,050,940

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