The Republic of Uganda
MINISTRY OF HEALTH

End Term Evaluation Report

of

The Second National Family Planning Costed Implementation Plan 2020/21-2024/25

November, 2025

Government of Uganda, Ministry of Health. The Second National Family Planning Costed Implementation Plan 2020/21- 2024/25 (FP-CIP II) End-term Evaluation Report 2025. Kampala, Uganda.

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List of Acronyms and Abbreviations

ADHOs	Assistant District Health Officer
AIDS	Acquired Immuno Deficiency Syndrome
CIFF	Children's Investment Fund Foundation
CIP	Costed Implementation Plan
DHO	District Health Officer
EKN	Swedish Export Agency
eLMIS	electronic Logistics Management Information System
EMU	Estimated Modern Use
FCDO	Foreign, Commonwealth & Development Office
FGD	Focus Group Discussion
FP	Family Planning
FPET	Family Planning Estimation Tool
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
KII	Key Informant Interview
mCPR	Modern Contraceptive Prevalence Rate
MOH	Ministry of Health
MSUG	Marie Stopes Uganda
NGO	Non-Governmental Organizations
NPA	National Planning Authority
OPM	Office of Prime Minister
PIP	Pharmaceutical Information Portal
PMA	Performance, Monitoring for Action
QAT	Quantification Analytics Tool
SDGs	Sustainable Development Goals
SS	Service Statistics
TMA	Total Market Approach
TWGs	Technical Working Groups
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UFPC	Uganda Family Planning Consortium
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

FOREWORD

The Second National Family Planning Costed Implementation Plan (FP-CIP II), spanning the fiscal years 2020/21 to 2024/25, represented a critical strategic commitment by the Government of Uganda to the health and socio-economic prosperity of its people. Moving beyond a purely clinical approach, the FP-CIP II was fundamentally designed as a development catalyst, integrating Family Planning into the core agenda of national development, as articulated in Vision 2040 and the Sustainable Development Goals (SDGs).

This **End Term Evaluation Report** serves as a vital instrument of accountability and learning, marking the culmination of this five-year effort. It offers an honest and evidence-based assessment of our collective journey against the ambitious targets we set, targets that focused not only on increasing the Modern Contraceptive Prevalence Rate (mCPR) but also on strengthening essential health systems, fostering sustainable domestic financing, and championing equity for marginalized groups and adolescents.

The findings presented here are invaluable. They articulate the successes achieved through multi-sectoral collaboration, acknowledge the persistent challenges of commodity security and sub-regional disparities, and provide critical insights into the effectiveness of scaling up High-Impact Practices (HIPs). Crucially, this report confirms the continued necessity of prioritizing sustainable financing and robust gender and youth programming to break the cycle of high fertility and contribute to Uganda's demographic dividend.

On behalf of the Ministry of Health, I commend the dedication of the National FP CIP Task Force, all implementing partners, and the Consulting Team for their rigorous execution of this evaluation. The lessons encapsulated within this document will be the foundation upon which we forge the next strategic phase, the FP-CIP III. We are resolute in our commitment to utilize this evidence to refine our policies, resource allocations, and implementation strategies, ensuring that every woman, adolescent, and family in Uganda has equitable access to high-quality, trusted Family Planning services.

The future of Uganda lies in the health and empowerment of its families. Let us act decisively on these findings.

Prof. Charles Olaro
Director General, Health Services

Acknowledgement

This **End Term Evaluation of the Second National Family Planning Costed Implementation Plan (FP-CIP II)** was a comprehensive exercise that required exceptional collaboration and commitment from a wide array of stakeholders across the public, private, and civil society sectors. We extend our sincerest gratitude to all who contributed their time, insights, and expertise to make this report possible.

We acknowledge the visionary leadership and technical guidance provided by the Ministry of Health (MOH) and specifically the National MOH FP CIP Task Force, who initiated this evaluation and ensured the highest standards of integrity and rigor throughout the process. Their commitment to evidence-based policy making is commendable and essential for the future of Family Planning in Uganda. Our profound thanks are extended to United Nations Population Fund (UNFPA) through Marie Stopes Uganda (MSUG), who commissioned this study and provided crucial financial and logistical support, demonstrating their unwavering partnership in advancing Uganda's reproductive health agenda. We are also grateful to all Development Partners whose sustained funding and technical assistance supported the implementation of the FP-CIP II over the past five years.

The success of this evaluation hinged on the cooperation of the implementers and data providers on the ground. We gratefully acknowledge the District Health Officers (DHOs), their teams, and the dedicated Health Facility Staff who graciously opened their facilities and shared operational data. A special note of thanks goes to the Key Informants and all Focus Group Discussion participants across the evaluated sub-regions, whose willingness to share their valuable time and candid experiences provided the rich, qualitative evidence necessary to understand the nuances of FP implementation.

Finally, we recognize the meticulous work of the Consulting Team, led by Dr. Isabirye Paul and Dr. Odot Moses, for their professionalism, diligence in data collection and quality assurance, and analytical skill in synthesizing complex information into actionable findings. This report is a testament to the shared conviction that Family Planning remains a crucial investment in Uganda's future, and we look forward to the collaborative use of these findings to inform the next era of FP programming.

Dr. Richard Mugahi
Commissioner – Reproductive and Child Health

Executive Summary

Background

Uganda's Second Family Planning Costed Implementation Plan (FP-CIP II, 2020/21–2024/25) was a strategic five-year initiative designed to accelerate progress in the country's reproductive health landscape. Building on its predecessor, FP-CIP II aimed to reposition family planning as a cornerstone of national development, aligned with Uganda's Vision 2040, the National Development Plan III, and global FP2030 commitments. Its core objectives were to reduce unmet need for family planning, increase the modern contraceptive prevalence rate (mCPR), and strengthen systems for sustainable service delivery. With the plan's conclusion, the Ministry of Health commissioned this end-term evaluation to assess its performance, document critical lessons, and generate evidence to guide the design of the subsequent FP-CIP III (2025/26–2029/30).

Methodology

The evaluation employed a cross-sectional, mixed-methods approach, guided by the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework. The assessment purposively selected 29 districts and cities across all 15 regions of Uganda, ensuring representation of both high and low-performing areas. Data collection integrated quantitative and qualitative sources, including a comprehensive desk review of key documents (UDHS, HMIS data, PIP, QAT, PMA surveys), KIIs, and FGDs participants. Stakeholders engaged ranged from national policymakers and development partners to district health teams, frontline health workers, and community representatives, ensuring a multi-faceted perspective.

Key Results

The evaluation results for FP-CIP II present a dichotomy of tangible operational gains undermined by profound systemic failures.

The program achieved significant measurable outputs, generating substantial protection by increasing the Couple-Year Protection (CYP) and expanding service access. This was bolstered by the successful scaling of High-Impact Practices (HIPs), including postpartum and post-abortion family planning, and a dramatic rise in the empowerment-focused self-injection for DMPA-SC, which accounted for 29% of all its doses by 2025. Concurrently, critical policy frameworks were advanced through the launch of national self-care guidelines, Total Market Approach (TMA) and post-abortion care (PAC) guidelines. Despite these achievements, the program fell short of its primary impact targets. The modern contraceptive prevalence rate (mCPR) for all women saw only a modest increase to 33.8% against a target of 39.6%, unmet need remained high at 19.9%, and teenage pregnancy stagnated at 24%. These failures were rooted in critical systemic gaps: a financing shortfall that created overwhelming donor dependency; gaps in supply chain resulting in chronic stock-outs at service points despite central warehouses being stocked; non-functional multi-sectoral collaboration that fragmented accountability; and weak data systems and stewardship that hampered evidence-based programming and local ownership.

Conclusion

The FP-CIP II period demonstrated Uganda's capacity to expand family planning access and innovate in service delivery. However, these gains are fragile and incomplete. The fundamental lesson is that increasing the number of users is insufficient without parallel investment in the systems that ensure sustained, high-quality, and equitable access. For FP-CIP III to secure the demographic dividend and contribute meaningfully to national development, it must prioritize institutionalization, financial sustainability, and robust governance. Failure to enact this paradigm shift will leave Uganda substantially off-track from its commitments to its people and its vision for a prosperous future.

Section One:

BACKGROUND

1.1 Introduction

Since 2015, Uganda embarked on developing costed implementation plans to guide the implementation of Family Planning (FP) programming in the country. Following the expiry of the first National Family Planning Costed Implementation Plan (FPCIP), 2015-2020, Uganda developed and launched the FP CIP II (2020/21-2024/25) which aspired to complete the unfinished business, in consideration of the experiences learnt from the FP-CIP I and the emerging global evidence, to accelerate increase in the modern contraceptive prevalence rate (mCPR) for all women and reduce unmet need for FP.

The tenure of the FPCIP II came with renewed global and country commitments to improve health, reduce inequities, and promote human rights. Increasing access and utilization of FP services hence contributing to achievement of Sustainable Development Goals (SDGs), among other national and programmatic strategic goals in the Vision 2040, the National Development Plan III (2020/24 – 2024/25 NDP III), the health sub-program Development Plan II, and the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Sharpened Plan.

Additionally, since 2012 (the start of the FP2020 global initiative) Uganda became a commitment making country to the FP2020 partnership, supporting the rights of women and girls to decide freely and for themselves whether, when, or how many children they want to have. Through the dedicated efforts of the government, program implementers, service providers, donors, and FP stakeholders, the country has better aligned to meet the needs of an ever-increasing number of women and girls contributing to the developed global community's shared vision for beyond 2020 through 2030 that builds on progress achieved.

1.2 Background

The Government of Uganda's Vision 2040 is a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years. The Government recognizes the role FP plays in the achievement of the country's Vision 2040's target to reduce the population growth rate from 3.2% to 2.4% which will contribute to harnessing the demographic dividend. The National Development Plan III and the Ministry of Health (MOH) Strategic Plan 2020/21 – 2024/25 target to reduce; Fertility rate (from 5.4 to 4.5), and teenage pregnancy rate (from 25% to 15%). Additionally, the FP-CIP II (2020/21-2024/25) ambitiously targeted to reduce unmet need for family planning from 28% to ultimately below 10%, and increase the mCPR for all women from 30.4% to 39.6% while for married women from 38.7% to 46.6%.

Over the past decade, the government of Uganda (GoU), with support from development partners, has implemented the FP-CIPs which outline the strategic objectives, actions, and resources required to increase access to and use of FP services across the country.

In 2020, the MoH, started implementing the FP-CIPII 2020/21-2024/25which was hinged on the learnings from the FP-CIPI, taking a programmatic rather than thematic focus through a technical and strategic approach.

Given this background and with the expiry of this plan approaching, it is critical to evaluate its implementation and effectiveness in achieving its stated goals, identify key successes, and uncover lessons learned for the development of the next phase of the country's FP plan.

1.3 Purpose of the Assignment

To conduct an End Term Evaluation of Uganda's Second Family Planning Costed Implementation Plan 2020/21 -2024/25 (FP CIP II) to inform the development of the third national family planning costed implementation plan.

1.4 Specific Objectives

The specific objectives for this evaluation were:

1 **To assess the performance and impact of the FPCIP II (2020/21-2024/25) across its strategic framework and thematic areas.**

2 **To identify key lessons learned, challenges, and best practices from the implementation of the FPCIP II.**

3 **To generate evidence for the design of FP-CIP III, ensuring alignment with national health priorities and the broader Sustainable Development Goals (SDGs).**

Section Two:

LITERATURE REVIEW

2.1 Multi-Sectoral Collaboration and the Developmental Role of Family Planning

Effective FP programming is widely recognized as a cornerstone of sustainable socio-economic development and public health advancement. Global evidence underscores that FP not only reduces maternal and child mortality but also enhances educational attainment, women's empowerment, and economic productivity by enabling families to make informed reproductive choices (Population Reference Bureau, 2010). The World Health Organization (WHO), UNFPA, and other global bodies advocate for a multi-sectoral approach that situates FP within a broader development agenda, linking population dynamics with education, gender equality, and economic planning. This integration reflects the understanding that fertility reduction and demographic transition are not driven by health interventions alone, but by coordinated actions across sectors that address social determinants such as early marriage, adolescent pregnancy, and limited female autonomy. Countries that have successfully accelerated contraceptive uptake, such as Bangladesh, have done so through policies that embed FP within education, gender, and community development frameworks, illustrating the necessity of inter-ministerial collaboration and shared accountability mechanisms.

2.2 Strengthening Health Systems and Ensuring Quality Family Planning Services

A second fundamental principle of successful FP programming lies in strengthening health systems and ensuring quality service delivery. The effectiveness of FP programs depends not only on availability but on the consistent delivery of a comprehensive, high-quality method mix supported by skilled providers, reliable supply chains, and responsive information systems. WHO's health system building blocks framework emphasizes the critical role of human resources, commodities, financing, and governance in ensuring equitable and client-centered FP services. Evidence highlights that method discontinuation, often driven by side effects and poor counseling, can erode contraceptive gains, demonstrating that quality of care must be prioritized alongside coverage. High Impact Practices (HIPs) in FP, such as postpartum and post-abortion FP integration, community-based distribution, and task-sharing for LARC provision, have proven cost-effective and scalable when supported by continuous mentorship and logistics management systems. Strengthening data systems, including digital HMIS and eLMIS platforms, ensures real-time tracking of service delivery and stock levels, key for sustaining FP gains at scale.

2.3 Equity, Sustainable Financing, and Social Behavior Change for FP Uptake

Equity, sustainability, and behavioral change, form the third pillar of effective FP programming. Sustainable FP programs require diversified financing models that combine domestic funding, private sector engagement, and innovative mechanisms such as health insurance and voucher schemes to reduce donor dependency. The Total Market Approach (TMA) is increasingly recognized as a pragmatic strategy for maximizing efficiency by aligning public, private, and social sector contributions according to population need and ability to pay. Meanwhile, achieving equity requires a deliberate focus on underserved populations, adolescents, rural women, low-income households, and those in fragile contexts, who often face cultural, geographic, or systemic barriers. Evidence from sub-Saharan Africa indicates that gender norms, limited male engagement, and stigma around adolescent sexuality remain persistent obstacles. Thus, successful FP programming integrates social and behavior change communication (SBCC), male involvement strategies, and community participation to create enabling environments for voluntary contraceptive use. Ultimately, the literature emphasizes that sustainable FP outcomes depend on strong governance, inclusive financing, responsive systems, and equity-driven interventions that leave no one behind.

Section Three:

METHODOLOGY

3.1 Introduction

This section provides an explanation of the methodology that was employed in the execution of the end-term evaluation of the FP CIP II. It details the general framework, evaluation design, criteria for selecting districts and participants, and the methods used for data collection and management.

3.2 General Approach

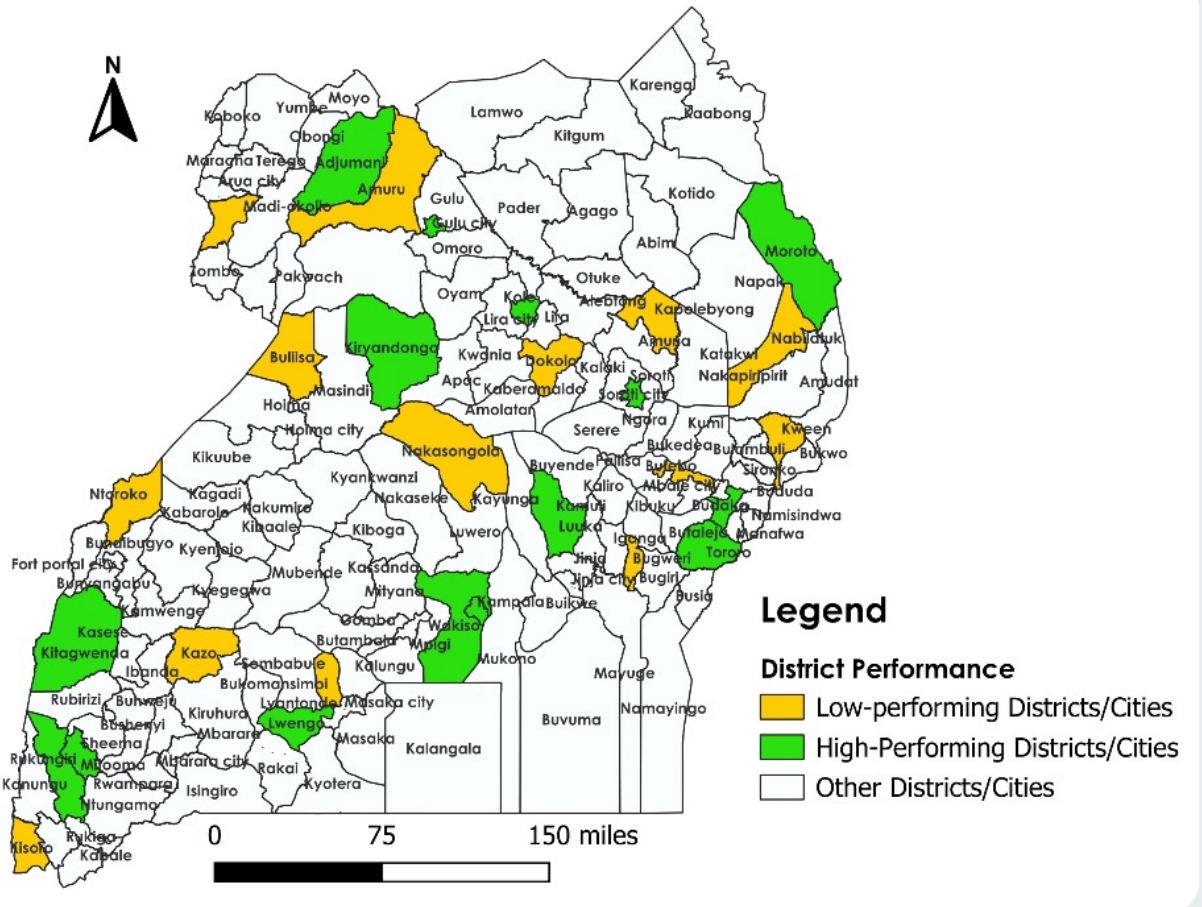
The evaluation adopted the Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) framework to interrogate all thematic areas of the FP-CIP II. The goal was to assess the plan's progress, relevance, effectiveness, efficiency, impact, and lessons learned.

A cross-sectional mixed-methods design was employed, combining both qualitative and quantitative data collection to provide a holistic view of the performance of the plan over its five-year period (2020/21–2024/25).

3.3 Evaluation Design and Participant Selection

A cross-sectional design was taken employing RE-AIM framework. Purposive sampling strategy was used to ensure a targeted and in-depth assessment. The evaluation covered 29 local governments (districts & cities) selected from all the 15 regions of Uganda. From each region, two districts were chosen (one identified as high-performing and the other as underperforming) based on key FP CIP II indicators. This approach ensured a balanced perspective of successes and challenges across diverse contexts.

Figure 1: Map showing the assessed districts (qualitative) for FP CIP II evaluation



Participants were purposively sampled at national and sub-national levels based on their roles in FP-CIP II implementation.

- **National Level:** Key actors were selected from the MOH, National Family Planning Consortium, development partners, Professional associations, and Implementing partners.
- **Sub-National Level:** Participants were categorized by FP-CIP II thematic area and included frontline health workers, District Health Officers (DHOs), Assistant District Health Officers-MCH, District FP focal persons, supply chain managers, political/cultural/religious leaders, Village Health Team (VHT) members, and youth representatives.

3.4 Data Collection Methods

Mixed methods were used for data collection to include:

- **Document Review:** Relevant reports were analyzed, including the FP-CIP II, surveys (PMA, UDHS), Health Management Information System (HMIS) data, Family Planning Estimation Tool (FPET) Estimates/ FP Annual Consensus Reports, Country FP2020/30 reports, annual health sector reports and Pharmaceutical Information Portal.
- **Key Informant Interviews (KIIs):** With help interview guides, undertook in-depth interviews with purposively selected informants at national and district levels.
- **Focus Group Discussions (FGDs):** Discussions were conducted with clusters of participants grouped according to the key thematic areas of the CIP.

3.5 Data Analysis

A rigorous process was followed for data analysis:

- **Qualitative Data Analysis:** Data from KIIs, FGDs, and documents were analyzed using thematic analysis. Transcripts and notes were coded, and multiple analysts consulted to generate consensus on emerging themes.
- **Quantitative Data Analysis:** Data from sources like FPET Estimates/FP Annual Consensus reports, PMA, HMIS, and eLMIS were entered into Microsoft Excel. Logical checks and frequency runs were performed to ensure accuracy and consistency before final analysis against the evaluation objectives.

3.6 Data Quality and Data Management

To ensure the highest standard of data quality and integrity throughout the evaluation, a rigorous process was established, spanning from the initial planning stages through to final analysis. All data collection instruments (including KII guides, FGD guides, and desk review checklists) were subjected to an intensive review by the MOH Task Team, drawing on their technical and subject-matter expertise for validation and refinement.

During data collection, quality was maintained through standardized training for all research assistants, which included pre-testing of the tools and inter-rater reliability checks. Data collected in the field were subjected to daily quality assurance checks by the team lead for completeness and consistency before being transmitted.

Finally, in the analysis phase, the quantitative data underwent rigorous cleaning and validation, including outlier detection and consistency checks against key national benchmarks, ensuring the figures presented accurately reflected the program's performance.

Section Four:

RESULTS

This section presents the key findings from the evaluation of the FP CIP II 2020/21–2024/25, derived from both quantitative and qualitative analyses. The results highlight progress made toward achieving the CIP's strategic objectives, the effectiveness and efficiency of implementation, and factors influencing performance across national and subnational levels. Quantitative data were drawn from routine health information systems, surveys, Modelled Estimates (FPET), and other reports to measure trends in service delivery, commodity availability, and resource allocation, among others. Complementary qualitative insights from stakeholder interviews (KIIs & FGDs) presented in here as italicized narrative quotes. Document reviews provided contextual understanding of the facilitators, challenges, and lessons learned during implementation.

Together, these findings offer a comprehensive assessment of Uganda's progress in advancing access to and use of family planning services under the CIP framework.

Table 1: Characteristics of the respondents (Qualitative)

Key Informants (N=70)		
	Count (n)	**Percent (%)**
Sex		
Female	62	89%
Male	8	11%
Category		
Frontline Health workers	37	53%
D/CHO, ADHO-MCH	27	39%
National Stakeholders & Partners	6	9%
Work Station		
HCIVs & HCIIIs	25	36%
Hospitals/Regional referral	11	16%
District/City Health Office	26	37%
National/ Central level	8	11%
Focus Group Participants (N=115)		
Community/Stakeholders	115	100%

4.1 Target Achievement over the 5-year Period

Uganda's progress toward national FP-CIP II and NDP III goals shows mixed results across three key indicators. The adolescent birth rate has experienced a substantial decline from 132 to 29 (NPHC 2024), marking one of the country's most significant achievements and signaling improvements in adolescent reproductive health services and access. In contrast, the teenage pregnancy rate remains largely unchanged at 24% (UDHS,2022), well above the national target of 15%, highlighting that despite fewer adolescents giving birth, many still experience unintended pregnancies, suggesting persistent gaps in prevention, sexuality education, and social support systems. Meanwhile, the unmet need for family planning stands at 19.9% against a target of 10% (FPET 2025), reflecting ongoing challenges in ensuring consistent availability, accessibility, and acceptability of contraceptive services. Together, these trends underscore progress in some adolescent health outcomes but reveal continued barriers affecting contraceptive uptake and early pregnancy prevention.

Table 2: Progress on Key Health Sector Development Plan (HSDP) Indicators

Indicator	Baseline	Target			Current Progress	Source
		MoH SP II (2021-2025)	NDP III (2020-2025)	Vision 2040		
Adolescent Birth Rate	132	128			29	NPHC 2024
Teenage Pregnancy Rate	25%	15%			24%	UDHS, 2022
Unmet Need for FP	28%	10%			19.9%	FPET, 2025

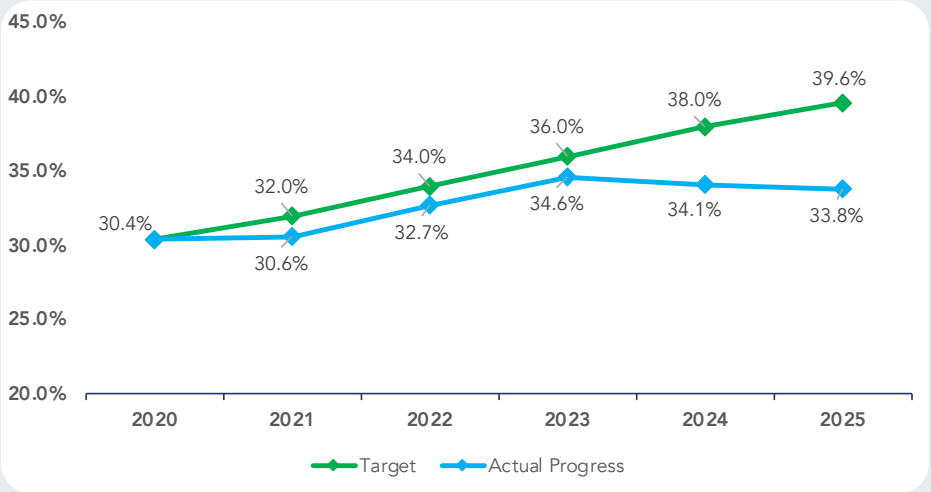
The CIP II set out to fundamentally improve Uganda's reproductive health landscape through three primary programmatic goals described in table 4 below.

Table 3: FPCIP II Programmatic goals/targets

No.	Programmatic Goal	Progress	Comment
1.	Increase national mCPR from 30.4% in 2020 to 39.6% (All Women) by 2025 through improving access to sexual and reproductive health and rights information and services.	33.8% (FPET, 2025)	This goal was not met, only 3.4% points over the last 5 years was registered.
2.	Increase national mCPR from 38.7% in 2020 to 46.6% (married women or women in union) by 2025 through improving access to sexual and reproductive health and rights information and services.	42.4% (FPET, 2025)	A modest progress was noted but fell short of the programmatic target of 46.6%.
3.	Reduce the unmet need to 15% with the ultimate goal of achieving below 10% by 2025	19.9% (FPET, 2025)	Unmet need dropped from 22% to 19.9% for all women. While for married women, still at 27%.

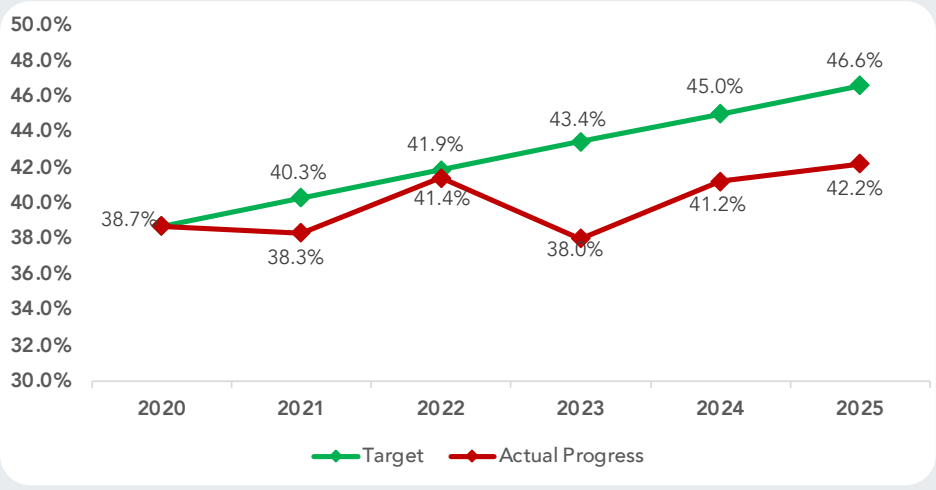
Overall little improvements have been noted in the programmatic goals of the FP-CIPII however, these improvements have not been significant to enable the country meet the targets set out in the plan as informed by FPET estimates; depicted in figures: 2-4 below.

Figure 2: Shows progress in mCPR (AW) growth against the target



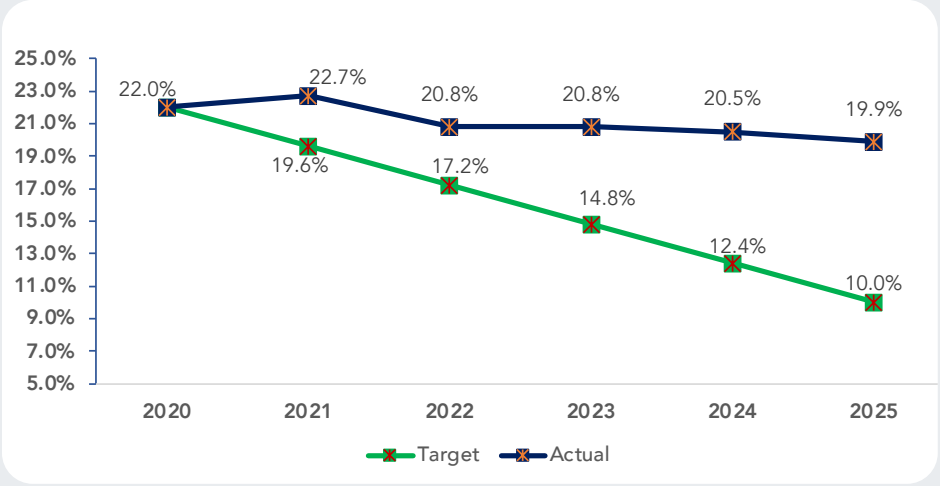
Source: FPET Estimates

Figure 3: Trend in mCPR (MW) growth against the target



Source: FPET Estimates

Figure 4: Progress towards reducing Unmet Need



Source: FPET Estimates

Whereas little improvements have been registered in increasing mCPR and reducing Unmet Need for FP, the country however witnessed significant strides across a number of other fertility-related indicators (Table 5 below). These outcomes highlight the positive ripple effects of the current mCPR (33.8%) growth, contributing to reduced fertility rates, and improved maternal health among others.

Table 4: Impact of mCPR growth in relation to other health indicators

Calendar Year	2020	2021	2022	2023	2024	2025
Maternal Deaths Averted	3,400	3,500	3,900	3,600	3,500	2,200
Unintended Pregnancies Prevented	1,252,000	1,291,000	1,430,000	1,556,000	1,571,000	1,604,000
Unsafe Abortions Averted	276,000	321,000	355,000	386,000	390,000	338,000
Estimated Modern FP users	3,321,000	3,470,000	3,836,000	4,132,000	4,208,000	4,290,000
CYP*	4,106,324	5,034,709	5,188,908	4,403,935	4,096,513	—

** Actual complete calendar year data*

4.2 Performance by Strategic Focus Areas of FP CIP II

The FP CIP II evaluation framework was structured around six strategic focus areas to comprehensively assess the program's performance. These areas were: Demand Creation; Service Delivery and Access; Contraceptive Commodity Security; Financing; Stewardship, Management and Accountability; and Data Management.

4.2.1 Demand Creation and communication channels

During the implementation of the FP CIP II, the Ministry of Health, in collaboration with various implementing partners, undertook a range of demand generation interventions to enhance access to FP information and services. These activities were implemented through multiple channels including community outreaches, interpersonal communication, mass media, and digital platforms as summarized below.

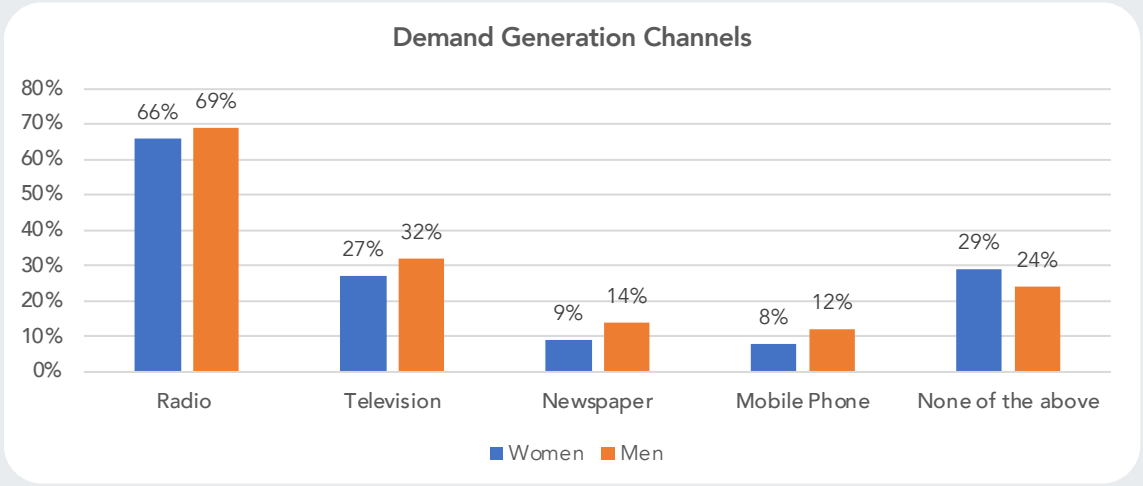
Table 5: Demand generation activities and estimated reach

Activity Type	Time Frame	Key Approaches
Social and Behaviour Change (SBC) interventions – radio, community dialogues, peer education	2018–2024	Focused on FP awareness in Eastern and Northern Uganda; targeted youth and women of reproductive age.
Multimedia SBC campaigns (radio, TV, social media, interpersonal communication)	2020–2024	National "Obulamu?" campaign integrating FP, MNCH, and HIV messages.
Community dialogues, mass media campaigns, youth-friendly outreach	2020–2024	Partnered with MoH and CSOs; focused on informed FP choice and ending teenage pregnancy.
Community outreach, radio talk shows, school-based programs	2020–2023	Targeted adolescents and women; combined FP education with service delivery.
Community health worker engagement, faith-based dialogues, radio sessions	2022–2024	Strengthened community trust and tackled myths about FP.
Nationwide multimedia SBC campaign (radio, TV, print, community roadshows)	2017–2022	Promoted integrated health messages including FP, HIV, MNCH.
Community dialogues, FP days, integrated outreaches	2020–2025	Supported by partners such as FHI360, RHU, and PSI Uganda.
Peer-led campaigns, community events, youth engagement	2022–2025	Promoted FP self-care through self-injection using the empathy-based counselling approach.
Interpersonal communication (VHTs, community dialogues, faith leaders, peer educators)	2020-2025	Face-to-face, small-group and community dialogues

As a result of these concerted efforts, Uganda has recorded a steady increase in family planning uptake, with the number of users rising from 3.4 million in 2021 to nearly 4.3 million currently. Despite this progress, the overall demand for FP remains at approximately 66%, showing minimal change across the two Costed Implementation Plan periods. This stagnation suggests that while service uptake has improved, underlying demand generation and sustained use require further attention.

4.2.1.1 Demand generation channels

Figure 5: Shows Demand generation Channels for FP information



Source: UDHS 2022

From the result, radio remains the predominant source of FP information in Uganda. According to UDHS 2022, 66% of women and 69% of men reported hearing a family planning message on the radio in the months preceding the survey (figure 5 below).

However, this over-reliance on radio exposes major weaknesses, primarily the abrupt collapse of demand when donor funding for campaigns ends, leading to cycles of progress and relapse. Furthermore, the effectiveness of radio is limited in regions with poor or no signal coverage, also supported by the qualitative finding below.

"The radio is a big success for creating demand where we have it. But here in a district with no network or radio, our messages don't get to anyone."

District Health Officer, Karamoja region.

Other potentially vital channels, such as television, digital platforms, and large-scale visual media like billboards, are significantly underutilized due to high cost, inadequate budgets, and lack of strategic investment, resulting in missed opportunities for continuous, sustained visibility outside of community outreach events as further quoted below.

"The main challenge is funding. We can't afford to run jingles on the radio regularly. The campaigns stop, and then the demand just drops again."

District FP Focal Person, Bunyoro region.

The effectiveness of these campaigns is marked by significant regional and urban-rural variations. While urban centers like Kampala offer vast, untapped potential for digital engagement (social media, text messaging), these platforms are underdeveloped. Conversely, rural areas are dominated by radio, and in infrastructure-poor regions like Karamoja, mass media efforts are nearly impossible. This highlights a critical disconnect between national strategies and community-level realities, as lower-level health facilities often rely on localized methods like posters and health talks.

"We have these big roads with nothing on them, no billboards. There's a big missed opportunity for continuous visibility."

Midwife, HCIV, South Buganda.

Consistent messaging through health talks, community engagement, and radio has led to a gradual decline in some FP myths and improved client trust, evidenced by people actively requesting specific methods. A health worker in Busoga remarked,

"Before, people were very afraid of injections. Now, because of all the health talks and radio messages, many of them come asking for it by name."

This shows that sustained communication efforts can transform fears into informed choices. However, major misconceptions persist, particularly fears that FP causes infertility, long-term illness, or promiscuity, with these being heavily reinforced by underlying social and cultural norms where rigid gender roles empower men and in-laws to control reproductive decisions, sometimes leading to violent opposition. The level of progress varies significantly by region; while myths are waning in areas with sustained outreach, they remain deeply entrenched in regions like Karamoja where poor infrastructure prevents consistent health messaging, highlighting the urgent need for tailored, culturally sensitive communication approaches.

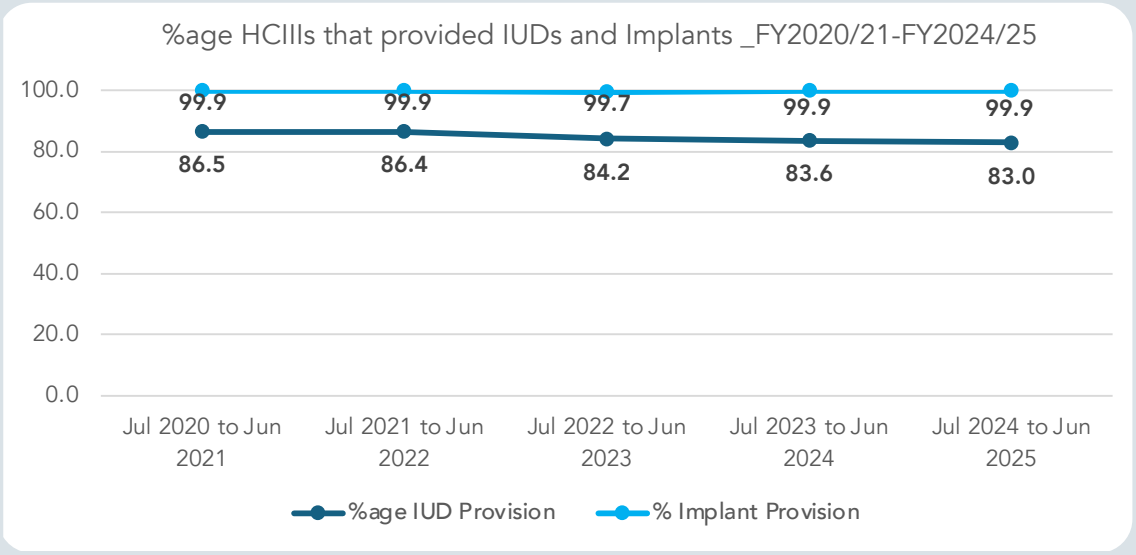
4.2.2 Service delivery and Access

The country envisioned increasing the number of HC IIIs and IVs providing both IUDs and Implants to 75% and 80% respectively, and reduce stockouts by 50%.

4.2.2.1 Provision of LARC services at HCIIIs and HCIVs

The graph below illustrates the proportion of Health Centre IIIs that provided IUD and implant services over the five financial years from 2020/21 to 2024/25. While the percentage of HCIIIs offering implants remained consistently high (above 99.9%), the percentage offering IUDs declined slightly from 86.5% to 83.0%. This decline coincides with the addition of new or upgraded facilities that lack the required skills and infrastructure for IUD services.

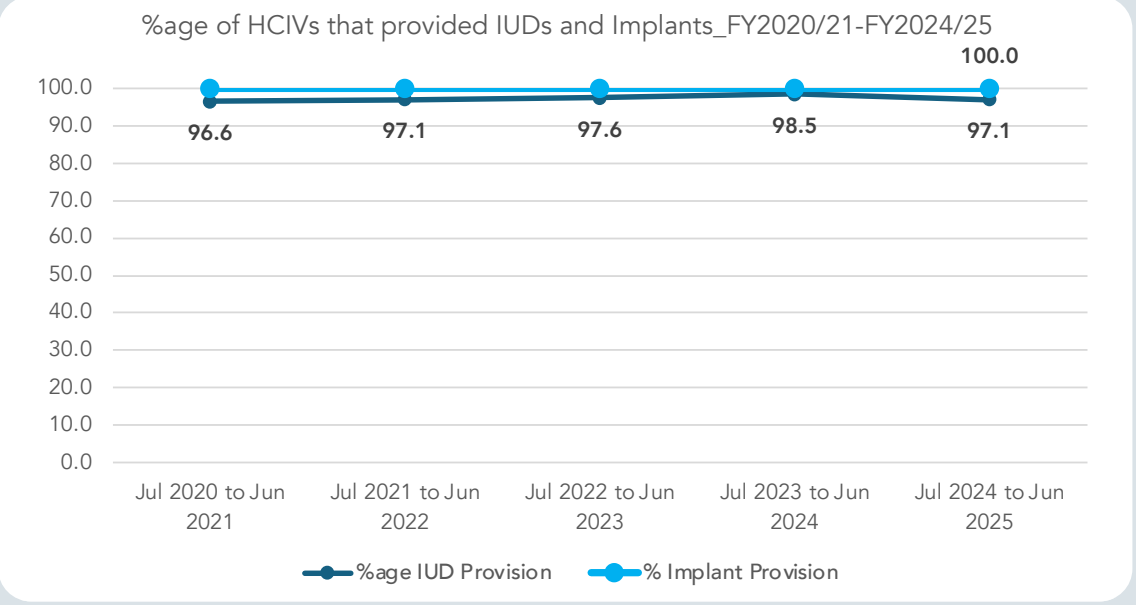
Figure 6: Provision of LARC services-%age of HCIIIs that provided IUDs and Implants



Source: DHIS2

The graph below shows the proportion of Health Centre IVs (HCIVs) that provided IUD and implant services over the same five-year period. For implant services, the coverage among HCIVs remained consistently high and stable. For IUDs, coverage also remained high overall, though with significant regional disparities, particularly in areas like Karamoja where over half of HCIVs did not offer the service. The proportion of Health Centre IVs not offering IUD services was highest in Karamoja (52%), followed by Bugisu (19%) and Acholi (17%).

Figure 7: Provision of LARCs services- %age of HCIVs that provided IUDs and Implants



Source: DHIS2

4.2.2.2 Quality of Care/Method Information Index Plus (MII+)

Between 2021 and 2024, Uganda recorded only marginal improvement in the Family Planning Method Information Index Plus (MII+), rising slightly from 43.8% to 45%, indicating that the proportion of women receiving comprehensive counseling across all four key information areas has remained largely stagnant – table 6 below.

Table 6: Method Information Index Plus (MII+)

Method Information Index Plus (MII+)	% Who answered "Yes"		
	2021	2022	2024
Were you told by the provider about **other methods** of FP than the method?	63%	67%	69%
When you obtained your method were you told by the provider about **side effects**?	59.6%	61%	61.5%
Were you told **what to do** if you experienced side effects or problems?	53.7%	56%	86.6%
Were you told that you could **switch** to a different method in the future?	67.7%	70%	67.8%
Total – answered Yes to all	**43.8%**	**48%**	**45%**

Source: Performance Monitoring for Accountability (PMA)

While there were notable gains in specific components, particularly in women being informed about what to do in case of side effects (increasing from 53.7% to 86.6%) and modest improvement in being told about other methods (62.5% to 69%) these did not translate into overall progress because other elements, such as information on switching methods and side-effect counseling, remained almost unchanged. The slow growth suggests persistent gaps in provider counseling practices and highlights the need for strengthened provider capacity, supervision, and quality improvement efforts to meet the national aim of at least 60% of women receiving full, informed counseling by 2025.

4.2.2.3 Skilling and Service Quality

The district approach to skilling health workers in FP heavily relied on a hybrid model where implementing partners fund and execute decentralized, on-site training to build capacity, often using Trainers of Trainers (TOTs) for knowledge transfer. An ADHO-MCH in Karamoja region highlighted this efficiency, adding;

"We initially conducted central TOT training, then shifted to on-site training. On-site is cost-effective and reaches more health workers simultaneously."
ADHO-MCH, Karamoja.

However, these gains were consistently undermined by critical understaffing, high staff turnover, and a heavy dependence on partner funding, which led to training abruptions when support ended. This resulted in inconsistent quality of FP services; while health worker knowledge was often cited as a strength, it was not universal and was severely compromised by pervasive stock-outs of commodities and excessively long waiting times, sometimes three to five hours, due to limited staff.

This compromised service quality directly contributed to significant challenges in accessing FP services for community members. Beyond the systemic issues of stock-outs and long waits, the most common barriers were geographical distance to facilities and the prohibitive cost of transport. Furthermore, access was severely hampered by deep-seated socio-cultural factors and stigma, particularly for youth. Religious and cultural doctrines reinforced pervasive myths, such as the fear that FP causes infertility, and male opposition to FP, which can lead to women seeking services secretly and risking gender-based violence. The overall quality of care was also affected by this pressure, as a Political Leader in Karamoja region noted:

"Providers, due to time constraints, often might not give counselling on all the different methods of family planning that we have, but you just go there and say, ah, we have only one."

This combination of access barriers and rushed, inconsistent counseling prevents comprehensive, effective FP service uptake, and sustainable use of especially LARCs.

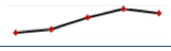
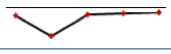
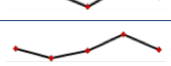
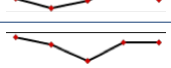
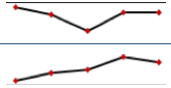
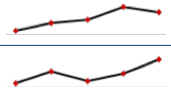
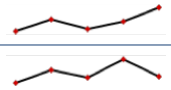
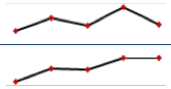
4.2.2.4 Community Outreaches

Uganda's performance on integrated SRH/FP outreaches has 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 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 has advanced, the table highlights the need for targeted support to consistently underperforming regions to ensure equitable community access to FP and other SRH services.

Table 7: 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

These efforts, often amplified by partners like Pathfinder and Marie Stopes who provide essential support and funding, have significantly boosted awareness and access in remote areas, with some facilities micro-planning for regular monthly outreaches.

"We make outreaches on a weekly basis... we go into every village with VHTs who have been trained to offer family planning services."
(Midwife, Health Centre III, Busoga Region).

However, the sustainability and reach of outreaches are compromised by reliance on partner funding, leading to service gaps when support ceases.

Crucially, FP uptake is continuously undermined by deeply entrenched cultural, social, and gender norms, with men and in-laws often discouraging women from using methods, sometimes resulting in women adopting FP in secrecy and risking domestic violence. This challenge is starkly illustrated by one midwife's observation:

"Some men inhibit their wives from accessing FP, so women use methods in secret. This sometimes leads to domestic violence."
(Midwife, Health Centre IV, South Buganda Region).

Addressing these barriers requires continuous sensitization, community dialogues, private counseling sessions, and the crucial involvement of health workers, local leaders, and religious figures to demystify myths and counter the powerful influence of traditional gender roles.

4.2.2.5 Access to Post-Partum Family Planning

The country has 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 is 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 8: 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%**	

4.2.2.6 Post Abortion Family Planning

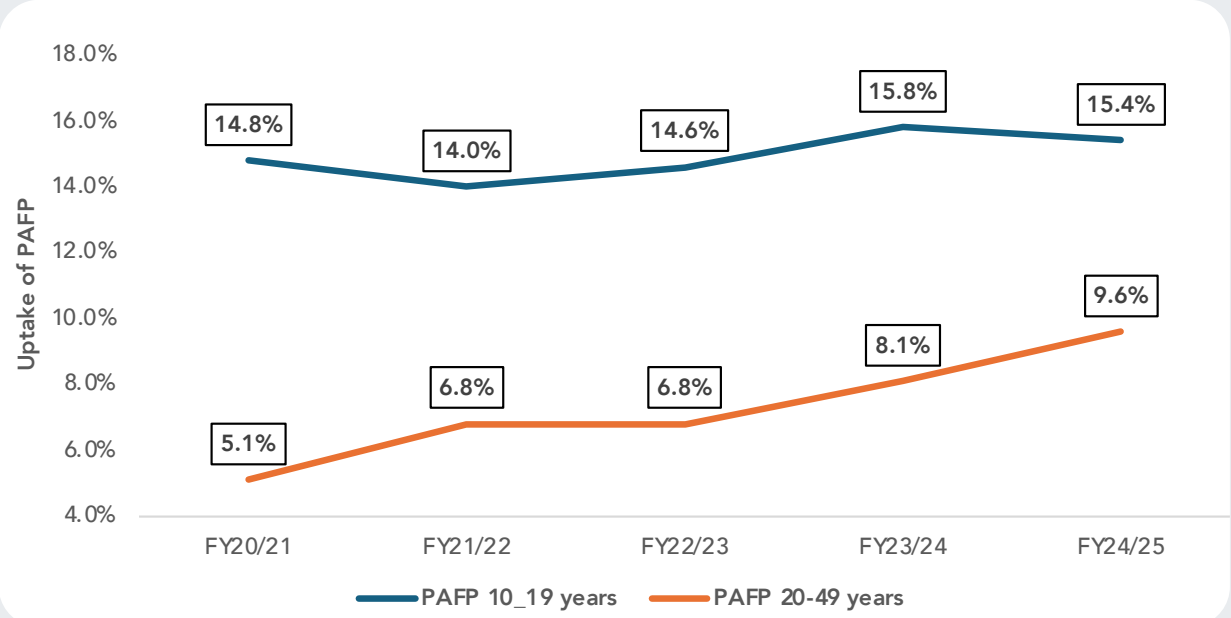
Overall, unlike iPPFP, Post Abortion FP uptake has improved greatly from 7.1% to 10.6% between FY20/21 and FY24/25 as shown table 9 below. Uptake of PAFP remained extremely low in Bunyoro and Teso while significant strides have been observed in South Buganda, Bukedi, Busoga and Kampala.

Table 9: 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%**	

Zooming in to assess uptake of PAFP by age group there is a marked improvement in the uptake among women aged 20–49 years from 5.1% to 9.6%, while only a modest increase was observed among adolescents – figure 9.

Figure 9: Trends in Post-Abortion FP by Age group



The low uptake of PAFP among the adolescents is concerning given the significantly high abortion cases among this age group potentially due to high rates of unintended pregnancies and limited contraceptive knowledge, access, and use.

These findings highlight the urgent need for targeted interventions that address the unique reproductive health needs of adolescents through improved access to youth-friendly, non-judgmental, and comprehensive post-abortion family planning services.

4.2.2.7 Method Mix

The country made significant efforts in ensuring a balanced method mix to foster client choice.

Figure 10: Changes in FP Method Mix

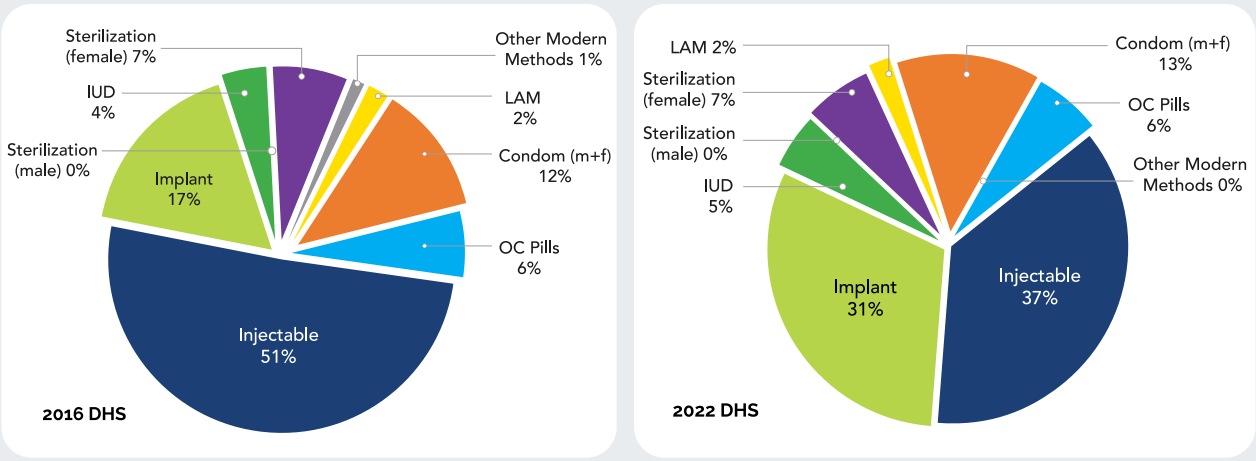
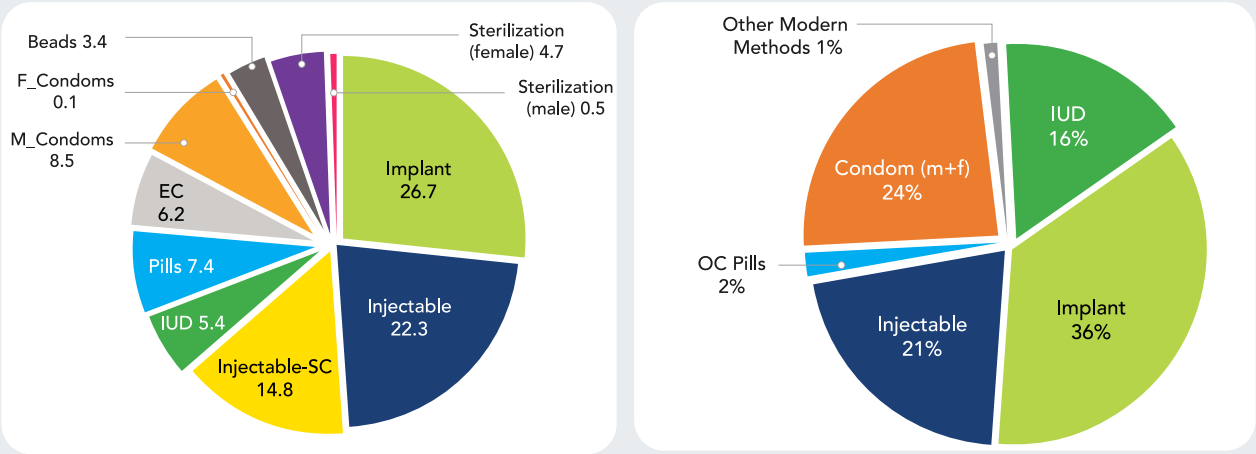


Figure 10 above, there is a growing diversity and greater equality between long-acting reversible contraceptives (LARCs) and short-term methods (STMs), with injectables and implants dominating.

Similarly, PMA 2024 survey method mix indicates injectables dominating at (37%) followed by implants (26.7%), not very much different from what service statistics to estimated modern use (SS to EMU)/ eLMIS warehouse data depicted – implants (36%), and injectables (21%) – figure 11.

Figure 11: Contraceptive Method Mix based on other sources (PMA, and SS to EMU - Warehouse data)



PMA, 2024

SS to EMU-Warehouse data

Overall, all sources depicted a balanced country's method mix being dominated by a short-term (injectables) and a long-acting reversible method (implants).

4.2.3 Contraceptive Commodity Security

Strengthening the Supply chain to ensure a reliable supply of full method mix through all FP market channels was one of the focus areas of the expiring plan, with a programmatic goal of reducing stock outs by 50%.

4.2.3.1 Contraceptive Commodity Availability at Central Level.

A zoom-in to the stock status at national level (warehouse level) revealed very healthy stock status (over-stocks) for most products through the year, though with some small variations of under-stocks (less than 3 MOS) for a few commodities within some years.

Table 10: Commodities Stock Status 5-Year Report - Combined (JMS AND NMS)

Commodities	2020/21		2021/22		2022/23		2023/24		2024/25	
Injectable Contraceptives	Jul-Dec	Jan-June	Jul-Dec	Jan-June	Jul-Dec	Jan-June	Jul-Dec	Jan-June	Jul-Dec	Jan-June
DMPA 150 mg/ml (Depo-Provera)	25.3	54.7	89.7	83.0	5.1	10.4	5.2	5.1	12.2	15.4
DMPA 104 mg/0.65 mL (Sayana Press)	27.1	54.0	58.3	70.1	8.2	11.1	7.3	3.5	5.8	9.5
Long-acting Reversible Contraceptives										
3yr Implant 1 rod (Implanon NXT)	21.9	29.8	63.2	61.9	2.4	9.9	4.6	1.9	6.5	11.2
5yr Implant 2 rod (Jadelle)	13.2	15.0	62.1	37.2	4.8	4.6	2.1	2.8	7.1	5.7
IUD Hormonal	0.0	0.0	0.0	0.0	0.0	0.0	4.7	8.9	2.1	4.8
IUD Copper - T	60.3	99.0	580.7	435.1	14.3	12.8	8.4	8.0	4.4	4.0
Oral Contraceptives										
Combined Pills	48.0	50.6	150.5	1584.9	7.1	6.8	5.6	6.1	1.7	2.3
Progestogen Pill	8.8	8.6	25.5	22.9	18.5	11.3	17.4	9.3	2.9	4.3
Emergency Pill	5.4	5.1	8.4	32.0	10.2	15.4	14.0	37.9	10.6	13.3
Other Contraceptives										
Cycle beads	0.0	0.0	0.0	0.7	5.7	33.9	29.1	17.5	9.0	6.9
Female Condoms	13.9	14.6	3.7	17.6	8.5	25.5	23.6	53.0	32.6	28.7
Male Condom	18.6	24.0	129.6	159.1	27.7	21.1	15.1	18.9	10.0	6.8

Stock out or 1MOS | Under stock (Less than 3MOS) | Good stock (Above 3MOS) | Over Stock (Over 6MOS)

Source: Pharmaceutical Information Portal - PIP

4.2.3.2 Contraceptive Commodity Availability at Service Points.

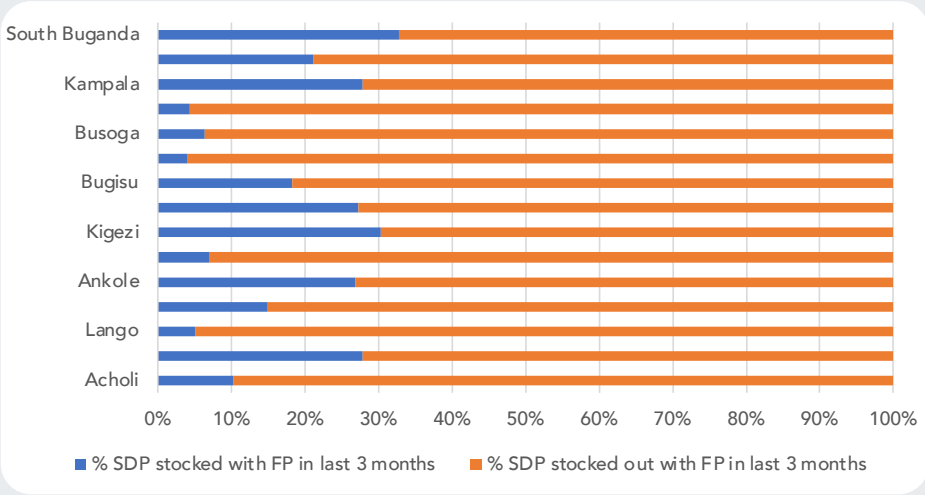
Commodity security remained the cornerstone of ensuring uninterrupted access to FP services under the CIP II framework. The evaluation of contraceptive security highlighted the progress and challenges in quantification, procurement, and distribution processes.

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 (Fig 12, and tables 11 & 12 below).

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%).

Method specific deep-dive further revealed increasing and significant stock-outs for most methods for the most recent period including for the most dominant methods.

Table 11: % Stock out by method

Method	2020	2023
Female Sterilization	3	19
Male Sterilization	5	21
IUD	6	18
Implant	13	18
Injection	11	18
Pill	13	18
Male Condom	10	13
Female Condom	24	64
EC Pill	18	25

Source: Service Delivery Point Survey

Table 12: Method Availability by Level (%)

Method Availability	2020	2023
Percentage of primary SDPs that have at least 3 modern methods of contraception available on day of assessment	82%	76%
Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment	88%	93%

Source: Service Delivery Point Survey

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.

However, in some instances where facility orders are accurately placed, orders end up with omitted items, while others are being delivered late/ delayed. An indication of supply chain inefficiencies and gaps in last mile distribution.

4.2.4 Financing for Family Planning under FP CIP II

For the greater part of the CIP, the MoH has been donor reliant in regards to funding for FP and reproductive health commodities.

Financing for the FP CIP II was characterized by a critical lack of dedicated funding and an overwhelming reliance on external partners. The desire to ring-fence part of the GoU - RH funding to cover FP commodities procurement and warehousing has not been realized.

Table 13 below gives an overview on how FP commodities financing during the tenure of the CIPII has been by funding agency.

Table 13: Family Planning Commodity Actual Funding Landscape

Family Planning Commodity Actual Funding Landscape					
Period (Calendar Year)	**2021**	**2022**	**2023**	**2024**	**2025**
Total Commodity Need	$27,389,716	$32,946,258	$38,270,349	$22,582,959	$22,773,211
*Government of Uganda (GOU)	$146,633	$-	$40,000	$1,789,841	$2,121,062
USAID	$9,193,585	$9,190,680	$8,902,401	$5,375,541	$636,509
UNFPA	$6,292,555	$7,392,114	$8,056,305	$9,771,128	$6,923,102
GFATM	$5,457,352	$8,808,135	$1,796,256	$2,577,469	$300,000

*Includes; GOU, WB & UCREPP Source: Quantification Analytics Tool (QAT)

The funding landscape for FP commodities reveals significant volatility over the past five years. The Government of Uganda (GoU), while starting from a minimal base in 2021, has demonstrated a clear and commendable upward trend, culminating in its most substantial contribution of over $2 million in 2025. However, this growth is overshadowed by dramatic fluctuations among major donors: USAID's funding, once the primary source, has sharply declined since 2022, while UNFPA's support has remained relatively stable, making it the leading funder in the most recent years. Concurrently, the Global Fund's contributions have been highly inconsistent though targeted to procurement of male condoms. This erratic funding environment, coupled with a consistent multimillion-dollar gap between the total commodity need and actual commitments, underscores a system that remains critically vulnerable to external shifts despite nascent progress in domestic financing.

It is however, commendable that the GoU is increasingly taking on its mandate of procuring FP commodities and related supplies. This progress has been achieved through sustained advocacy and collaboration with partners including the Parliamentary Committee on Health.

Other innovative strategies that have spurred GoU increasing funding for FP commodities procurement include the UNFPA Matching Fund Initiative under the UNFPA Supplies Partnership. Through this mechanism, UNFPA provided supplementary funding for reproductive health commodities when the GoU increased its own financial commitments. This approach incentivizes greater investment in the procurement and distribution of essential contraceptives and health supplies, helping to ensure the consistent availability of commodities. Despite the increasing GoU contribution, funding deficits for FP commodities however, continued to exist through the tenure of the FP CIP II as seen in table 13 above.

Districts were expected to mobilize funding as one of the stop-gap measure to the GoU funding gap, however, a foundational issue was the limited availability and implementation of district family planning costed implementation plans (DCIPs) which are seen as resource mobilization tools, many of which were either outdated or completely unknown to local officials.

"I am hearing it for the first time. So, we don't have it."

ADHO-MCH, Bukedi region.

This underscores a critical disconnect between planning and implementation. Although the DCIPs were designed to serve as strategic tools for resource mobilization and accountability, their absence or underutilization at the subnational level meant that district budget allocations towards FP remained minimal or absorbed within broader health budgets, with no distinct line item for FP activities. As a result, districts continued to rely heavily on implementing partners (IPs) to fund key interventions such as outreaches and training, leaving local resource mobilization efforts weak or non-existent.

This reliance on external funding created a precarious and unsustainable financial structure for FP services, severely hindering service provision due to associated stock out of commodities at service delivery points. When partner priorities change, and support withdrawn, the program gets at crossroad as a Political Leader in KCCA, Kampala Region emphasized:

"Without implementing partners, we may not have deliverables... we will only wait for when there is a funder to come and give us money."

This dependence also meant that partners often prioritized their own agendas over locally identified needs.

While FP services are provided free of charge at government facilities, financial challenges persist: the mismatch between requested and delivered supplies led to persistent stock-outs, while integrated primary healthcare (PHC) funding is insufficient to cover crucial operational costs like transportation for outreaches. Ultimately, while the FP methods are free, clients still bear the significant financial burden of transport costs to reach facilities, highlighting the fragility and inequality of the current financing model.

4.2.4.1 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, will play a role in addressing fertility concerns and also increasing 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 introduction of other FP products into the private sector market, broadening method choice and engaging new market players.
- Supported the finalization of the Last Mile Assurance (LMA) guideline, ensuring integration of critical components such as leakage mitigation for national-level implementation.
- 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.
- Some insurance companies have expanded their maternal health service packages to include FP though still largely restricted to short-term methods.

4.2.4.2 Key Challenges to the TMA Implementation

- Absence of clear private-sector targets and indicators upon which performance can be tracked.
- Accessing private sector data for FP market insights is difficult.

The FP program going forward will need to;

- Strengthen data systems, including leveraging DHIS2 for drug shop reporting and developing new methods to capture pharmacy sales and user data from unconventional outlets.
- Improve quality assurance such as pharmacovigilance, adverse event monitoring, and accountability in pharmacies and drug shops remains essential. Stronger collaboration with MoH, district structures, and private-sector forums will support coordinated action.
- Need to refocus the engagements as many are central level and therefore knowledge of the total market approach at the local government level is limited.

4.2.5 Family Planning Data Management

The use of DHIS2 data to guide FP programming was strong at the national and district level for strategic planning but weak for operational decisions at the facility level. National level among others utilizes the family planning DataPro dashboard while District officials primarily leveraged data during quarterly performance reviews to conduct broad analyses, identified high-level trends, targeted interventions strategically, and informed resource allocation. As a District FP focal person in Bunyoro region explained;

"When we have performance reviews, all indicators are well generated from DHIS2 and analyzed, then you can easily tell the family planning performance status for related facilities in the district."

Conversely, lower-level facilities often struggled with data application, lacked routine performance feedback, and relied on district staff for report generation, limiting their ability to use data proactively for continuous quality improvement.

Data quality verification mechanisms, involving both internal staff cross-checks and external support supervision (including national level monthly FP data quality reports shared with sub-national level), were used to improve the accuracy of FP reporting, but their influence on day-to-day decision-making was limited. While verified data was effectively used to correct errors and target geographic areas with low uptake, demonstrating a direct link to resource allocation, the process remained largely focused on retrospective reporting accuracy. A recurring vulnerability was the reliance on implementing partners for data cleaning and analytical support, which was unstable and often ceased due to budget cuts. This limited the ability of districts to generate evidence beyond mandatory quarterly reviews, leaving the system fragmented and often unable to produce the real-time, forward-looking intelligence needed to proactively shape program strategy.

4.2.6 Stewardship, Management and Accountability

District stewardship and management of FP programs were fundamentally fragile due to an overwhelming dependence on implementing partners for core functions, a critical lack of dedicated funding, and weak institutional structures. Districts were not autonomously prepared to manage FP programs, as they lacked ring-fenced budget allocations and often simply "followed" the scope set by partners rather than executing district-owned strategies. An ADHO-MCH in South Buganda region explicitly stated,

"we've been majorly relying on partners,"

which creates a passive, reactive management system where strategic planning and financing were not built for the long term. This reliance extended to supervision and mentorship, which were often inconsistent, infrequent, and couldn't be sustained when partner support was withdrawn, leading to skill gaps, especially given the high rate of staff turnover.

The systems for tracking and managing FP programs were moderately effective for routine reporting via DHIS2 but suffered from fragmentation, particularly due to the lack of integration with community-based data from Village Health Teams (VHTs). The most critical systemic failure was the near-universal absence of a functional FP multi-sectoral coordination committee; most districts either lack one entirely or had structures that were inactive due to funding constraints. This failure hindered multi-stakeholder engagement, causing partners to work in silos without strategic alignment. Moreover, the influence of local leaders was complex: while some political figures champion FP, the opposition from influential religious and cultural leaders actively discouraged uptake, forcing women to access services "secretly", creating a major barrier that a fragmented management system was ill-equipped to overcome.

Section Five:

DISCUSSION

The evaluation of FP-CIP II (2020/21–2024/25) reveals a program of mixed progress. The modern Contraceptive Prevalence Rate (mCPR) for all women increased modestly from 30.4% to 33.8%, and the total number of users grew to an estimated 4.3 million. On the other hand, the program fell short of its primary targets for mCPR (39.6%), unmet need (10%), and adolescent pregnancy, constrained by profound systemic weaknesses in sustainable financing, multi-sectoral coordination, commodity security, and data utilization. The country generated a substantial increase in the Couple-Year of Protection (CYP), integrated High-Impact Practices (HIPs) like postpartum and post-abortion family planning, and made strides in policy development, such as launching national self-care, TMA and post-abortion care guidelines. Demand creation efforts reached millions through radio and community dialogues, contributing to a gradual shift in some FP myths.

5.1. Multi-Sectoral Collaboration and Stewardship

The intended multi-sectoral approach remained largely theoretical. While a National FP Steering Committee was established, its operations were irregular, and engagement from key ministries like Gender and Education was minimal. At the district level, coordination committees were largely non-functional. This resulted in fragmented planning and implementation, with partners often working in silos. This finding aligns with the literature, which emphasizes that successful FP programs, like those in Bangladesh, are driven by coordinated actions across sectors that address social determinants like education and female autonomy.

The lack of robust multi-sectoral stewardship means FP continues to be viewed as a health-sector issue rather than the broader developmental imperative it is. This limits the scope of interventions, hampers resource mobilization from other sectors, and undermines accountability for national demographic goals. The evaluation focused on the health sector's perspective and documented structures. A deeper analysis of the budgetary allocations and policy integration within other line ministries (e.g., Education, Finance) was beyond its scope but is critical for a full understanding of multi-sectoral failure.

Future evaluations should conduct a formal policy and budget analysis across all key government sectors to quantify the level of multi-sectoral commitment and identify specific entry points for stronger integration in FP-CIP III.

5.2. Health System Capacity and Quality of Care

The expansion of service access, particularly for LARCs, and the scaling of HIPs are commendable achievements. However, the marginal improvement in the Method Information Index Plus (MII+) from 43.8% to 45% indicates persistent gaps in the quality of client counseling. This was compounded by reliance on partner-funded, often one-off trainings, high staff turnover, and chronic stock-outs. As noted in the literature, quality of care is paramount; method discontinuation, often driven by side effects and poor counseling, can erode contraceptive gains. The focus on access was not matched by sustainable investments in the consistent quality envisioned by the WHO's health systems building blocks framework.

Simply increasing the number of service points is insufficient. The slow growth in mCPR, despite more users, suggests challenges with method continuation and client satisfaction, as well as contraceptive dynamics. The reliance on partners for service delivery in hard-to-reach areas creates a fragile system that collapses when funding ends.

However, the evaluation provides a system-level view of quality (MII+). It does not capture the nuanced client-provider interactions or the specific reasons for client dissatisfaction or discontinuation that deeper qualitative studies might reveal. Further studies are needed to investigate the specific drivers of method discontinuation in Uganda and to evaluate the cost-effectiveness and impact of continuous, competency-based mentorship models compared to traditional one-off training.

5.3. Sustainable Financing

Financing was the most critical failure of FP-CIP II. The government's average annual contribution of $2 million was a fraction of the $21 million required, maintaining overwhelming donor dependency. This directly led to the collapse of demand creation campaigns when donor funding ceased and left districts without budgets for core FP activities. The TMA, which the literature promotes as a strategy for diversifying funding and enhancing efficiency, remained unrealized due to weak private sector regulation and a lack of sustainable domestic financing mechanisms like the National Health Insurance Scheme.

The current model is financially unsustainable. The program's progress is vulnerable to shifts in donor priorities and funding cycles. Without decisive action to secure domestic funding, Uganda will remain off-track from its FP and development targets, unable to harness the demographic dividend.

This evaluation highlights the funding gap but did not conduct a comprehensive resource tracking exercise to map all public and private FP expenditures, which would provide a more precise picture of financial flows. A comprehensive National Health Accounts exercise for Family Planning is recommended to precisely track all public and private expenditures. This would provide the evidence base to advocate for more targeted and efficient domestic resource allocation.

5.4. Commodity Security and Supply Chain Management

A paradoxical situation was observed: while central-level warehouses often had healthy stock levels, service delivery points experienced chronic and worsening stock-outs. This points to a critical breakdown in the "last mile" of the supply chain, including weak facility-level forecasting, inefficient distribution, and inadequate funding for transport and logistics. This systemic dysfunction directly undermines client trust and service continuity, negating gains made in demand creation and service availability.

Persistent stock-outs are more than a logistics failure; they represent a breach of trust with clients, potentially leading to method discontinuation and unintended pregnancies. It also leads to inefficient use of resources, as commodities paid for sit in central warehouses while facilities report shortages. The evaluation identified the symptom (stock-outs at facilities) but could not conduct a deep, process-oriented audit of the entire supply chain to pinpoint the exact bottlenecks in quantification, procurement, or distribution between the central level and health facilities. An operational research study is urgently needed to diagnose the specific root causes of last-mile supply chain failures, focusing on ordering procedures, redistribution mechanisms, and the impact of integrating community-level data into national forecasting.

5.5. Equity, Adolescents, and Socio-Cultural Norms

Significant inequities persist such as teenage pregnancy rate remains stagnant at 24%. Successful pilot programs for youth and male engagement were not scaled nationally. Deeply entrenched socio-cultural norms, male opposition, and provider bias continue to be major barriers, corroborating the literature on sub-Saharan Africa which identifies gender norms and stigma as persistent obstacles. The evaluation found that women often use contraception secretly, risking domestic violence.

A "one-size-fits-all" approach fails to address the unique barriers faced by adolescents and other marginalized groups. Without targeted, culturally sensitive, and scalable interventions that engage men and community leaders, Uganda will not overcome the social resistance that fuels high fertility and unmet need.

While the evaluation captured stakeholder perceptions of these barriers, it did not quantitatively measure the prevalence of specific socio-cultural norms or the direct impact of male opposition on contraceptive use at the population level. Research should focus on evaluating the scalability and cost-effectiveness of different male engagement and gender-transformative intervention models to identify which approaches are most impactful and feasible for national rollout.

5.6. Demand Creation and Communication Channels

The country successfully utilized a multi-channel approach, with radio being the dominant medium for FP messages, reaching 66% of women. Community-based dialogues and partner-driven campaigns also played a significant role in creating awareness and gradually reducing misconceptions in some regions. However, this system was overly reliant on donor funding and a single channel (radio), making it fragile and inequitable. As the literature on Social and Behavior Change Communication (SBCC) emphasizes, effective programming requires a sustainable, multi-platform strategy that is tailored to diverse audiences. The underutilization of digital platforms, television, and billboards, especially for urban and youth engagement, represents a significant missed opportunity.

The "stop-start" nature of campaigns, dictated by donor funding cycles, leads to a cycle of progress and relapse in demand generation. Furthermore, the over-reliance on radio excludes populations in regions with poor reception (like Karamoja) and fails to adequately engage younger, more digitally-connected audiences. This creates a critical gap between generating initial awareness and sustaining informed demand over the long term.

The evaluation data shows the reach of various channels but does not provide a qualitative deep-dive into the specific messaging resonance, the comparative effectiveness of different channels in driving service uptake, or the precise reasons for the stagnation in overall FP demand.

Further research is needed to conduct a comprehensive media landscape and channel effectiveness analysis. This would identify the most cost-effective and impactful mix of channels for different demographic and geographic segments to inform a more resilient, targeted, and sustainable national SBCC strategy for FP-CIP III.

In conclusion, the FP-CIP II period demonstrated that tactical expansions in service delivery are achievable, but strategic goals remain elusive when foundational system weaknesses are not addressed. The plan's overreliance on external partners created a project-based, rather than a system-based, approach. For FP-CIP III to succeed, Uganda must transition from project-based to institutionalization, making decisive investments in domestic financing, multi-sectoral governance, and a resilient, data-driven health system to ensure equitable and sustainable family planning for all.

Section Six:

RECOMMENDATIONS FOR THE FP-COSTED IMPLEMENTATION PLAN III (2025/26–2029/30)

The following recommendations are designed to address the systemic gaps identified in the FP-CIP II evaluation. They provide a strategic roadmap for FP-CIP III, focusing on institutionalizing interventions within government systems, leveraging evidence from global and local literature, and specifying implementation pathways to ensure sustainable and equitable family planning outcomes for Uganda.

6.1. Institutionalize Multi-Sectoral Collaboration through Embedded Governance Structures

To address the gap of fragmented, health-centric stewardship, FP-CIP III must transition from standalone committees to integrated accountability mechanisms. Drawing on global evidence from countries like Bangladesh, which successfully embedded FP within broader development agendas, we recommend anchoring FP objectives within existing and robust sectoral platforms. This should be implemented by formally integrating FP targets and reporting into the performance frameworks of key ministries, notably Gender, Education, and Local Government, led by Office of the Prime Minister (OPM) and embedding FP review items into the agenda of established district-level RMNCAH and development committees. This approach leverages existing mandates and resources, ensuring FP is treated as a multi-sectoral development priority rather than a vertical health program, thereby fostering shared ownership and accountability.

6.2 Elevate Service Quality as the Cornerstone of Expanding Access

While expanding the physical access to services was a key achievement of FP-CIP II, the stagnation in key outcomes like method continuation reveals that mere availability is insufficient. The critical gap now is ensuring that expanded access is matched by an unwavering commitment to quality, as defined by the World Health Organization's health system building blocks and evidence confirming that poor counseling and side-effect management are primary drivers of discontinuation. Therefore, FP-CIP III must execute a deliberate reorientation from a quantity-focused to a quality-centered model. This should be implemented by pivoting from ad-hoc, partner-funded trainings to a sustainable, government-led system of competency-based mentorship and supportive supervision embedded within routine health system structures. Furthermore, the plan will institutionalize and fund the regular application of quality metrics, such as the Method Information Index Plus (MII+), to systematically monitor and enhance client-provider interactions. This ensures that every new service point becomes a trusted node of high-quality, client-centered care, thereby transforming increased access into lasting contraceptive security and improved health outcomes.

6.3. Secure Program Sustainability through Mandatory Domestic Financing

The critical gap in sustainable financing, which rendered FP-CIP II vulnerable to donor volatility, must be addressed through decisive and integrated domestic resource mobilization. Moving beyond the siloed approach of ring-fenced health budgets, FP-CIP III needs to champion the integration of family planning as a line item within the operational plans and budgets of all relevant sectors at national and subnational levels. Informed by the literature on the Total Market Approach (TMA) and the developmental multiplier effect of FP, this strategy recognizes that investments in FP advance the core goals of sectors like Education (reducing school dropouts), Gender (promoting women's economic empowerment), and Local Government (improving community resilience). This should be coupled with capacity building for sectoral planners on how to cost and integrate FP interventions, ensuring that domestic financing for FP becomes a shared, multi-sectoral responsibility, thereby weaving it into the very fabric of national development planning and budgeting.

6.4. Fortify Commodity Security by Optimizing the Last-Mile Distribution System

The persistent paradox of central-level stockpiles and facility-level stock-outs highlights a critical inefficiency in the final leg of the supply chain, undermining client trust and service continuity. To address this, FP-CIP III must strategically strengthen

and augment the existing Last Mile Assurance program. Implementation should focus on enhancing the collaboration between the contracted logistics provider, the National Medical Stores (NMS), and district health teams. This can be achieved by establishing formalized and funded coordination mechanisms at the district level, empowering District Biostatisticians and Medicines Management Supervisors (MMS) to use real-time consumption data with logistics partners, strengthening the commodity supply chain and addressing localized stock imbalances.

6.5. Advance Equity through Scaled-Up, Youth-Responsive, and Gender-Transformative Programming

Persistent inequities for adolescents and the pervasive influence of restrictive gender norms represent a major gap that FP-CIP II failed to close at scale. Informed by evidence on the effectiveness of youth-friendly services (YFS) and the necessity of engaging men and boys to shift socio-cultural norms, FP-CIP III should prioritize targeted, inclusive programming. Implementation should involve a dual approach: firstly, by mandating and equipping all Health Centre IIIs and above to provide standardized, non-judgmental Youth-Friendly Services, integrated within ANC, PNC, and outpatient departments. Secondly, the plan should scale up evidence-based, gender-transformative interventions by systematically engaging men, community elders, and religious leaders through existing community structures to deconstruct harmful myths and foster an enabling environment for voluntary contraceptive use.

6.6. Transition to a Sustained, Multi-Platform Demand Generation Strategy

The over-reliance on donor-funded, radio-centric campaigns created an unsustainable and inequitable demand generation model. To build a more resilient system, FP-CIP III must adopt a diversified and sustained Social and Behavior Change Communication (SBCC) strategy. Drawing on SBCC literature that emphasizes the need for consistent messaging across multiple channels, implementation can involve developing a national, multi-year SBCC plan that strategically blends mass media (radio, TV), digital platforms, and interpersonal communication. This plan can be backed by a dedicated domestic budget to ensure campaign continuity. Furthermore, robust monitoring mechanisms can be established to track reach and impact across different demographics and regions, allowing for real-time adjustments to ensure messages effectively counter persistent myths and reach underserved populations, including those in areas with limited radio coverage.

Conclusion

The FP-CIP II evaluation reveals a critical juncture for Uganda's family planning program; while commendable progress was made in expanding access, the fundamental measure of impact, the CYP generated, remains constrained by systemic weaknesses that prevent these gains from being fully sustainable or equitable. The program's heavy reliance on external partners created a fragile foundation, leading to unpredictable commodity security, variable service quality, and an inability to effectively reach the most marginalized. Therefore, the strategic imperative for FP-CIP III is not to choose between expansion and institutionalization, but to pursue them in tandem. Future success requires a dual focus: continuing to extend service access while simultaneously building a resilient, nationally-owned system through mandatory multi-sectoral financing, an optimized last-mile supply chain, institutionalized quality assurance, and targeted equity strategies. Only by strengthening these core systems can Uganda convert short-term user numbers into long-term, high-quality CYP and secure the demographic dividend essential for its socio-economic transformation.

References:

1. WHO (2023) Maternal Mortality Regional Factsheet.
2. Uganda Bureau of Statistics (UBOS) and ICF. (2023). Uganda Demographic and Health Survey (UDHS) 2022: Key Findings. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.
3. Republic of Uganda. (2013). Uganda Vision 2040. Kampala, Uganda: National Planning Authority.
4. National Planning Authority. (2020). The Third National Development Plan (NDPIII), 2020/21–2024/25. Kampala, Uganda: National Planning Authority.
5. Ministry of Health. (2020). Ministry of Health Strategic Plan, 2020/21–2024/25. Kampala, Uganda: Ministry of Health.
6. Ministry of Health. (2015). National Family Planning Costed Implementation Plan (FP-CIP I). Kampala, Uganda: Ministry of Health.
7. Ministry of Health. (2020). The Second National Family Planning Costed Implementation Plan (FP-CIP II), 2020/21–2024/25. Kampala, Uganda: Ministry of Health.
8. Family Planning 2030 (FP2030). (2020). FP2030 Commitments. Washington, D.C., USA: FP2030.
9. Annual Pharmaceutical Service Performance Report 2023/2024
10. The Integrated Quantification Report for Essential Medicines and Health Supplies 2022/23-2026/27
11. The Ministry of Health Fact Sheet
12. PMA Survey Results 202102025
13. The National Housing and Census Report, 2024.

Appendix: Progress on the Strategic Outcomes Outlined in CIP II

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
Technical Strategy 1: Multi-sectoral Collaboration for Socio-Economic Development					
Strategic Outcome 1: National FP Multi-sectoral Committee functional	Re-Activate the National FP Multi-Sectoral Steering Committee	Multisectoral Approach for FP Operational at National Level	National Level Advocacy Meetings to orient sectors on the National Multi-sectoral approach, the CIP and their role	Steering committee held a few meetings. Meant to be quarterly with MPs but did not happen during 2023/24 & 2024/25	Gender and Education was not involved in this multisectoral meetings.
			Annual Planning meetings to include FP in the National Sectoral (all sector plans) and allocate funds for implementation.	Annual planning meetings have been held at MoH Level to include FP in the National plans and allocate funds for implementation	There are no other sectors of government with clear FP incorporated into their policies or plans.
			Bi-annual National FP steering committee coordination meetings	The meetings have been happening regularly with diverse stakeholders.	Attendance and participation at regional level have declined over the course of the last 5 years.
			Annual Sector led resource mobilization campaigns for FP	Progressed in the first two years but meetings have since stopped.	The meetings are no longer happening as they should.
	Support sub-regions to set up multi-sectoral FP subcommittees	Multi-sectoral approach for FP operational at district level	Induction meeting for the district FP multi-sectoral steering committees (100% of districts)	These meetings happened only in districts supported by partners. Overtime they stopped meetings and are currently dysfunctional.	Due to the inefficiencies in the dissemination of the CIP, many regions lack knowledge on the composition and the need for the FP multi-sectoral committees.
			Annual Planning Meetings to include FP in the district departmental annual workplans and allocate funds for implementation.	There are no documented evidence of such meetings happening specific for Family Planning. However, USAID UHA supported 72 districts in planning and budgeting. FP budgets are all consolidated under the RH budget	These meetings are part of the general district planning and FP has no specific plans.
			Set up subcounty FP multi-sectoral committees anchored and led by the subcounty chiefs with support from CDOs (100% districts)	This has not been done in any district or region and sub county chiefs have not been involved in supporting FP work.	There was no effort put in place to sensitize the district leadership on creation of FP teams at sub county level
			Bi-annual District FP multi-sectoral steering committee coordination meetings (100%)	This has not been done since the committees are not functional.	There was no effort put in place to sensitize the district leadership on creation of FP teams at sub county level
Strategic Outcome 2: FP supportive policies adopted and implemented	Finalization and roll out implementation of sectoral FP related guidelines, policies and laws.	Proportion of service delivery points (all sectors) with FP relevant policies, guidelines and SOPs and job aides.	Revise policies (ADH, SRHR, TMA, Self-Care, OTC, Task Shifting). Revise and roll out age-appropriate Sexuality Framework.	The Guidelines on Self-Care Interventions were launched in 2024, and the Total Market Approach (TMA) was revised. All other policies were merged into the one sector one policy and thus ASRHR awaiting cabinet approval.	The National Self-Care guideline launched late in 2024. However, no policy exists on task shifting. MoH was advised to merge Adolescent Health (ADH) and Sexual and Reproductive Health and Rights (SRHR). A Regulatory Impact Assessment has been completed, and the process currently awaits Cabinet approval, with interactions now in the final stages.

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
			Produce all national sector specific guidelines, standard operating procedures, quality standards and job aids relevant to FP.	Key activities undertaken include the development of a comprehensive family planning training manual, a competency assessment tool, and a quality-of-care assessment tool, as well as the roll-out of the hormonal IUD and Levoplant. In addition, job aides for community health workers, health workers, and health facility staff are currently under review. PAC guidelines launched in October 2025.	All these documents are currently in development except PAC completed in October but none has so far been rolled out for use at National, District or site level.
			Disseminate to 100% districts, all national sector specific policies, strategies, guidelines, standard operating procedures (SOPs), quality standards, job aides which are relevant to FP.	Guidelines on Self-Care launch at NSMC in 2024 but not disseminated at sub national level. The FP CIP II and the TMA strategy was disseminated at National level. PSI supported its dissemination in 65 districts.	Total Market Approach (TMA) has not been disseminated at the district level in Lango, Teso, Bugisu, Bukedi, Karamoja & Ankole and the Costed Implementation Plan (CIP) was rolled out only in 42 select districts, mainly with partner support from MSI Uganda and USAID FPA (11 districts)
	Implement advocacy activities on FP through each line sector	FP line sectors knowledgeable about FP and owning the FP Program	Form district FP Advocacy groups (100%) all districts.	There are no districts with specific advocacy groups dedicated to Family Planning.	
			FP Promotional events e.g., meetings, sector led FP mass media campaigns at National and in 100% districts	Events like World contraception day, World self-care day are now commemorated annually, National Safe Motherhood Conference, Exhibitions events like Partners Day -MSU, Edutainment activities using radio, social media and drama at community level, Protect the girl-save the nation by UNICEF, UNFPA & MOH, Donor driven SBCC adverts on TV and radio station e.g., Obulamu supported by partners.	Many activities are donor driven and funded and therefore still a long way to go in terms of sustainability
			Sector led FP promotional campaigns (mass media, meetings in 100% districts	No specific MOH led but various implementing partners have been able to conduct region specific engagements in their regions of operation.	All these are donor driven and most have been stopped by 2025 due to the change in the funding landscape.
			Hold advocacy meetings between line sector representatives.	A few meetings held based on availability of funds.	
			Convene national and sub regional high-level dialogues and engagements with stakeholders from various sectors to facilitate alignment of FP as a development agenda.	Regular meetings in Karamoja, Teso, West Nile, Bunyoro ADHOC meetings that used to happen. They were not routine but based on available of funds and donor levels.	This too, was donor dependent and thus
Technical Strategy 2: Universal Coverage and Sustainability					
Strategic Outcome 3: Strengthened health system to ensure delivery of a standardized minimum package for FP	Update and implement the FP related pre-service and in-service training curriculum for HW, VHTs and strengthen referral systems at all levels	% Of HC IIIs, HC IVs offering a standard minimum package of FP services.	Revise pre-service and in-service FP training curriculum to incorporate HIPs for HCW	In service FP training curriculum was revised with HIPs incorporated.	Pre-service curriculum has not been revised

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
			Hold Planning meetings between MOH, sector experts, MOH policy makers and MOES including the NCDC to review and update the respective curriculum as required.	Meeting did not happen with all those stakeholders. Revision was done by the Ministry of Health.	Other stakeholders were involved in revising this curriculum for Family Planning.
			Develop guidelines to facilitate self-referral, community to facility and inter-facility referrals using digital tools.	It was developed as part of comprehensive FP training manual and self-care guidelines. Community was integrated in the community health care strategies.	
			Update, upload and monitor the national electronic iHRIS on service trainings	This has been done at National level but challenges still exist with individual trainings by National IPs not captured fully.	A number of IPs do not have access to that system. Many do not upload and few were able to upload them.
			Train the district local governments on iHRIS for in service training management (Target 100% of districts)	Formal regional trainings were organized on the revised iHRIS transiting from Version 4.3 to 5.0 focusing on modules attendance from v4.3 to v5	This training was not very specific to the FP components and was driven largely by implementing partners.
			Procure and distribute to 100% RRH, HCIV and HCIIIs FP related training models.	The MOH placed efforts to develop set skills training labs based at RRH for RMNCAH. A few mannequins were obtained through partners and given to all RRHs	There are currently no guidelines streamlining how these skills labs should operate
			Review existing VHT training materials and referral guidelines for FP harmonization.	There exists already a VHT training manual highlighting referrals for service provision	It is not specific to FP
		% Of clients from special groups accessing FP information and service	Train service providers on FP counselling, management of side effects and provision of all methods targeting those that serve with special groups (PLWDs, military and those in humanitarian settings)	Draft of a minimal service package when disaster happens. It is not clear cut. There is no clear documentation of trainings for soldiers and PWLDS	There is no Uganda Specific MISP.
			Identify, train & equip VHTs serving special groups (PLWD, CSW)	Training specific to Family Planning was not done specifically for VHTs serving communities with special interests.	There is no clear guidance on training VHTs providing FP for PWLD and CSW
			Target FP outreach for special groups (PLWDs & CSW)	Outreaches in Barracks during male involvement day. No special camps for PLWD	There is no clear guidance on FP for PWLD
	Effective Engagement and Capacity building of the private sector to provide quality FP services	Proportion of Private Facilities providing FP service as per the set National Standards	Conduct accreditation process for FP service provision on private facilities (PFP, pharmacies, drug shops) in the districts (100% DLGs)	Secured authorization for the provision of injectable contraceptives through accredited pharmacies, a major milestone led by the Pharmacy Advocacy Committee under the TMA Task Team.	This process was only finalized in October 2024 and therefore not all private providers have been accredited.
			Train service providers on LARCs, FP Counselling and management of side effects in private facilities offering FP services (100% districts)	As outlined in the guidelines, staff were trained supported by DKT, PATH in Kampala, West Nile, Teso as per the process guideline above.	
			Hold training workshop for selected private sector FP providers in service delivery including QoC protocols	QoC is part of the package for the trainings above as outlined in the accreditation guidelines.	

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
			Supervise service providers in private facilities offering FP services (100% of districts)	There have been weak supervisory structures from the DHOs & NDA over the private pharmacies and drug shops	
			Strengthen UFPC to coordinate implementing partners supporting the private sector.	The role of coordinating Implementing partners is largely conducted by MOH.	
			Annual FP Quality audits of private sector facilities (100% of all districts)	This happened for the 1st 3 years but there has been an issue in the last two years since facilities were dropped due to funding gaps.	
			Disseminate guidelines and supervise providers on self-care in drug shops, pharmacies in 100% districts	At the national level it has been disseminated but at district level it has been piecemeal. Minimal dissemination of self-care at district levels.	
			NDA to fast-track the policy on provision of injectable contraception in pharmacies and drug shops.	It has been approved. There is a pilot going on in Kampala district at the moment.	
Strategic Outcome 4: Supply Chain Strengthened to ensure a reliable supply of full method mix through all FP channels	Streamline the FP commodities security in the public and private sectors	Availability of at least 3 methods at service delivery points.	Annual Meeting to forecast, quantify, supply planning and monitor FP commodities, related supplies and consumables	These meetings have been happening consistently; quantification has been done.	Quantification is based on financing available and not the needs of the consumers.
			Procure relevant FP commodities, FP consumables, FP instruments and related equipment.	Procurements have happened and SDP survey data shows availability of at least 3 methods in 19.4% sites.	Stock outs of all methods still rampant despite warehouses having adequate quantities.
			Orient district Local Governments and monitor the operationalization of "one facility, one warehouse" approach (100% of districts)	These orientations were done to both IP staff and districts-based commodity. This was done during RH SPARS routine support.	
			Carry out quality of contraceptive commodities including post-market surveillance	This has been actively conducted although it is a mandate of the NDA	
	Ensure functionality of the ADS and strengthen the public sector supply chain	Order fulfilment rate in the National Medical Stores	Train the national team on eLMIS for supply chain management targeting public sector	Trainings were conducted to all relevant teams within the public sector on the eLMIS for supply chain management. Supported by partners.	
			Run and maintain the web-based commodity electronic logistics system.	This exists and is in use	
		Order Fulfilment rate in the ADS	Train the national team on eLMIS for supply chain management targeting the ADS	National teams were trained on the ELMIS for supply chain management	
			Link the private clinics and drug shops to the ADS and within the TMA for commodity security.	Alot has been done and some drug shops are linked to ADS	Some accreditations were revoked.

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
		Transition from PUSH to PULL system for ordering contraceptives at lower-level facilities.	Train district local governments on web-based FP commodity electronic logistics management system -RH WAOS	All district local government staff trained on all web based electronic logistics management systems.	
			Run and maintain the District Local Government Web based commodity electronic logistics management system targeting 100% of the districts.	This has been continuously done, one all web-based portals for ordering, quantification or management of stock.	
			Train service providers at facility level and community level on logistics management targeting 100% districts.	There were service providers trained nationally on logistics management done on a regular basis integrated in most activities	
	Address mismatch in classification of contraceptives in the law vs distribution channels	Relevant laws appropriate for addressing commodity security.	Meetings to amend the NDA act on contraceptive classification and distribution.	This was done; NDA act was amended. CHEWs are now allowed to handle class B (Prescription) and VHTs now provide Sayana and drug shops are now allowed.	
Strategic Outcome 5: Current Nascent FP Market transformed into a commercial sector	Implement Total Market Approach	Total Market Approach Strategy approved and implemented	Map, update and maintain inventory on access to FP service delivery, FP commodity and devices availability and brands in the public sector, social marketing and commercial sector	No such inventory has been mapped and availability of devices and brands in the private sector not done except for the new "Sayana" developed to be sold in pharmacies and drug shops.	
			Market analysis of quality FP services and device availability in public, private (social and commercial sectors)	There is no documented evidence of this market analysis being conducted.	
			Annual FP services and commodity analysis. Monitor annually the private sector FP channels on FP service provision and commodity availability.	This has not been done continuously in regard to the private sector.	
			Social market FP commodities and services.	MSI/Marie Stope, Samasha, DKT, CMS and PSI have continued to social market commodities supporting the	
			Revive/strengthen the National TMA subcommittee nested within the RH division to implement the TMA approach	TMA subcommittee (task force) has been functionalized and now meets regularly. A total of 14 meetings has been held so far since 2021.	
			Quarterly district TMA coordination meetings (100% all districts)	There is no evidence of functionality & meetings of the district TMA coordination meetings.	District TMA meetings are not happening. Many interviewed at district level indicated non-functionality.
	Scale up access to self-care interventions	Proportion of districts in which self-care interventions are optional.	Develop and disseminate policies, guidelines and SOPs for self-injection.	National guidelines for self-care were developed and launched at the 4th NSMC 2024.	No clear SOPs specific to self-injection was done. The self-care guidelines are all encompassing.

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
			Improve user acceptability and health system integration of self-care at health facilities and community levels.	In progress	
			Orient district Local governments on applying self-care interventions at service delivery points.	In progress	
Strategic Outcome 6: Sustainable Financing to enhance government contribution to the FP program at National & Sub National Level	Family Planning Financing, Governance, Stewardship and Accountability	Proportion of contraceptives procured using domestic revenue.	Annual national fundraising events (advocacy meetings with Parliamentary forum, Ministry of Finance, MOH, Development partners using the National CIP	Meetings happened until 2024 leading to MOH allocating 25% of vote 118 to Family Planning.	With the decline in donor funding, a larger commitment may be necessary to address the contraceptive procurement shortages.
		Proportion of the budget for non-contraceptive activities (FP Program Financed) annually.	Develop district CIP in remaining 46 districts	New FP costed plans developed were 11 supported by MSU and another 14 by USAID FPA and 19 by UNFPA	Many districts could not trace their developed CIPs and thus an indication that it was perhaps not used.
			Voucher scheme financing model (12 sub regions) with inequitable access by the poor)	Marie Stopes Uganda RISE Program covered 86 districts in 7 sub regions using a voucher scheme financing model.	5 regions were not covered
			Advocacy meeting to complete setting up of the National health Insurance financing model	Meetings were organized by MOH and the TMA task force supported by PSI, PATH.	No progress has so far been registered in this effort.
		Proportion of the counterpart funding realized annually	Counterpart funding of the CIP model by Government of Uganda (50% of the entire CIP budget)	Government commitment in funding the CIP II has risen from zero to about $2m. This is just about 10% of the required $21m	With declining donor funds, the commitment by government of Uganda will need to be revised upwards.
		Proportion of the districts with resources mobilized for the CIP or FP workplans	Annual Fundraising event in the districts (advocacy meetings) using the district CIPs and district development plans. (100% of districts)	This has not been documented to be happening in any district. Specific IPs like Jhpiego's TCI do provide grants to specific cities/towns to provide Urban FP.	FP at districts is largely supported by Implementing partners
			Finance FP CIP Quality Improvement activities using RBF Financing model.	A number of health facilities used proceeds from RBF to purchase supplies and improve quality of health services.	
		Updates on FP resource & expenditure status	Annual National Assessment on FP budget and resource tracking (100% of districts)	This has not been actively done in all districts	
			Develop tools/guides to support subnational accountability mechanisms to conduct FP Policy implementation and track FP funding flows in their respective districts.	This was also not implemented at district level. There are no districts tracking funding inflows for FP in their respective districts.	
			Form subnational accountability mechanisms (SAM) in each district to bring together CSOs in the district and hold district leaders accountable in implementing multi-sectoral FP plan.	Sub National Accountability meetings were done in 14 districts with 9 supported by Marie stopes and 5 by UNFPA.	No evidence of Sub National Accountability Meetings in the rest of the districts.

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
Strategic Outcome 7: Information generated and used for evidence-based prioritization & FP Programming	Strengthen data quality management, monitoring and evaluation systems	Evidence based policies and strategies. Evidence of use of data for prioritization of FP interventions	Conduct research on FP and related issues	This has been done on a routine basis e.g. Consensus meetings, PMA, SDP survey, UDHS etc	It is heavily reliant on funding and some periods are occasionally missed eg PMA 2023.
			Support generation, access and use of FP information to identify and better target vulnerable groups.	This has also been done e.g., the National Strategy to end child marriage and teenage pregnancy.	Much of this information and policy generated does not trickle down beyond MOH, Implementing partners/CSO to the district local governments.
		% Of facilities reporting timely	Run and maintain DHIS2 (100% of districts)	This has been maintained with support from MOH and implementing partners.	The system has experienced occasional system downtimes lasting days.
			Annual FP data quality verification and validation	This is done by the M&E team. Data is downloaded and shared with district staff who then plan and conduct the data cleaning.	
		Updated FP CIP Indicators	Develop the CIP 2020-2025 performance monitoring and evaluation plan	A fully developed performance & monitoring plan was developed for this current CIP II period.	A number of indicators cannot be readily tracked with available data and would need specific data sources.
			Implement FP CIP 2020/21-20204/25 performance monitoring and evaluation plan (Data source being DHIS2, PMA, UDHS, assessment surveys, Activity reports	This has been done	
			Review and update the electronic CIP database	Not done	
			Bi-annual FP targeted technical support supervision.	This is done based on availability of funds and partner support.	
Technical Strategy 3: Sub Regional Focus to address Inequities					
Strategic Outcome 9: Decrease in proportion of women that have had a child before 18 years	Youth programming (both multi-component youth programming & integrated youth response	Teenage Pregnancy Rates	Support youth led organizations to provide youth responsive services in 15 regions	The ministry of health provided support to youth led organizations like peer to peer, AVSI, reach a hand in providing youth or adolescent responsive services to address teenage pregnancy. MOH in addition has organized the teenage pregnancy surveillance platform and re-activated the DICA teams in districts	Despite all the efforts and investments, teenage pregnancy has not significantly reduced over the period of two UDHS.
	Integrate adolescent responsive service into FP service delivery points	Improved knowledge of young people on FP.	Incorporate age-appropriate sexuality education framework in school curricular and community engagements	Framework not yet approved since it was bundled up with Adolescent Health Policy.	
		Increased access to contraceptive services among married adolescents	Mentor and supervise service providers on adolescent responsive services integration into FP services (100% HCIV, IIIs and IIs)	Done through the DREAMs project in Ankole, Lango, South and North Buganda and Busoga supported by USAID RHITES, OVC and other IPs	

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
		Increased male engagement	Sub region age appropriate SBCC activities (mass media, peer, promotion campaigns	Radio talk shows leveraging male involvement, events like WCD. Specific examples are limited to partner involvement.	These initiatives are heavily donor reliant. Radio is accessible and the best means but is also very expensive.
			Male-led community dialogues in 15 sub regions	Happened in the 7 USAID supported regions Lango, Teso, Karamoja, Bugisu, Bukedi, Busoga, Ankole & Kigezi under USAID UHA & OVC Programs.	
			GBV prevention dialogues (15 sub regions)	Happened in the 7 USAID supported regions Lango, Teso, Karamoja, Bugisu, Bukedi, Busoga, Ankole & Kigezi. Examples include Get Up Speak out campaign, MOH adolescent awareness campaigns	
			Male support groups	No documented evidence for their implementation.	
			GBV prevention advocacy campaigns in 15 sub regions.	This was mainly done by partners across the 15 regions under the USAID OVC partners.	
Strategic Outcome 10: High Impact Practices scaled Up.	Increased % of women attending PNC within 6 weeks	% PNC attendance by post-partum women	Equip and train VHTs on referral of post-partum mothers for FP	This has largely happened in many of the USAID supported regions by USAID programs.	
	Integrate FP into RMNCAH-N services	Integrate FP into RMNCAH services	Train and mentor service providers on provision and integration of FP into RMNCAH service delivery, PPFP, PAFP, HIV in 100% HCIIIs, HCIVs and Hospitals	No formal trainings have happened for integration of FP into different services. Specific effort was done by USAID UHA in 72 districts in 7 regions. Other activities have been region and program specific.	
		% of facilities offering quality PPFP counselling in ANC	Recruit midwives (Facilities not meeting norms)	Only select districts with wage have been able to recruit midwives to provide extra hands based on the new staffing norms	Many districts still have the old staffing norms due to unavailability of wage to implement the new structures.
		% Postpartum women taking up FP	Task sharing FP service provision 100% of districts	Task sharing is not being implemented with fidelity	
		% women taking up post abortion FP			
		% HIV + clients taking up FP	Train service providers on comprehensive FP (target HIV related clinics, child health clinics or service providers)	Has largely been done within the USAID funded projects like USAID UHA, RHITES and FPA	
	Increased Health Centre IIIs providing LARCs	% HCIIIs offering LARCs	Train and mentor service providers on provision of LARCs (IUDs & Implants) 75% in HCIVs & HCIIIs	This was done through the Local Maternity and Newborn systems supported by the various partners.	
			Procure and provide to health facilities LARC equipment (100% HCIIIs)	No direct procurements have happened. Few of these facilities were supported by Ips and not direct delivery.	

STRATEGIC OUTCOMES	INTERVENTIONS	INDICATORS	ACTIVITIES	COMMENT ON PROGRESS	WHAT HAS NOT WORKED
Strategic Outcome 11: Reduced Inequities in FP service provision and greater equitable access to underserved groups.	Develop and Implement context specific SBCC approaches and scale up male involvement strategy to increase uptake and acceptability of FP services including special and vulnerable groups	Increased knowledge on FP services	Sub region specific mass campaigns on FP, mass media, peer to peer education by FP champions. IEC material development, drama groups, social media for youth	Regional specific: Action specific programs regionally invited women for two weeks under RISE projects	
			Develop, translate and disseminate group responsive SBCC tools and materials for individuals with disabilities.	Not done within the last 5 years	No initiative was started regarding this particular special interest/needs group
			In service training on sign language 100% in HCIII, HCIVs and Hospitals.	Not done within the last 5 years	
		Increased male engagement	Male led community dialogues in 15 sub regions	This was not done specifically but various IPs supported widespread SBCC e.g. USAID SBCA Activity and other OVC partners	
			Disseminate the male engagement strategy to district local governments for implementation in 100% of districts.	Disseminated under APC project to select regions. Done by Implementing partners	
			Male engagement advocacy campaigns using male FP advocates (mass media talks, community dialogues, male to male peer educators) through male groups.	Done through the MANZI approach project targeting the young men and sexually active older men.	
	Provide FP services to hard-to-reach communities and other special groups.	% FP uptake by persons living in hard-to-reach areas and high fertility hotspots	Targeted outreach services to underserved sub regions and hard to reach communities.	Done by PSI, FHI360, USAID IPs, RHU and Marie stopes Uganda in addition to the 130,773 outreaches conducted out of the 135,749 planned in the 5 years.	Beyond the routine PHC outreaches, the rest are entirely partner driven. Many have scaled down due to resources available
			Fertility hot spot mapping-targeting FP service provision and SBCC interventions.	Not documented except for teenage pregnancy related interventions.	Categorization has solely been based on risk groups and not specific hotspots.
			Print, disseminate and orient FP service providers on guidelines and SOPs for self-care interventions e.g., self-injection, self-awareness in 5 hard to reach sub regions.	This has been done by partners in select districts in 7 regions (30 districts) by PSIU/FHI360, 5 districts by MOH, CEHURD and PATH in numerous private clinics, drug shops and pharmacies.	This has been done in piece meal with several partners handling different components and in selected districts within the cited regions.
			Implement the guidelines and SOPs for self-care interventions e.g., self-injection self-awareness in 5 hard to reach sub regions.	These have been done in 30 districts in Uganda supported by USAID IPs, PATH, FHI360 & PSIU, CEHURD and MOH.	Most of these areas are supported by projects and the extent of roll out is based on available financing and not need.

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