THE REPUBLIC OF UGANDA

Ministry of Health

ANNUAL REPORT

Multi-Sectoral Efforts To Ending Teenage Pregnancy And Child Marriage In Uganda, 2024/2025

Working Together for Adolescents.

1st Edition

December 2025

National Teenage Pregnancy Surveillance response and Accountability,
Ministry Of Health, Adolescent and School Health Division.

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FOREWORD

This Annual Report for Financial Year 2024/25 presents both sobering realities and compelling evidence that coordinated action can yield measurable results in addressing teenage pregnancy and child marriages that continue to undermine Uganda's human capital development.

The data reveals a troubling paradox and I am pleased with the Adolescent Health Division for realizing that surface-level trends can be misleading without disaggregation, and thus have provided us with valuable granular examination of teenage pregnancy data, and exposed nuances that are often lost in summary statistics. While teenage pregnancies as a proportion of antenatal visits have stabilized at approximately 19%, absolute numbers show a 17% percentage increase in teenage pregnancies across our 30 high-burden districts, translating to nearly 15,000 additional pregnant teenagers. This distinction demands that we fundamentally recalibrate our approach, focusing not merely on percentages but on preventing each individual pregnancy among our adolescent girls.

I am happy to learn that within these challenges lie demonstrable pathways to progress. Some Districts are implementing comprehensive multi-sectoral interventions with remarkable outcomes. Lamwo's parenting groups achieved 53% school dropout reduction; Budaka's post-abortion care integration reached 95% family planning uptake, Omoro's talking compounds correlated with measurable pregnancy rate reductions. These are not theoretical models but implemented, tested interventions proving that this crisis is solvable when we combine political will, community engagement, and evidence-based programming.

The Teenage Pregnancy Surveillance and Response Framework represents Uganda's first coordinated accountability mechanism across health, education, justice, and community sectors. With 30 districts now on boarded, and a functional digital tracking system undergoing field validation, we possess unprecedented capacity for real-time surveillance, targeted intervention, and data-driven decision-making.

However, systemic barriers persist. Health worker shortages at the community level is being addressed by expanding the CHEWs coverage. Others are funding gaps, commodity stockouts, fragmented data systems, and deeply entrenched harmful social norms. Addressing these requires sustained commitment beyond project cycles, integrating interventions into routine systems, mobilizing domestic resources, and maintaining relentless focus on implementation quality.

The 1,000 teenagers becoming pregnant daily are not statistics—they are daughters whose futures depend on our collective response. This report charts the pathway forward; implementation remains our shared imperative.

Dr. Charles Olaro
Director General Health Services

PREFACE

This report serves as both a measure of our progress and a stark reminder of the challenges that persist. As we reflect on the journey towards reduction of adolescent pregnancy and improvement of the health, wellbeing and resilience of our young people in the vision 20240, we are compelled to look ahead with determination. The stories behind the data, the rising anxiety among our young people, the disproportionate impact of violence on adolescent girls, school dropout, Adolescent parenting culture deficit especially among fathers, and the early sexual debut among adolescents calls for a more nuanced and compassionate multi-sectoral collaborative systems.

Moving forward, our mission is to collectively build Health, Social, Education, Justice and community level systems that not only treat or serve, but also empower and keep adolescents and families safe. This means deepening the integrated social support into every touchpoint, reinforcing protective environments to safeguard against violence, and empowering young people with the knowledge, life skills and services to manage their health holistically. The coming period (2026 – 2031) will be dedicated to laying the groundwork for achieving the next plan, one that is informed by this evidence and bold in its ambition to reduce adolescent pregnancy to below 14% by 20230 and reduce morbidities and mortality among young people.

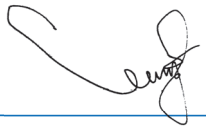
Commissioners

Ministry of Health:

Dr. Mugahi Richard

Ministry of Education and Sports:

Dr. Cleophus Mugenyi



Ministry of Local Government:

Idha Koma Stephen

Ministry of Gender, Labour and Social Development:

K. F. Mondo

ACKNOWLEDGEMENT

The successful compilation of this Teenage Pregnancy Surveillance and Response report for the Financial Year 2024/25 is a testament to the multi-sectoral collective effort and unwavering commitment of numerous individuals and organizations.

First, we extend our sincere gratitude to the dedicated healthcare workers across Uganda—the nurses, clinical officers, counselors, doctors, teachers, police and other social service providers on the front lines. Your resilience and compassion in providing services to adolescents, often under challenging circumstances, form the very foundation of the data and successes captured in this document.

We are profoundly thankful to our development partner UNFPA for the financial and technical support, Save the Children, UNICEF, European Union and others for the invaluable contribution. Your collaboration is crucial in amplifying our reach and enhancing the quality of interventions aimed at safeguarding the well-being of our young people.

A special note of appreciation goes to the National Co-Chairs, the TPSR Secretariat, the district health teams and committees, Health workers and the community structures. Your tremendous work in provision of health services, data collection, validation, and reporting from the community and facility level provides the essential evidence that guides our National policies and strategies.

We also recognize the vital role of community leaders, police, teachers, VHTS, Para social workers, peer educators , cultural , religious leaders and parents who act as the first line of support for adolescents, guiding them towards healthier choices and creating a more enabling environment.

Finally, we acknowledge the adolescents of Uganda, Your engagement with the health system, your resilience, and your potential are the reason for this work. This report is ultimately for you, and we are committed to listening to your voices and refining our efforts to better serve your needs.

It is through this spirit of partnership and shared responsibility that we can ensure every adolescent in Uganda has the opportunity to survive, thrive, and transform our nation.

Sincerely,

Dr Irene Mwenyango
Assistant Commissioner – Health Services,
Adolescent and School Health

ABBREVIATIONS

AFHS: Adolescent-Friendly Health Services

ANC: Antenatal Care

DHIS2: District Health Information System 2

FP: Family Planning

FY: Financial Year

GBV: Gender-Based Violence

MHPSS: Mental Health and Psychosocial Support

MOH: Ministry of Health

NCD: Non-Communicable Disease

OPD: Out-Patient Department

SRH: Sexual and Reproductive Health

STI: Sexually Transmitted Infection

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Executive Summary:

Background and Context

Uganda confronts a persistent adolescent health crisis that threatens the nation's human capital development and transformation aspirations. Despite minimal progress over the past decade, with teenage pregnancy rates declining by merely 1% from 25% in 2016 to 24% currently, Uganda still ranks 16th among 25 countries with the highest rates of teenage pregnancy and child marriage globally. This stagnation occurs even as Uganda demonstrated remarkable capacity to reverse adverse health trends, most notably reducing maternal mortality ratio from 336 to 189 per 100,000 live births between 2016 and 2022. With approximately 1,000 teenagers becoming pregnant daily and 34% of girls married before age 18, the crisis demands coordinated multi-sectoral action.

The National Teenage Pregnancy Surveillance, Response and Accountability Framework (TPSR), developed by the Ministry of Health's Adolescent and School Health Division with UNFPA support, represents Uganda's first coordinated, multi-stakeholder effort to address this challenge. The framework establishes a comprehensive system for surveillance, response, and accountability aimed at substantially reducing teenage pregnancy from 24% to 15% by 2030, aligning with Uganda's Fourth National Development Plan (NDP IV) covering fiscal years 2025/26 to 2029/30.

Framework approach and implementation

A critical innovation is the framework's emphasis on robust data systems enabling data driven and evidence-based programming. The system is based on key/prioritized indicators across all stakeholder categories, with clearly defined data sources, reporting frequencies, and responsibility centers. The Ministry of Health successfully completed design of a functional TPSR tracking system and dashboard aligned with the multi-sectoral TPSR framework, currently undergoing field pretesting in two learning Districts of Kamuli and Lamwo before National scale-up.

Multi-Sectoral Interventions

The Ministries of Education and Sports, Gender Labour and Social Development, and Health work in close partnership to address adolescent needs comprehensively. The Ministry of Education and Sports developed the National Framework on Education for Health and Life Skills through a robust multi-sectoral governance structure involving the Ministry of Health, the Inter-Religious Council of Uganda, and nine religious institutions, ensuring interventions respect cultural values. The Ministry of Gender Labour and Social Development coordinates the Uganda National Joint Adolescent and Youth Programme (UNJAYP), launched in August 2023, which brings together 13 UN agencies under shared governance structures including a National Coordination Committee and Inter-Ministerial Steering Committee. The Ministry of Health anchors this collaborative effort through the TPSR platform, serving as the National accountability mechanism that catalyzes collective action across all sectors. Two inter-ministerial coordination meetings in December 2024 and July 2025 secured high-level political commitment, with the platform engaging political and cultural champions including the First Lady and the Busoga King to drive social norms change across 30 onboarded districts.

District-level innovations and results

Uganda's sub-National entities have implemented innovative, context-specific interventions across multiple sectors. Health service innovations include Zombo's youth-friendly clinic days at four facilities, Oyam's CUAMM project establishing 11 youth-friendly spaces with trained peer educators and a free anti-violence hotline, Lamwo's expansion of youth-friendly service coverage, Lira and Bugiri's group-based antenatal care specifically targeting pregnant teenagers, and Budaka's integration of family planning into post-abortion care services. Education-focused interventions include Omoro's "talking compounds" in 56 schools creating safe spaces for adolescents to discuss taboo topics, Budaka's deployment of Journey

Plus curriculum in digital format with tablets and teacher training for learners aged 9-14, and Kole's "Debate for Development" competitions engaging over 25 schools. Community and cultural approaches include Lamwo's establishment of 72 parenting groups across seven sub-counties and Otuke's replication with 42 parenting groups, Namayingo's deployment of drama groups for community engagement, cultural reforms including Zombo's Alur Kingdom one-day traditional marriage ceremony policy and Busoga Kingdom's Kyabazinga certification requiring only 18+ for customary marriages, and Obongi's enrollment of adolescent mothers in alternative education and skills training programs.

Key findings and the teenage pregnancy data paradox

National analysis reveals a concerning paradox i.e. while teenage pregnancies as a proportion of all ANC1 visits have plateaued at approximately 19%, absolute teenage pregnancies have increased by 17% in the 30 high-burden TPSR districts between 2023/24 and 2024/25 performance periods, representing 14,865 additional pregnant teenagers. This means that although teenagers constitute a smaller percentage of all pregnant women, actual numbers of pregnant teenagers are on the rise across all regions, even above that 1,000 teenagers becoming pregnant daily Nationally.

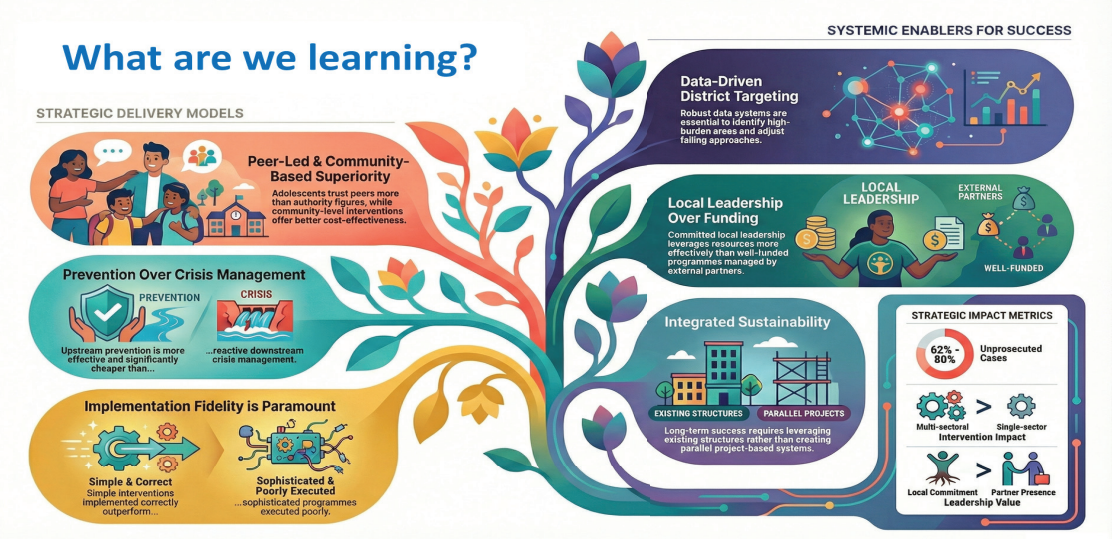
Critical barriers and challenges

Implementation faces critical systemic barriers including inadequate and unsustainable funding that forces districts to cancel outreaches and makes programs project-dependent, severe health worker shortages with some districts experiencing 61% staffing gaps leading to impossible workloads and burnout, geographic and infrastructure barriers affecting remote communities, and commodity stock outs of adolescent-preferred family planning methods that cause frustration and disengagement.

Data and service quality challenges severely hamper programming effectiveness. Incomplete and inconsistent data with districts reporting over 24 instances of missing critical indicators, fragmented sectoral data systems operating in silos across Health (DHIS2), Education (EMIS), and Community Services that make tracking adolescent journeys impossible.

Broader structural challenges require multi-sectoral solutions beyond health sector capacity, including a life skills education vacuum, school re-entry failure affecting 85-95% of pregnant girls due to stigma and economic constraints, prosecution failure with only 20-30% conviction rates undermining deterrence, and harmful cultural norms, parenting gaps, and economic vulnerability creating intersecting risks requiring structural transformation.

Lessons learned



Recommendations for scaling teenage pregnancy and child marriage prevention

1. **Strengthen localized data use and surveillance:** Districts cannot manage what they cannot measure; thus without actionable data systems tracking pregnancies at village level, interventions may become guesswork rather than data driven.
2. **Support the Scale up of promising practices and interventions:** Implementation fidelity determines success more than design; Budaka achieved ninety-five percent post-abortion care uptake while Omoro achieved zero percent with identical interventions.
3. **Influence school Environments through active talking compounds:** Schools provide critical platforms where adolescents spend significant time, yet traditional health education fails to address sensitive topics peers discuss effectively together.
4. **Adapt and scale-up tested approaches for adolescent parenting:** Poor parenting emerges as a universal root cause, yet Lamwo's systematic parenting groups achieved fifty-three percent dropout reduction by addressing communication gaps directly.
5. **Promote youth-friendly health services:** Adolescents avoid judgmental health facilities requiring parental consent; Lamwo's youth-friendly coverage correlates with double the family planning uptake compared to standard services.
6. **Roll out Education for Health and life skills framework:** Critical knowledge gaps drive risky behaviors when adolescents lack accurate information about reproductive health, consent, relationships, and consequences of early pregnancy.
7. **Increase meaningful male engagement and participation and social norms change:** Men function as perpetrators, decision-makers, gatekeepers, and role models; only four districts document systematic male engagement despite transforming gender relations requiring dedicated programming.
8. **Nurture community-led surveillance:** District-level data systems miss village-level realities where pregnancies occur. Community-owned surveillance creates early warning systems identifying potential and hidden pregnancies thus accelerating prevention.

Introduction and background

The financial Year 2024/25 has been a period of significant learning strides and renewed commitment in advancing the health and well-being of Uganda's adolescent population. As a Nation with one of the youngest demographics globally, where over 78% of the populace is under 30, our focus on the 10-19 age group is not merely a Health sector priority but a National imperative for achieving the demographic dividend. This report presents an overview of the Ministry of Health's activities, achievements, and lessons learned during the year, all directed towards ensuring our adolescents are healthy, empowered, and able to realize their full potential.

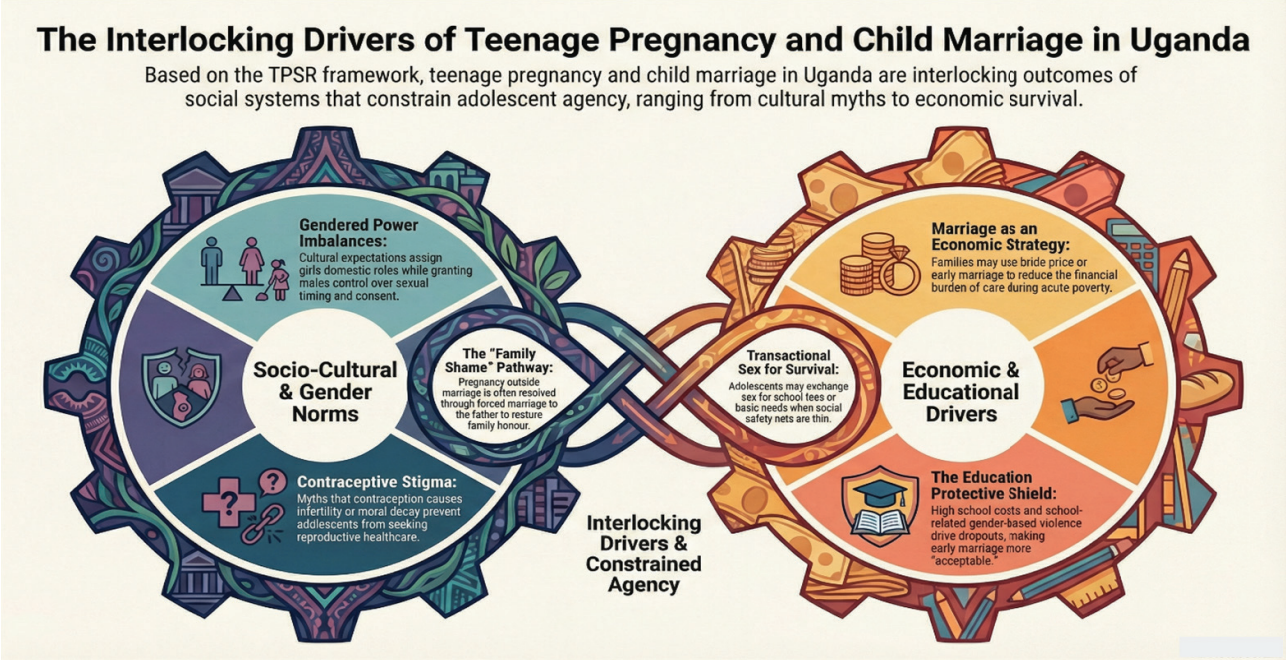
Our efforts remain firmly anchored in the strategic direction set forth by the National Adolescent Health Policy (2019) and its implementation blueprint, the National Adolescent Health Strategic Plan (2020-2025), the National Strategy to End Child Marriage and Teenage Pregnancy. This year marked a critical point of reflection as we passed the mid-term of the Strategic Plan, allowing us to assess progress against its ambitious targets and realign our interventions for the final stretch. This report, therefore, serves as a key accountability document, demonstrating how our work in FY24/25 directly contributes to the Plan's core pillars: improving sexual and reproductive health, reducing HIV transmission, addressing mental health, preventing substance abuse, and strengthening adolescent-responsive health systems.

According to UDHS 2022 report, by age 15-19, the proportion of women who are in union is higher than that of men by sixteen percentage points (17% versus 1%). Early marriage increases the risk of teenage pregnancy, which can have a profound effect on the health, lives of young women, and contribute to the country's high fertility rate.

Adolescents aged 10-19 years represent nearly a quarter of Uganda's population, making their health and well-being a critical determinant of the Nation's future. The Government of Uganda, through the Ministry of Health, has demonstrated its commitment to this group through the National Adolescent Health Strategic Plan (2020-2025) and the Teenage Pregnancy Surveillance and Response framework. This Annual Report for FY 2024/25 serves as a primary accountability mechanism, tracking progress and highlighting areas requiring intensified intervention. The findings within this document are intended to guide implementation efforts, guide targeting, accelerate community-level data use and influence resource allocation to ensure every adolescent can survive, thrive, and contribute to Uganda's development goals.

Social determinants of teenage pregnancy and child marriage

Teenage pregnancy and child marriage largely stem from intersecting social determinants rather than individual choices or knowledge deficits alone. Poverty drives fathers and father figures to marry off their daughters for bride price. It reduces perceived value of Girls' Education, gender inequality positions girls as commodities and limits their agency over bodies and futures. Harmful social norms normalize early marriage and adolescent childbearing while stigmatizing abstinence and contraceptive use. Educational barriers including school fees, distance, and poor quality push girls out of protective school environments; weak family structures leave adolescents without guidance or support; and systemic failures in health, justice, and protection systems create environments of impunity and vulnerability. According to the TPSR framework, the major entry-level social determinants of teenage pregnancy and child marriage are social cultural norms and traditions, social economic pressures, Education and gender bias - interlocked as illustrated as below:



Determinant category	Key factors and underlying pressures
Social-Economic pressures	• Financial Incentives: Fathers are influenced by bride price and dowry practices, creating a financial motivation to accept Early marriage. • Wealth & resource access: Marriage is viewed as a strategy to access resources through a husband's family or to reduce the domestic cost of caring for girls in poverty-stricken households. • Transactional Sex: Acute poverty leads to adolescents exchanging sex for basic needs, school fees, or transport, often with the tacit acceptance of adults in the community.

Determinant category	Key factors and underlying pressures
Social Cultural Norms and traditions	• Gendered Roles: Deeply rooted norms assign girls to early motherhood and domestic labour while valorizing • Male sexual control. • Family Shame: Pregnancy outside of wedlock is framed as a "family shame" that is frequently "resolved" by forcing the girl to marry the father of the child, regardless of her age or consent. • Contraceptive Stigma: Myths that contraception causes infertility or "corrupts" youth prevent adolescents from seeking help or using protection.
Education Access	• Economic Barriers: Unaffordable school fees, uniforms, and menstrual products lead to intermittent attendance and eventual dropout, making early marriage more culturally acceptable. • Safe Learning Spaces: School-related gender-based violence and punitive responses to pregnancy (such as expulsion) accelerate the transition from learner to wife. • Information Ecologies: A lack of practical reproductive health education and parental taboos leave adolescents reliant on social media and peers, which can facilitate misinformation.
Gender bias and constrained agency	• Power Imbalances: Significant inequality restricts a girl's ability to negotiate consent, the timing of sex, and the use of contraceptives. • Systemic SGBV: Sexual and Gender-Based Violence (SGBV) is both a result of power imbalances and a direct pathway into unintended pregnancies and forced unions. • Customary Resolutions: Local arbitration systems often prioritize family settlements and "restoring" family honour over legal justice for defilement cases.

These social determinants interlock to channel adolescents toward early unions and pregnancy, even when formal laws are in place to prohibit such practices. The impact of these factors varies by region, with rural areas often facing more restrictive gender norms and urban areas experiencing intensified pressures from transactional economies and digital media.

The Teenage Pregnancy Surveillance, and Response (TPSR) Framework)

The National Teenage Pregnancy Surveillance and Response Framework (TPSR) represents Uganda's first coordinated, multi-stakeholder effort to address the persistent challenge of teenage pregnancy and child marriage. Developed by the Ministry of Health's Adolescent and School Health Division with support from UNFPA, this framework establishes a comprehensive system for surveillance, response, and accountability aimed at substantially reducing teenage pregnancy from the current 24% to 15% by 2030.

Uganda faces a critical adolescent health crisis. Despite minimal progress over the past decade, with teenage pregnancy rates declining by only 1% from 25% in 2016 to 24% currently, Uganda is among the top 20 countries with the highest rates of teenage pregnancy and child marriage globally. This stagnation occurs despite Uganda's demonstrated capacity to reverse adverse health trends, most notably the remarkable reduction in maternal mortality ratio from 336 to 189 per 100,000 live births between 2016 and 2022.

The scale of the problem is substantial. Twenty-four of every 100 girls between ages 15 and 19 have become pregnant at least once, with regional variations showing Eastern Uganda experiencing the highest prevalence at 25.6%. Teenage pregnancy contributes disproportionately to 20% of infant deaths and 28% of maternal deaths.

Just within the past year alone, about **1,154** girls were getting pregnant each single day in Uganda, bringing the total teenagers reporting pregnant at ANC1 during the year to 421,274. The TPSR was conceived as one of the pillars to contribute in addressing this problem.

Rationale:

The TPSR Framework is driven by compelling evidence of the devastating consequences of failing to address teenage pregnancy. According to UNFPA's 2019 Cost of Inaction study, without intervention, the percentage of girls at risk of child marriage and teen pregnancy will rise by 50% annually. Furthermore, 64% of teenage mothers face the risk of not completing primary education, with 60% ending up in peasant agriculture due to their inability to complete schooling and access viable employment.

The financial burden is staggering. In fiscal year 2019/2020, teenage pregnancy accounted for 43% of all health expenditure, with Government spending projected to peak at UGX 645 billion (US$182 million) annually over five years on healthcare for teenage mothers and education for their children. Families of teenage mothers spent UGX 1.2 trillion (US$290 million), while health expenditure specifically on teenage mothers reached UGX 246.9 billion (US$70 million).

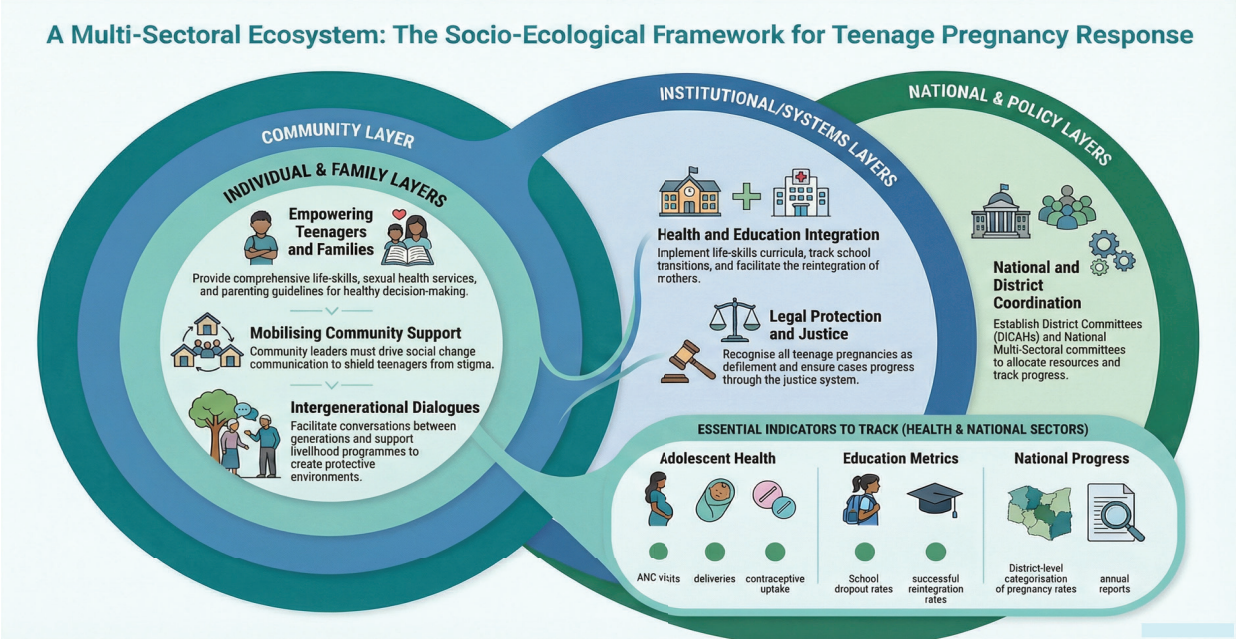
Potential benefits of action:

Conversely, the potential rewards of successfully implementing the framework are transformative. By curtailing child marriage and teenage pregnancy, Uganda could realize welfare benefits of US$2.4 billion by 2030 through reduced annual population growth rates. Women who delay marriage and complete school could earn potential wages of UGX 1.922 trillion (US$514 million) annually. Additionally, achieving Universal Secondary Education targets for girls could generate budget savings of US$257 million by 2030 in Government education expenditure.

Beyond economic considerations, addressing teenage pregnancy tackles fundamental issues of social injustice, gender-based violence, and development failures. Girls aged 15-19 years face twice the risk of death during childbirth compared to women over 20, while pregnant adolescents experience higher risks of eclampsia and other complications. The framework recognizes that when individuals exercise informed choice over their health, bodies, and futures, they contribute to more prosperous societies and a more sustainable, equitable world.

Primary objective of the TPSR

The primary objective of the TPSR framework is to reduce the National Teenage Pregnancy rate from 24% to 15% by 2030, in alignment with strategies in Uganda's 4th National Development Plan (NDP IV) covering fiscal years 2025/26 to 2029/30. The framework establishes specific objectives for each stakeholder group within the teenage pregnancy ecosystem as below:



TPSR implementation approach:

The TPSR framework establishes and operates under a multi-level implementation structure spanning from Household to National level. Here is a narrative description of the different levels where implementation and actions take place.

1. **National Level:** Two committees provide governance, i) the National Multi-Sectoral Coordination Committee of Ministers for political and technical guidance, and ii) the Inter-Ministerial Technical Committee of Permanent Secretaries for technical oversight, coordinating with the National Child Well-being Inter-Ministerial Committee. A key innovation of the TPSR Framework is its emphasis on robust data systems enabling evidence-based programming. The framework establishes 30 prioritized indicators across all stakeholder categories, from Household to NNational level, with clearly defined data sources, reporting frequencies, and responsibility centers. Data flows systematically from individual/household level through VHTs and community health workers using the Electronic Community Health Information System (eCHIS), the LCs through the LC1 Adolescent registration and surveillance tools, Para social workers, through sub-county and district levels via DICAHs and Child Wellbeing Committees, ultimately reaching NNational authorities through DHIS2, National surveys, and administrative reports. This data infrastructure enables targeting of high-burden areas, assessment of intervention effectiveness, celebration of successes, and adjustment of failing approaches.
2. **District/City Level:** District Councils, through DICAHs and District Child Wellbeing Committees, must synthesize data and reports for evidence-based decision-making, planning, and budgeting, working alongside statutory committees and the District Youth Councils.
3. **Sub-County/Town Council/Division Level:** Child Wellbeing Committees, chaired by Senior Administrative Officers with Community Development Officers as secretaries, synthesize reports from parishes, schools, health facilities, and police stations.
4. **Parish/Ward Level:** Leveraging the Parish Development Model, this level

replicates services from the sub-county level, ensuring grassroots service delivery.

5. **Village/Cell Level:** LC I/village authorities, secretaries for children, community health workers, VHTs, and para-social workers maintain records, do surveillance of teenage pregnancies and child marriage, and report on related cases.
6. **Household Level:** Parents, guardians, and teenagers participate in programs that advance positive living (e.g. adolescent parenting programs, norms change activities, income generation), ensure school continuation and completion, practice positive social-cultural norms and engage responsively with rights protection efforts.

Joint interventions at National level

The TPSR is coordinated from the National Level, and the key actors are Ministry of Health (MOH), Ministry of Gender Labour and Social Development (MGLSD), Ministry of Local Government (MOLG), Ministry of Justice and Constitutional Affairs (MOJCA) and Ministry of Education and Sports (MOES). Through the TPSR coordinating mechanism, all the 5 ministries have key role to play and are intervening collectively to address teenage pregnancy and child marriage.

Joint interventions and activities

1. **Joint technical support visits together with MOH in Namayingo**: Ministries conducted joint technical support visits to Namayingo District, bringing together officials from Health, Education, Gender, and Local Government to assess multi-sectoral TPSR implementation. These collaborative supervision missions assessed service delivery across Health Facilities, schools, and community structures, identifying gaps and strengthening integrated interventions.

2. **Co-chairing the weekly TPSR learning and sharing meetings at National level**: Establishing a regular platform was vital for cross-sectoral dialogue and adaptive management. Technical officers from Health, Education, Gender, Local Government, and Justice sectors convened alongside implementing partners to review district performance data, document emerging innovations like Budaka's 95% post-abortion care family planning integration, and address implementation bottlenecks including commodity stockouts and data quality challenges. This co-chaired forum transformed coordination from periodic high-level meetings into systematic joint problem-solving forums, ensuring continuous learning and shared accountability for teenage pregnancy reduction.

3. **Joint planning for TPSR implementation for the learning districts**: The different ministries and stakeholders worked jointly to support Kamuli and Lamwo District teams to develop district-specific TPSR action plans with shared indicators, and integrated interventions spanning health facilities, schools, and communities. This ensured that the TPSR implementation is aligned with all relevant National level policies and frameworks.

Ministry specific interventions

Ministry of Local Government interventions and role

- The Ministry of Local Government (MoLG) coordinates Uganda's TPSR across 176 local governments by establishing governance frameworks, managing human resources, and overseeing planning, budgeting, and revenue mobilization at local levels.
- MoLG continued providing oversight through inspection, supervision, and mentoring to ensure efficient service delivery. It promotes socio-economic transformation and democratic governance while facilitating NNational programs like the Parish Development Model and critical health initiatives including TPSR.
- The Ministry provided timely guidance, monitoring, policy development, capacity building, project implementation, coordination, harmonization, and

decentralized development, thereby contributing to collective strengthening of grassroots TPSR implementation efforts and service delivery across all local governments.

Ministry of Education and Sports (MOES) interventions and role

- Under the Uganda Secondary Expansion Project (USEEP), MoES conducted a baseline assessment on violence against children (VAC) and re-entry of child mothers. The baseline identified key drivers of violence as economic hardship (93% of secondary students; 82% TVET); Peer pressure (54% secondary; 49% TVET); Parenting gaps (37% secondary students; 57% administrators); harmful cultural norms and drug and alcohol abuse. The assessment identified the key perpetrators of violence against children as fellow students (over 30% of all forms), Teachers (27% of physical violence in secondary schools), Community members (68.8% of sexual violence) and parents (85% of economic violence).
- The Ministry of Education and Sports developed the National Framework on Education for Health and Life Skills (NFEHLS), aimed at addressing adolescent health and sexual reproductive issues while responding to stakeholder concerns about language, content, age-appropriateness, and roles for parents, religious, and cultural leaders. A multi-sectoral Governance structure guides implementation, with a technical core team from MoES, MoH, and IRCU, a taskforce including MoGLSD and MoLG; and a Steering Committee with Cabinet Ministers ensuring high-level political commitment.
- By addressing knowledge gaps, inadequate life skills, limited parental guidance, peer pressure, and GBV through coordinated, culturally sensitive education, NFEHLS supports Uganda's strategy to end teenage pregnancy and child marriage - but requires sustained commitment, adequate financing, and continuous monitoring for measurable results.

Ministry of Gender Labour and Social Development (MGLSD) interventions and role

- Uganda National Joint Adolescent and Youth Programme (UNJAYP), a flagship initiative to unlock adolescent and youth potential through coordinated multi-sectoral action is being implemented, with the Ministry of Gender, Labour and Social Development (MGLSD) serveing as the coordinating lead ministry, ensuring government ownership and alignment with NNational Development plans and strategies.
- UNJAYP established robust governance structures including a National Coordination Committee, Inter-Ministerial Steering Committee, and functional secretariat team that meets regularly with outcome leads. Two National Coordination Committee meetings approved Terms of Reference for governance structures, while the first Inter-Ministerial Steering Committee meeting in August 2024 secured high-level political commitment. The programme rolled out to eight focus districts through comprehensive orientation sessions, where district-level action plans were developed with local stakeholders.
- The programme directly contributes to teenage pregnancy and child marriage prevention through coordinated interventions across multiple outcome areas: life skills education; sexual and reproductive health services; economic empowerment and skills development; gender-based violence prevention; and strengthened child protection systems through multiple UN agencies. This integrated approach recognizes that preventing early pregnancy and marriage requires simultaneously addressing education access, economic alternatives, harmful social norms, and protection mechanisms.

- **Busoga Kingdom's Bold Intervention – "Abasaadha Ne'Mpango":** Busoga Kingdom has emerged as a pioneering case study in culturally-rooted efforts to preventing teenage pregnancy. In May 2025, His Majesty William Wilberforce Gabula Nadiope IV, the Kyabazinga of Busoga, launched "Abasaadha Ne'Mpango" (Men are the Pillars), a campaign that reframes teenage pregnancy from a women's issue to a shared responsibility requiring active male engagement. Serving as UNAIDS Goodwill Ambassador, the Kyabazinga

convened students, teachers, district officials, and partners including UNAIDS, UNICEF, and UNFPA at the Igenge Royal Palace Grounds in Jinja City to forge a strategic partnership addressing the root causes of teenage pregnancy i.e. poverty, inadequate parental involvement, and limited access to reproductive health services. The country indeed cannot end teenage pregnancy without confronting the silence of men. ***Men must be present, protective, and proactive.*** The campaign's power lies in its dual approach, repositioning men as protectors of girls' potential while mobilizing entire communities through cultural accountability structures. As one secondary school girl testified at the launch, "We want to learn. We want to become doctors, teachers, leaders. But we need protection from our communities, and especially from the men who are supposed to guide us." "Abasaadha Ne'Mpango" offers critical lessons for adaptation by other cultural leaders and regions and National scale-up since it is now clear that teenage pregnancy is not merely a Health issue, but a development crisis, a gender equality issue, and a barrier to realizing the full potential of girls and society.

Ministry of Justice and Constitutional Affairs (MOJCA) interventions and role

- The Ministry of Justice and Constitutional Affairs positioned itself neatly, to amplify the protection lens of Uganda's TPSR framework, recognizing all teenage pregnancy as defilement under law. The Ministry implements dual approaches i.e. prevention through victim protection and apprehension through perpetrator prosecution, requiring systematic case identification, documentation, and progression through the justice system to create deterrence.

- Implementation faces significant challenges undermining justice sector protection. During 2023/24-2024/25, only 20-30% of reported defilement cases reached conviction, with processing averaging 8+ months, creating impunity that emboldens perpetrators and discourages survivors. However, high-performing districts like Lamwo achieved 100% case submission and 50% prosecution rates through better coordination between police, health facilities providing medical evidence, prosecutors, and community support structures, demonstrating achievable improvement.

- Without a functional justice sector accountability, prevention efforts across health, education, and community sectors remain fundamentally compromised, as perpetrators operate without fear of consequences and communities lose confidence in formal protection systems.

Ministry of Health interventions and role

- The Ministry of Health's Teenage Pregnancy Surveillance and Response (TPSR) platform is a National accountability mechanism designed to combat teenage pregnancy and child marriage. Guided by the TPSR Framework and the Adolescent Health Costed Implementation Plan, this multi-sectoral initiative integrates health, education, local government, and justice sectors.

- A key milestone is the launch of a digital TPSR tracking system and dashboard, which provides real-time data from local leaders, schools, and police. Currently, 30 districts are onboarded, with Kamuli and Lamwo serving as primary learning sites. These districts will pilot system performance and data quality before a National scale-up.

- High-level political commitment was secured through inter-ministerial meetings (2024–2025), strengthening collaboration across frontline ministries. By targeting high-burden regions and challenging harmful social norms, the TPSR model utilizes a systems approach to ensure evidence-based interventions reach the most vulnerable adolescents.

District level interventions

Uganda's sub-National entities have pioneered diverse, context-specific interventions that demonstrate creativity, cultural responsiveness, and evidence of measurable change. This synthesis presents unique innovations emerging from districts and regions, offering replicable models for National adaptation, scaling and spreading systematically.

District-level Health sector interventions:

Multiple districts developed specialized adolescent service delivery approaches. Zombo District established youth-friendly health services with dedicated clinic days at four health facilities, creating stigma-free environments through age-segregated provision. Oyam District implemented the CUAMM "Don't Stop Me Now" Project, featuring 11 youth-friendly spaces with recreational materials, 14 trained peer educators, a free anti-violence hotline receiving 75 calls reporting 63 GBV cases in nine months, and 2,281 VHT door-to-door visits reaching 16,678 community members. Lamwo District achieved 69% youth-friendly service coverage (11 of 16 facilities), correlating with high adolescent family planning uptake at 21.2% of new users—nearly double Omoro's 11% rate.

Improvement in post-abortion care and family planning integration; with 80-95% uptake rates. Budaka Town Council exemplifies best practice with 98-99% PAC-family planning uptake, near-universal integration across all facilities preventing rapid repeat unintended pregnancies. This contrasts starkly with regional averages of 0-27% uptake, demonstrating that systematic integration is achievable even in resource-constrained settings.

Community-based service delivery: For family planning services, Namayingo, Kamuli, Amuru, Kapelebyong, Adjumani and Lamwo are good examples of Districts that deployed Village Health Teams to accelerate community-based sevice delivery. Amuru District mobilized 1,200 VHTs for adolescent health messaging and referrals. Kole District implemented continuous VHT home visit models integrated with peer-led community engagement and family planning distribution.

District-level Education sector interventions

Talking Compounds in Schools: Omoro District created "talking compounds" in 56 schools—designated safe spaces where teenagers openly discuss taboo topics including puberty, relationships, sexuality, contraception, and violence. The innovation requires no new infrastructure, just designated space, trained teachers, and scheduled discussion time, suggesting high scalability potential.

Digital Sexual and reproductive health education: Budaka District pioneered the Journey Plus curriculum in digital format, equipping schools with tablets and training 20 teachers on rollout to learners aged 9-14. This early intervention targets children before high-risk ages, using engaging digital content to deliver comprehensive health education and life skills. Technology offers proven pathways to increasing scale and access.

School Debate Competitions: Kole District implemented "Debate for Development" competitions on teenage pregnancy prevention, exceeding targets by engaging students in over 25 schools. The model leverages adolescent energy and competitive spirit, shifts peer norms through student-led discourse, creates minimal cost but high engagement, and sustains through school clubs without external funding. This adolescent-led intervention builds girl-child agency and boy-child responsibility.

Menstrual hygiene management programs: Multiple districts addressed menstruation-related school dropout. For example, Butaleja District trained 200 girls in making reusable pads and liquid soap, combining practical skills with school retention strategies. Budaka District implemented similar interventions. These address the explicitly cited barrier of inadequate menstrual products driving school absence and eventual dropout.

District-level Community based services

Parenting models Male action groups: Lamwo District established 72 parenting groups across seven sub-counties, bringing parents together monthly to discuss parenting ideas for raising and protecting teenagers. Results included 53% school dropout reduction (676 to 314 students in six months), progressive increase in child marriages (3 to 5 to 7 progressively), and girls' re-entry into school increasing from 2.1% to 12.3%. Otuke District achieved almost on similar scale with 42 parenting groups engaging 1,680 parents, demonstrating replicability. Strategic partners implementing parenting programs include Child Health and Development Centre with Parenting for Respectability, Somero Uganda implementing REAL Fathers approach (For

young fathers 18-25), Bantwana Initiative Uganda implementing SAFE in our Hands parenting program and Fidelitas Scientific Execution Facility with their tailored Ateker REAL Fathers Adolescent Parenting approach.

Para-social worker networks: Otuke District engaged 468 para-social workers meeting quarterly (296 males, 172 females), reaching 885 adolescents through community dialogues. This model harnesses educated but unemployed youth, builds local capacity, provides community-level surveillance and case management, and creates sustainable local structures.

Drama-based community mobilization: Namayingo District deployed drama groups performing at public events, reaching 754 people in a single Women's Day celebration—15-fold more efficient than typical community dialogues reaching 30-50 people. This edutainment approach overcomes literacy barriers, creates emotional impact, and provides culturally resonant messaging.

Cultural institutions are being engaged for transformation. Zombo District's Alur Kingdom established one-day traditional marriage ceremonies to limit time that often leads to sexual acts, reducing economic incentives for families to marry daughters early. In Kapelebyong and Amuria, Fidelitas Scientific Execution Facility worked with Iteso Cultural Union adapting Ateker REAL Fathers Adolescent Parenting approach. Luuka District worked with Busoga Kingdom implementing certification requirements mandating individuals be 18 years or older to have customary marriage certificates from the Kingdom. The Kingdom operates Ekisagati youth camps conducting annual camps for adolescents ages 13-17 focusing on life skills, and provides education scholarships through the Kyabazinga Education Scheme.

Alternative education, skilling and social-economic support: Obongi District enrolled 345 adolescent mothers in alternative education and skilling programs, achieving approximately 60% re-entry rate. The district graduated 140 teenage mothers from skills training in tailoring, weaving, bakery, salon, and hairdressing in January 2025. Many districts established adolescent VSLA groups linked to Youth Livelihood Program, Uganda Women Entrepreneurship Program, and Parish Development Model for capital access.

District-level interventions for Justice law and order

Namayingo District conducted proactive child marriage rescue operations, counseling and rescuing 4 girls from forced marriages. Lamwo District achieved superior justice outcomes with 100% submission of defilement cases to prosecutors and 50% reaching court prosecution—doubling Omoro's 26% rate, suggesting better coordination between police, health facilities, prosecutors, and community supporters.

Results on teenage pregnancy prevention and response

This section presents a comprehensive analysis of the National Teenage Pregnancy Surveillance and Response (TPSR) framework, examining multi-sectoral performance across key indicators that intersect with teenage pregnancy and child marriage. While antenatal care visits serve as the primary proxy indicator for measuring teenage pregnancy trends, the analysis extends to a broader assemblage of Adolescent Health metrics that are linked. These include data on adolescent utilization of outpatient department services, incidents of gender-based violence among adolescents, adolescent mental health outcomes, and prevalence of sexually transmitted infections, adolescent deliveries, and adolescent mortality. Together, these programmatic and thematic areas provide a holistic view of the factors contributing to and resulting from teenage pregnancy and child marriage, enabling a more nuanced understanding of the multi-dimensional challenges facing adolescents and the need for complexity aware interventions across sectors.

Adolescent outpatient department attendance

The trend in OPD attendance has been

slightly declining over the last three years from 21.6% in 2022/23 to 20.5% in 2024/25 period. This could suggest improved health and therefore no need to visit health facilities, a stronger community health system for adolescents or an increasingly poor health seeking behaviours among adolescents. A regional comparison across the current TPSR targeted districts shows that the Northern, Northwestern and North Eastern regions have the highest Adolescent OPD attendance rates as per figure 1 and table 1 below.

Figure 1: Trends in proportion of OPD attendance aged 10-19 years-National

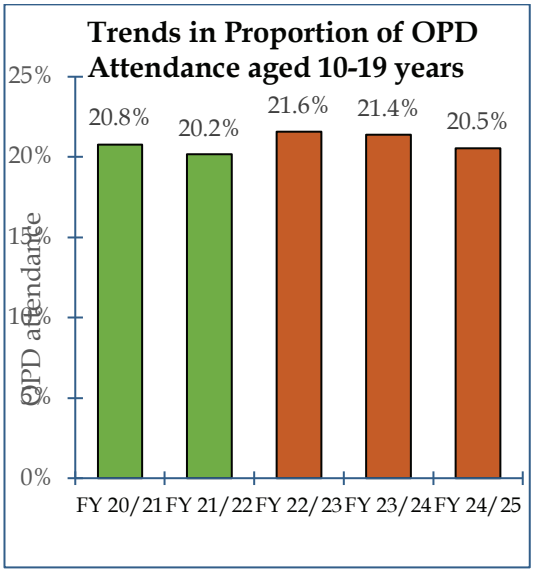


Table 1: Trend in proportion of OPD attendance (10-19) by region

Region	FY 22/23	FY 23/24	FY 24/25
Acholi	26.8%	26.3%	24.8%
Bugisu	21.0%	20.1%	20.0%
Bukedi	22.7%	21.4%	21.7%
Bunyoro	22.1%	22.5%	22.2%
Busoga	19.7%	20.5%	20.1%
Lango	25.4%	25.7%	24.6%
Teso	26.4%	26.6%	25.7%
Tooro	21.2%	21.9%	20.6%
West Nile	26.3%	26.8%	25.0%
National	21.6%	21.4%	20.5%

These regional variations suggest differences in healthcare access, health-seeking behavior, or the underlying burden of adolescent health issues. The slight decline and general stability at the National level, despite some regional increases and decreases, indicates that systemic factors influencing adolescent OPD utilization have remained largely consistent over this period

Adolescent antenatal attendance

Nationally, over a five-year period, the percentage of adolescents attending ANC 1 has ranged between 19%-20% of the total ANC 1 visits – suggesting a persistent stagnation in terms of reducing adolescent pregnancies as illustrated in figure 1.

Antenatal first visit rates among adolescents in Uganda show significant regional variation but a consistent National decline over the five-year period, from 19.5% in FY 20/21 to 18.2% in FY 24/25. Regions like Lango, Bukedi, and Bugisu consistently reported the highest proportions of adolescent first-time attendees, with Lango peaking at 26.8%, while Kampala had by far the lowest rate, remaining below 8.8% throughout all fiscal years. Most regions, including the high performers, experienced a general downward trend in these rates after FY 21/22, contributing to the overall National decrease and indicating a potential reduction in adolescent pregnancies or shifts in service uptake across the country

Table 2: The burden of teenage pregnancy based on 1st Antenatal visit by Region

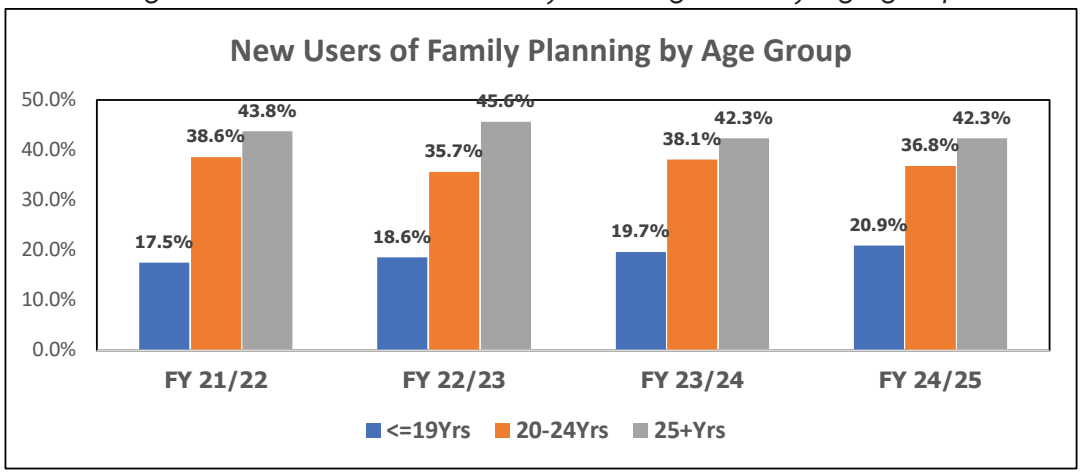
Region	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Acholi	21.9%	22.8%	21.3%	19.9%	19.8%
Ankole	14.4%	14.4%	13.3%	13.0%	13.3%
Bugisu	24.0%	24.1%	22.4%	22.3%	21.4%
Bukedi	25.3%	25.1%	23.0%	22.7%	22.1%
Bunyoro	21.7%	22.1%	20.8%	21.0%	20.9%
Busoga	22.0%	22.4%	21.2%	21.3%	20.9%
Kampala	7.5%	8.2%	7.7%	7.8%	7.8%
Karamoja	14.4%	16.0%	13.4%	13.6%	14.3%
Kigezi	15.4%	15.4%	13.9%	14.2%	14.6%
Lango	26.4%	26.8%	23.3%	23.6%	23.3%
Teso	23.5%	23.8%	20.7%	20.7%	20.4%
Tooro	20.5%	21.3%	20.0%	19.7%	19.8%
West Nile	20.8%	21.5%	21.5%	21.6%	20.8%
South Buganda	15.6%	15.5%	14.9%	14.4%	14.0%
North Buganda	18.0%	18.2%	17.6%	17.1%	16.6%
Grand Total	**19.5%**	**19.8%**	**18.5%**	**18.4%**	**18.2%**

Adolescent Family planning uptake

Access to comprehensive family planning services is fundamental to preventing both teenage pregnancy and child marriage by empowering adolescents with reproductive autonomy and expanding their life choices. When young people receive age-appropriate contraceptive information and services, they can delay sexual debut, prevent unintended pregnancies, and resist pressures toward early marriage. Families are less likely to marry off daughters when effective family planning enables smaller family sizes and reduces economic strain, while adolescents with reproductive health knowledge gain negotiating power over marriage timing. Youth-friendly family planning programs that address stigma and accessibility barriers enable teenagers to pursue education and economic opportunities, making early marriage less appealing.

Data shows that adolescents new to family planning methods increased by 1.2 percentage points between 2022 and 2023 as indicated in figure 2.2 below.

Figure 2.2: Trends of New family Planning users by Age group



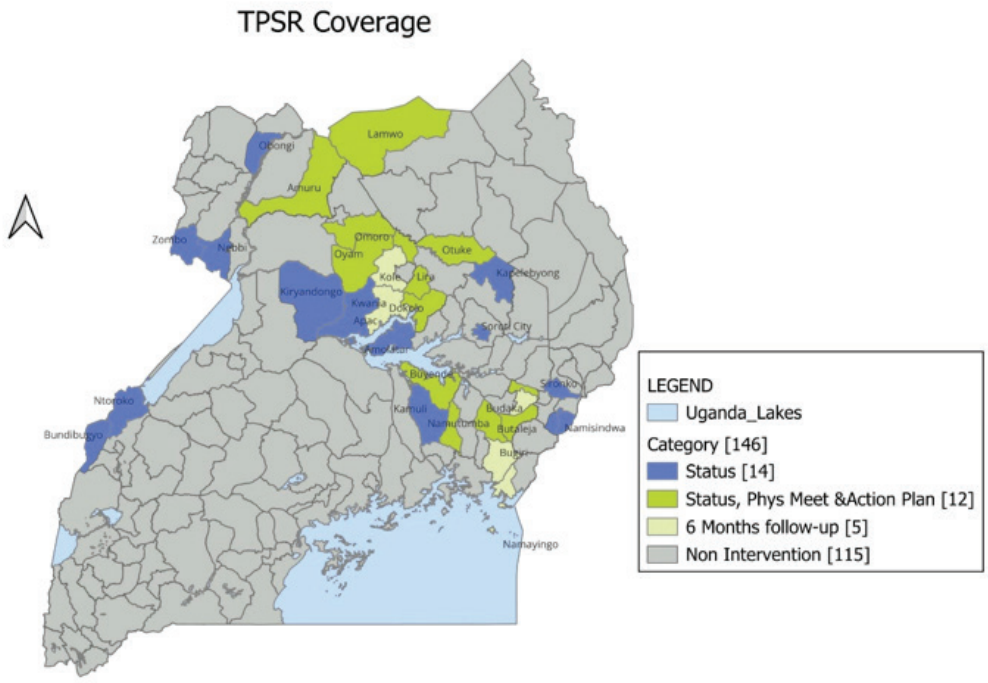
Teenage pregnancy rates in the 30 high burden districts of Uganda

The Teenage Pregnancy Surveillance and Response (TPSR) secretariat undertook a deliberate and strategic selection process, identifying 30 high burden districts distributed across 9 distinct sub-regions of Uganda, namely Teso, Bunyoro, Tooro, Busoga, Bukedi, Bugisu, West Nile, Lango, and Acholi. The designation of these districts as "high burden" reflects the fact that they carry a disproportionately heavy load of public health, socio-economic, or developmental challenges relative to other parts of the country, making them priority areas for targeted intervention.

In epidemiology and public health science, concentrating resources where a problem is most densely concentrated allows for the greatest potential reduction in absolute numbers, meaning that even modest percentage improvements translate into significant real-world gains for large numbers of people. High prevalence settings also provide the statistical power necessary to rigorously detect, measure, and attribute change to specific interventions, which is essential for building a credible evidence base.

Furthermore, if a multi-sectoral intervention model proves effective under the most challenging conditions, where social, economic, and systemic drivers of teenage pregnancy are most deeply entrenched, it validates the robustness and transferability of the approach to lower burden settings. This hotspot-first approach therefore serves a dual purpose: it delivers immediate, concentrated impact where it is most urgently needed, while simultaneously generating the scientific evidence and refined implementation lessons required to responsibly scale the intervention across broader populations.

Map of Uganda showing the 30 teenage pregnancy high burden Districts

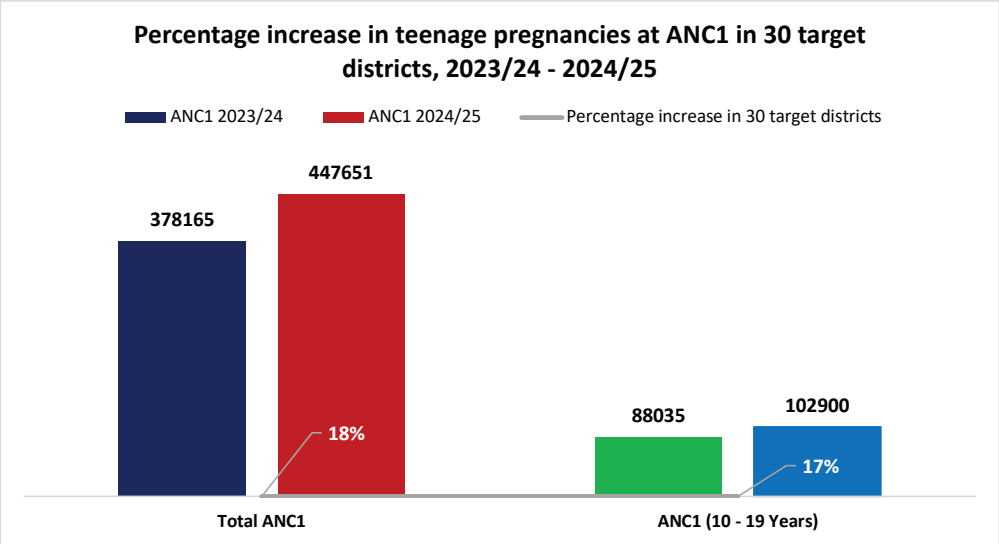


Across all the target high burden regions, we have noted a data paradox of declining rates but increasing absolute teenage pregnancies.

A comparative analysis of the ANC 1 in the 30 high burden districts enrolled for the TPSR program indicates a 17% (n=14,865) increase in teenage pregnancies between 2023/24 and 2024/25 performance periods. This suggests that while the teenage pregnancies as a proportion of all ANC 1 visits have plateaued at 19%, the absolute teenage pregnancies have increased by 17%.

This is the first output computed based on the TPSR data and dashboard linked to the DHIS2 as seen in figure 3 below.

Figure 3: Percentage increase in ANC1 (Total) and ANC1 (10-19) in TPSR target districts

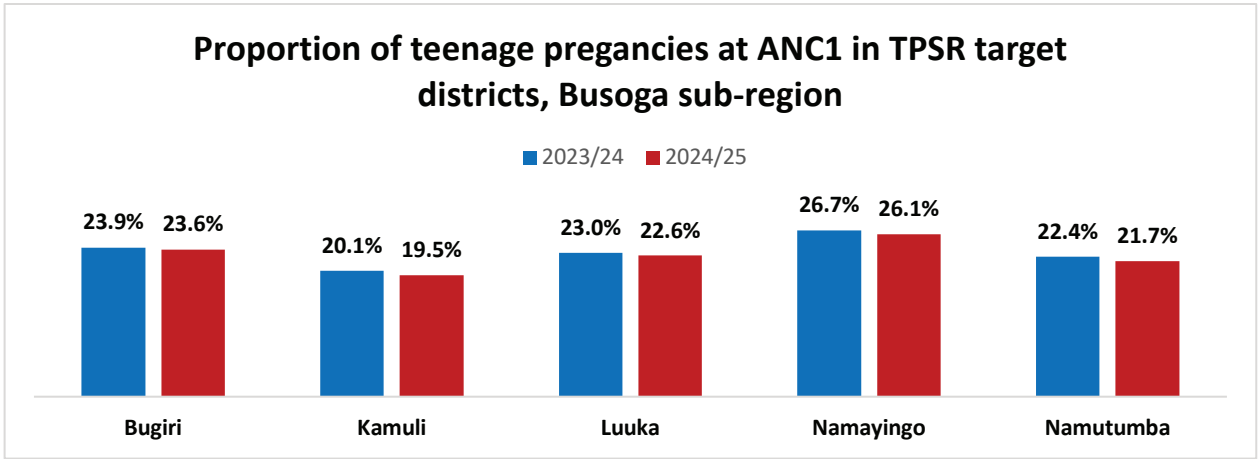


The teenage pregnancy rates are declining as a percentage of all pregnant women attending health facilities, which appears positive. However, the absolute number of pregnant teenagers is actually increasing across the regions. **The good news** is that teenagers make up a smaller slice of the ANC1 pie. **The concerning news** is that there are more pregnant teenagers in total numbers than before. Therefore, with the rollout of TPSR implementation, our focus moving forward will be focusing more at reducing the absolute number of teenagers getting pregnant. Below is the district comparative analysis of teenage pregnancy rates versus absolute numbers per target region.

Teenage pregnancy in target Districts of Busoga sub-region

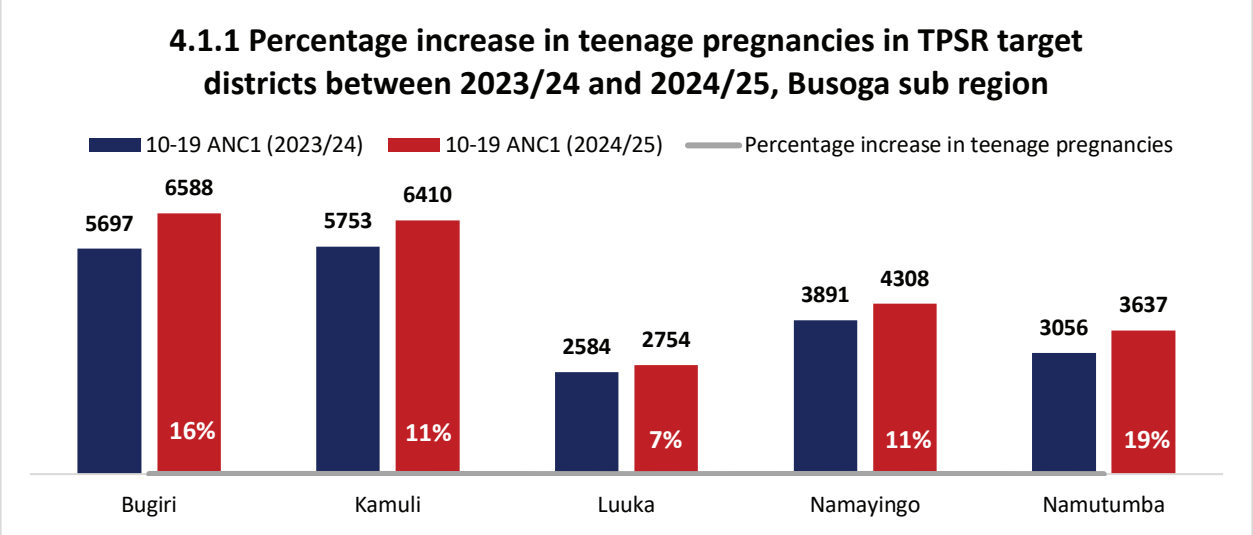
An analysis by proportion reveals that Namayingo has the highest proportion of ANC1 visits by teenager (26.1%) and Kamuli has the lowest (19.5%). Across all the districts in Busoga, the teenage pregnancies at ANC1 are experiencing a slight decline as illustrated in figure 4.1 below.

Figure 4.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Busoga



Generally, there is no significant shift in the teenage pregnancies at ANC1 as a proportion of the total ANC1 visits across the 5 target districts.

However, a granular and focused comparative analysis of the teenage pregnancies between the 2023/24 period and 2024/25 period of TPSR introduction reveals that the absolute teenage pregnancies are increasing as seen in figure 4.1.1.

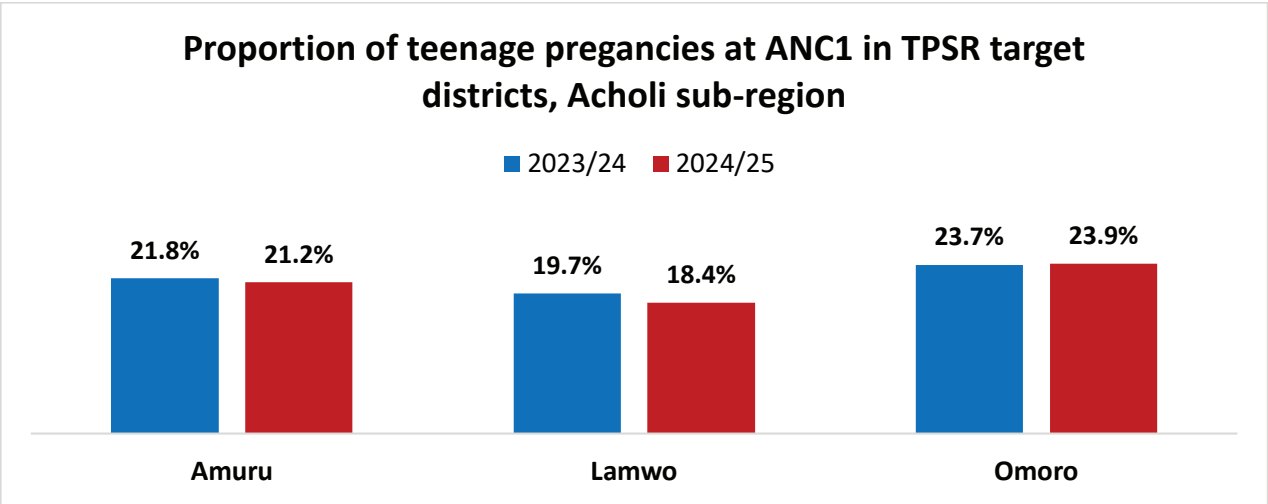


Based on the above analysis, Namutumba is experiencing the biggest percentage increase in teenage pregnancies of 19%, while Luuka district experienced the lowest increase of 7%.

Teenage pregnancy in target Districts of Acholi sub-region

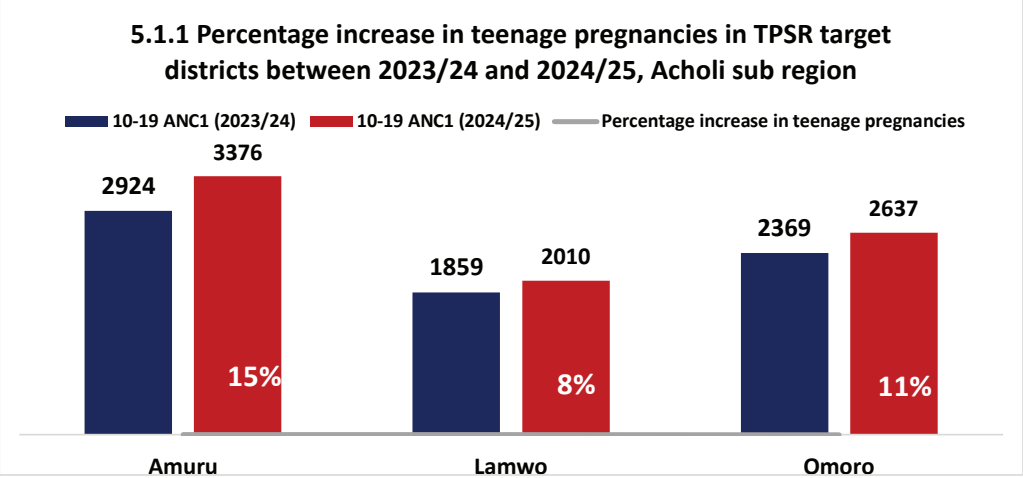
In Acholi sub-region, the teenage pregnancies as a proportion of all ANC1 visits also reduced slightly or remained stagnant – hence teenagers constitute a small and declining or static proportion between 2023/24 and 2024/25. As seen earlier, several interventions are being implemented in Acholi. Figure 5.1 shows that Lamwo has the lowest and fast declining proportion of teenage pregnant adolescents at 18.4%, while Omoro has the highest and slightly increasing proportion at 23.9%.

Figure 5.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Acholi



However, a comparative analysis and estimation of percentage increase in teenage pregnancies based on absolute numbers indicates that all 3-targeted districts are experiencing an increase in teenage pregnancies, with Amuru having the highest percentage increase in teenage pregnancies

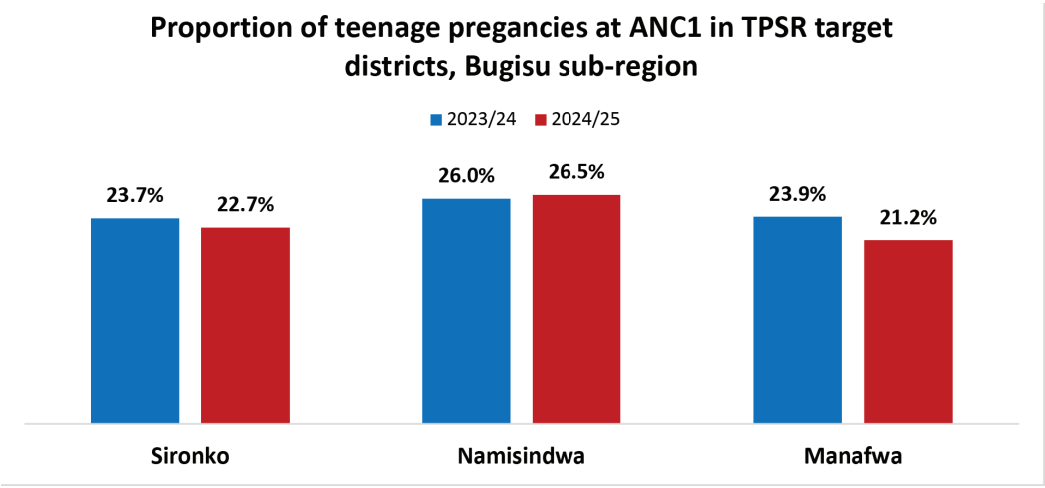
(15%) and Lamwo with the lowest at 8%. This is illustrated in figure 5.1.1 below.



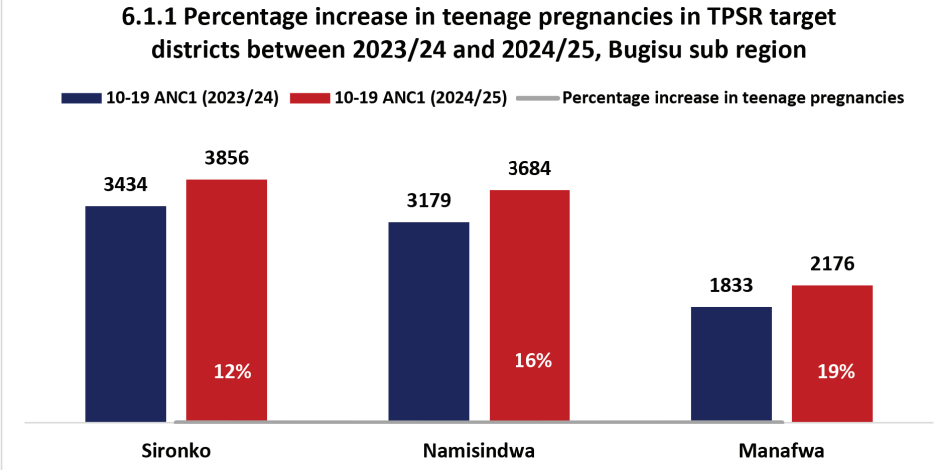
Teenage pregnancy in target Districts of Bugisu sub-region

In Bugisu sub-region, Namisindwa has the highest teenagers as a proportion of all ANC1 visits in 2023/24 and 2024/25 periods. Manafwa has the biggest reduction in the proportion of teenage ANC1 visits, reducing by 2.7% points between 2023/24 and 2024/25 as illustrated in figure 6.1

Figure 6.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Bugisu



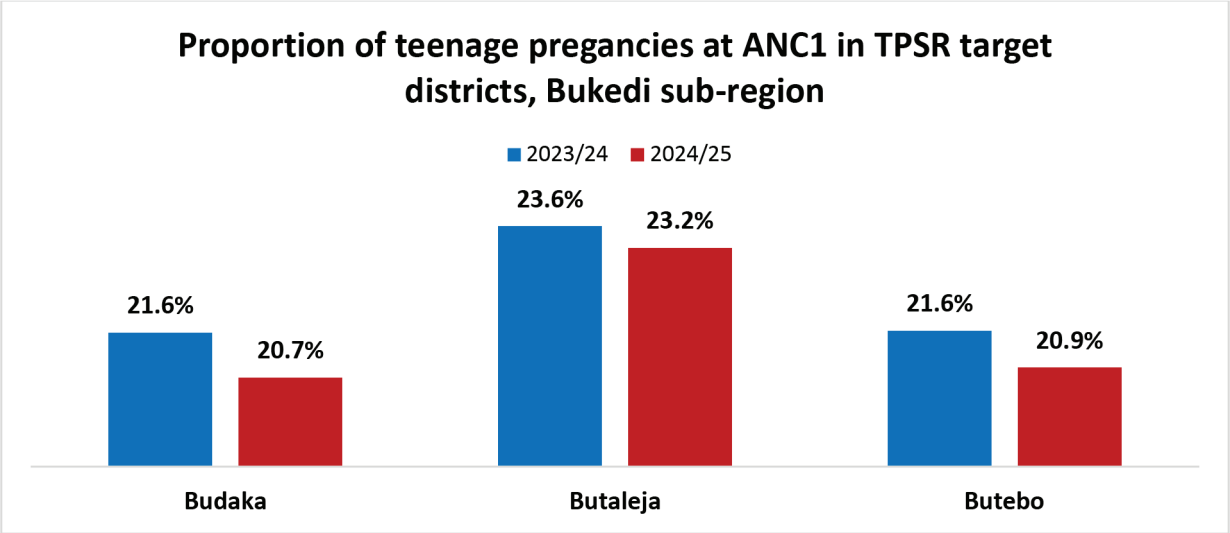
A granular look at teenage pregnancies in absolute numbers reveals that all target districts in Namisindwa are experiencing an increase in teenage pregnancies with Manafwa having the highest percentage increase of 19%, Namisindwa at 16% and Sironko district at 12% as per figure 6.1.1 below.



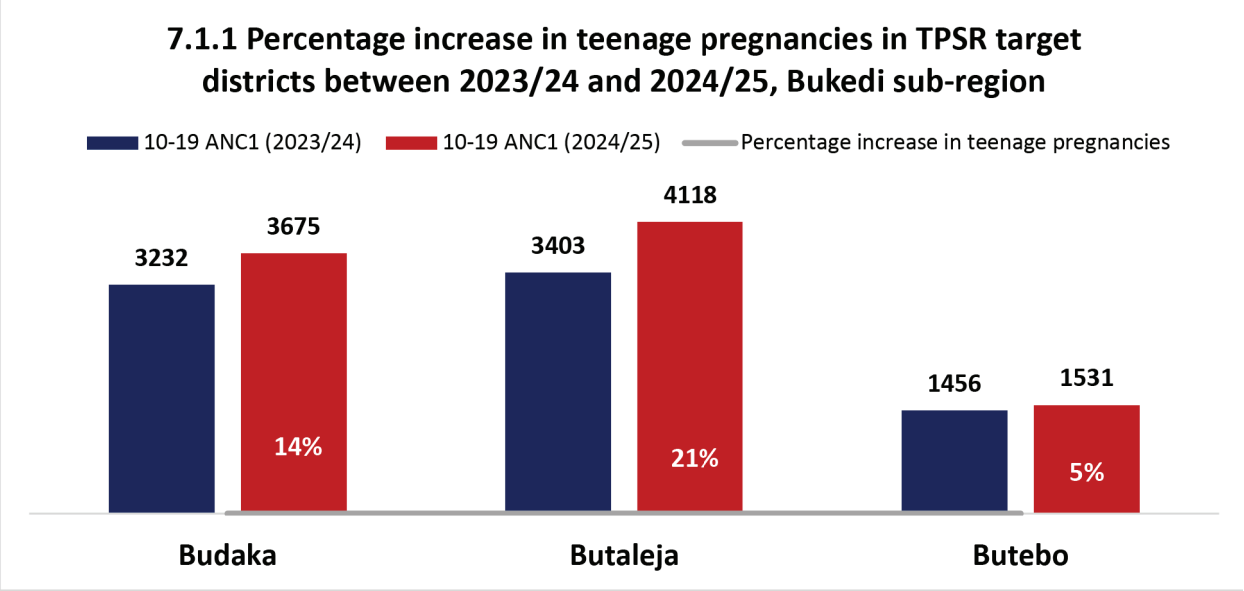
Teenage pregnancy in target Districts of Bukedi sub-region

In Bukedi sub-region, the number of pregnant teenagers as a proportion of all people visiting for ANC1 is declining with Butaleja having the biggest teenage ANC1 proportion of 23.2% and Budaka with the smallest proportion of pregnant teenagers at 20.7%. This is illustrated in figure 7.1 below.

Figure 7.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Bukedi



Like the other targeted regions and districts, the analysis of changes in the number of teenagers getting pregnant indicates increase across the three districts with Butaleja having a percentage increase of 21%, while Butebo has the lowest percentage increase in teenage pregnancy of 5% between 2023/24 and 2024/25 as per figure 7.1.1 below.

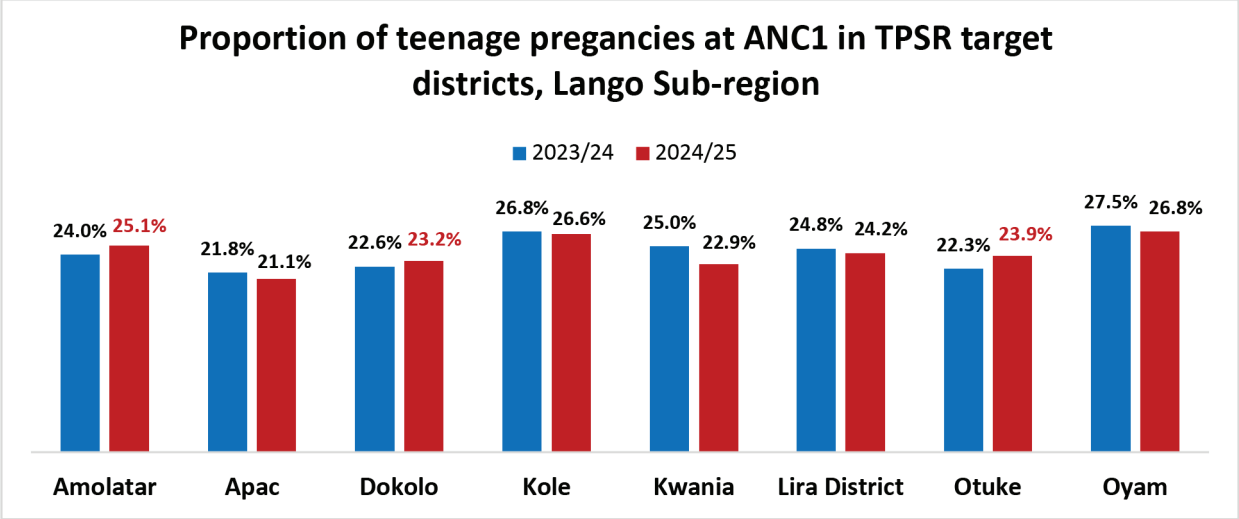


Teenage pregnancy in target Districts of Lango sub-region

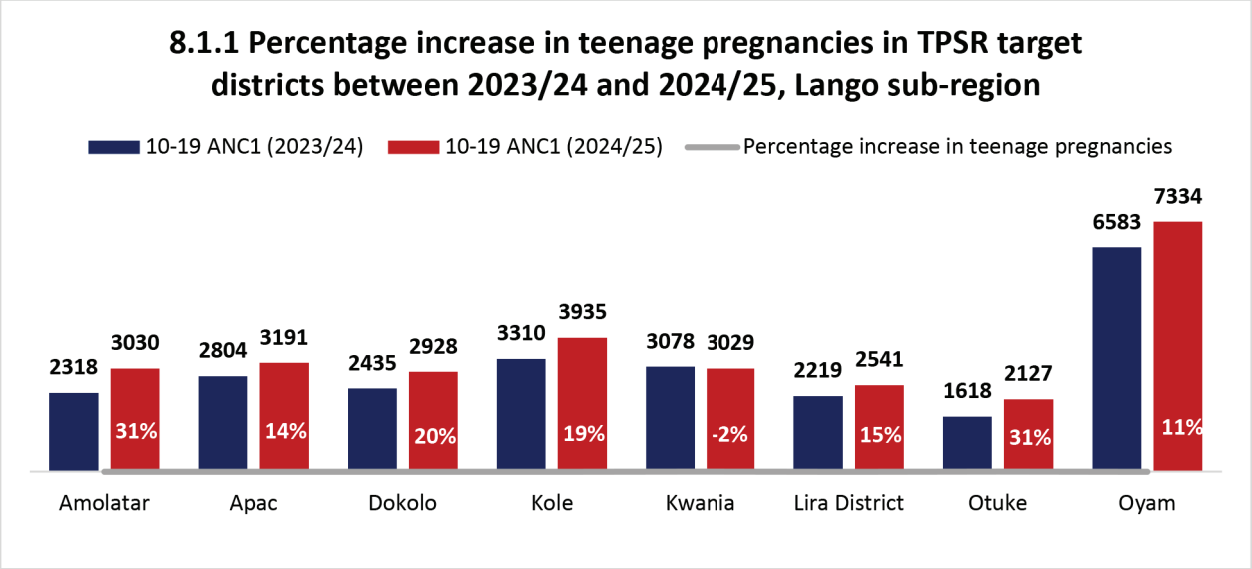
In Lango sub region, the TPSR is targeting 8 high burden districts and analysis of data between 2023/24 and 2024/25 shows that Amolatar District, Dokolo District and Otuke District have had an increase in the number of teenagers as a proportion of the total ANC1 visits by 1.1%, 0.6% and 1.6% respectively. All other districts experienced slight reductions with Kwania having the

biggest reduction of 2.4 percentage points as illustrated in figure 8.1 below.

Figure 8.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Lango



An analysis of changes in absolute teenage pregnancies indicates that only Kwania experienced a reduction in both proportion of teenagers of all ANC1 visitors, and a percentage reduction in the number of teenage pregnancies by 2 percentage points. Amolatar and Otuke Districts had the highest percentage increase (31%) as per figure 8.1.1.

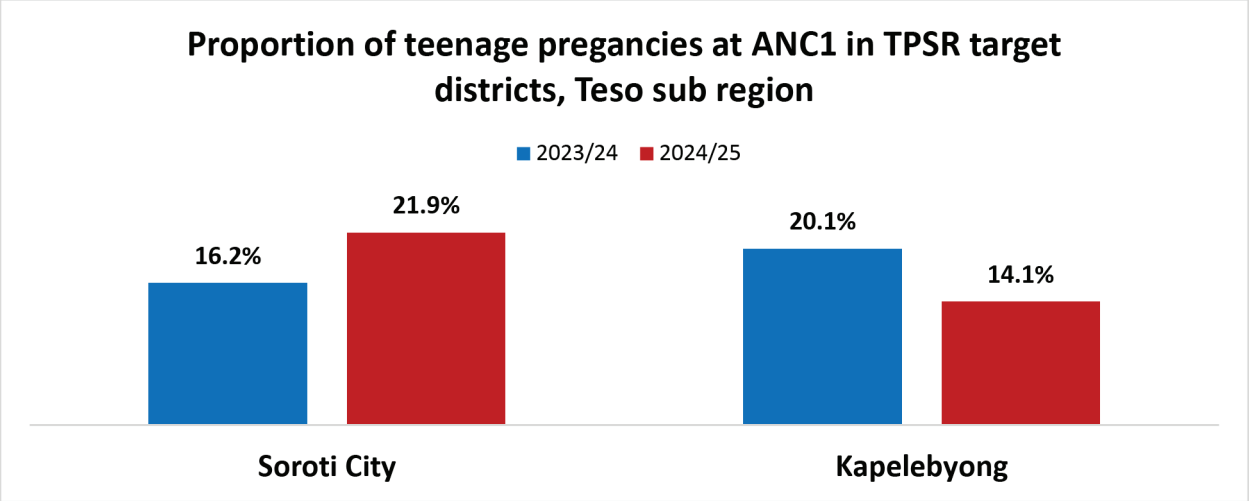


Teenage pregnancy in target Districts of Teso sub-region

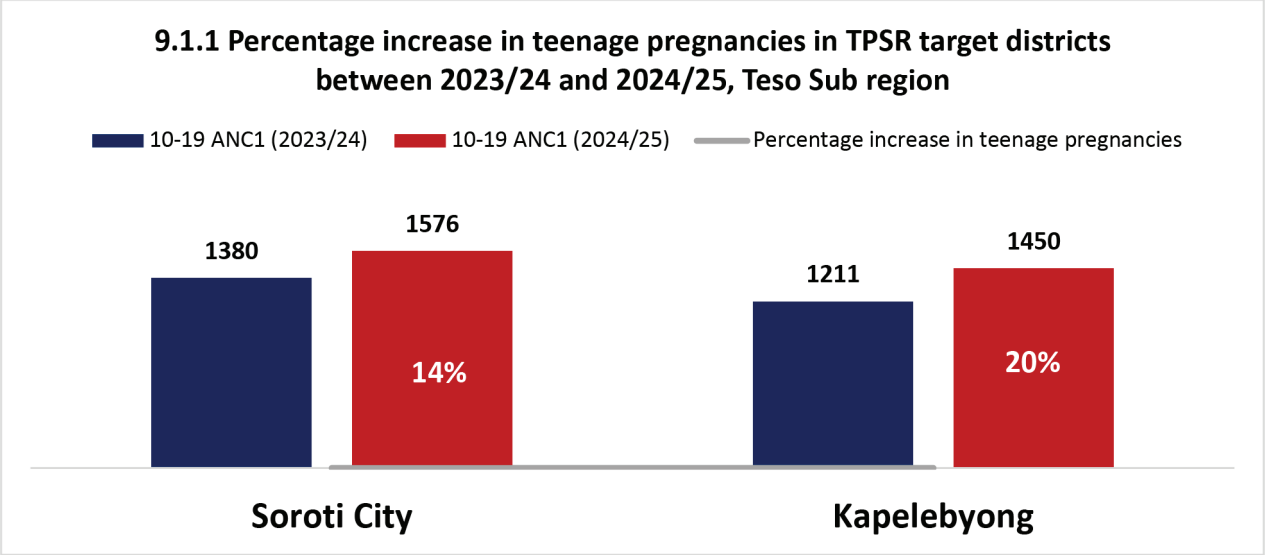
In Teso sub-region, the TPSR program enrolled Soroti City and Kapelebyong District. Analysis of DHIS2 data shows that the proportion of teenagers as a proportion of all ANC1 pregnant women increased in Soroti City from 16.2% to 21.9%, while reducing in Kapelebyong District from 20.1% to 14.1% as shown in figure 9.1

below.

Figure 9.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Teso



Interestingly, a deeper analysis of percentage change showed that in Kapalebyong District, the percentage increase in teenage pregnancies between 2023/24 and 2024/26 was at 20%, six percentage points above Soroti City – as per figure 9.1.1 below. This further confirms a need to humanize the numbers, because numbers mean real people, and allow individualised analysis. On a personal and sensitive issue like pregnancy, and in the spirit of reducing individual pregnancies, it is better if we analyze their data independent of other categories of people.

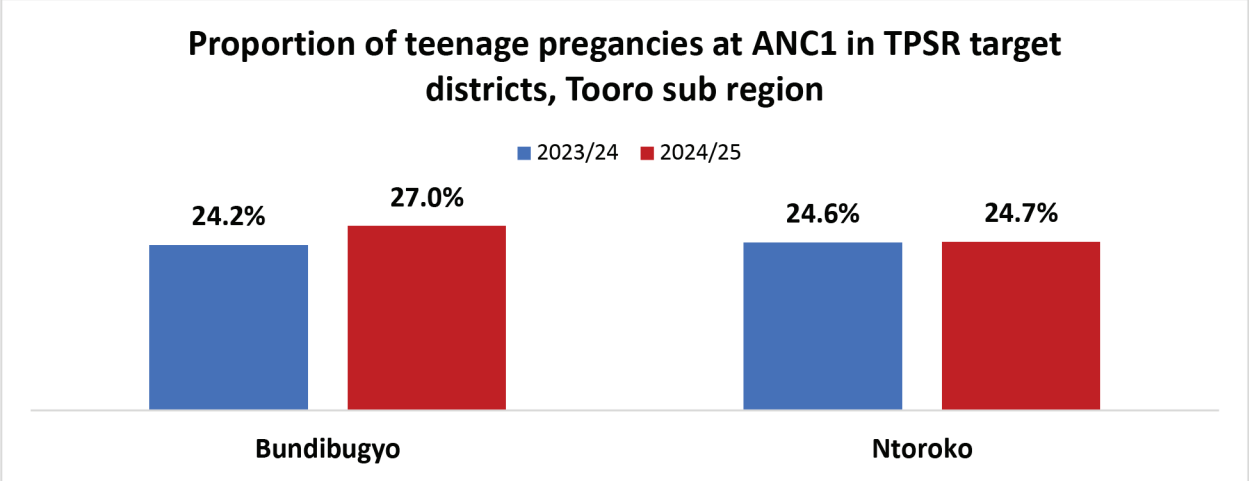


Teenage pregnancy in target Districts of Tooro sub-region

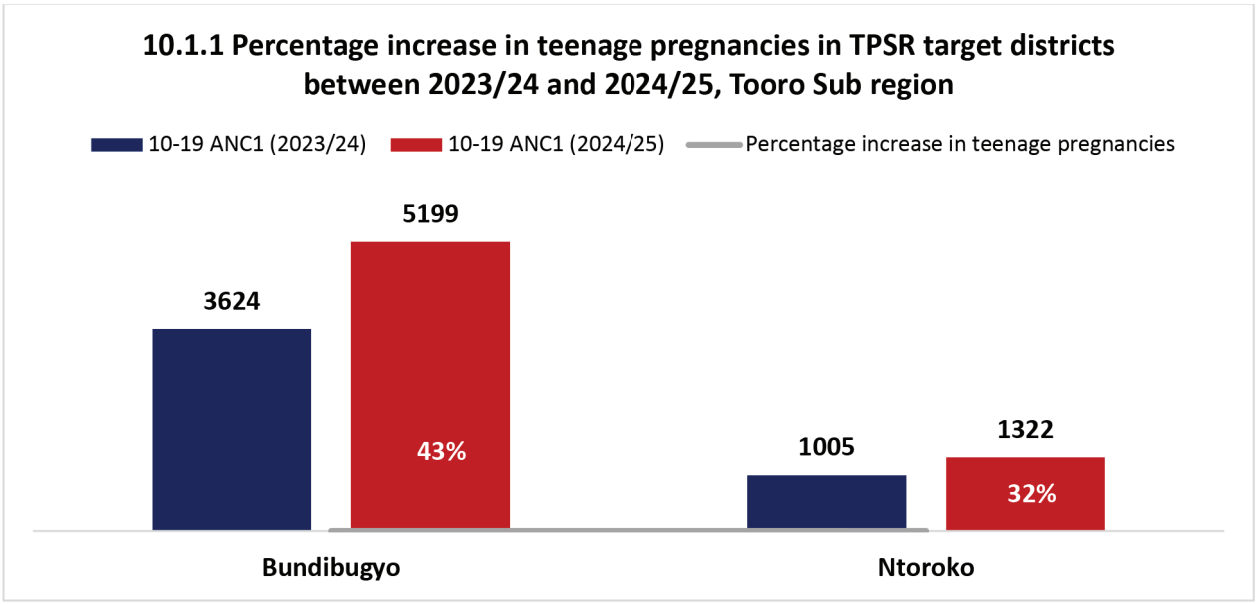
In Tooro sub region, the TPSR framework targets two Districts of Bundibugyo and Ntoroko. Unlike other regions, comparative analysis of two performance years indicates an increase on the proportion of ANC1 visitors who are teenagers with Bundibugyo increasing from 24.2% to 26% and Ntoroko from 24.6% to 24.7% between 2023/24 and 2024/25. This means that of all the ANC1 visits, the proportion of teenagers increased in both districts – a clear signal of high teenage

pregnancy as shown in figure 10.1 below.

Figure 10.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of Tooro



Similarly, an analysis of percentage change in the number of teenagers getting pregnant indicates that in both Districts, there was a percentage increase in the teenage pregnancies with Bundibugyo District having an increment of 43% and Ntoroko District with 32% as shown in figure 10.1.1 below. These are very high increments that need to be urgently addressed.

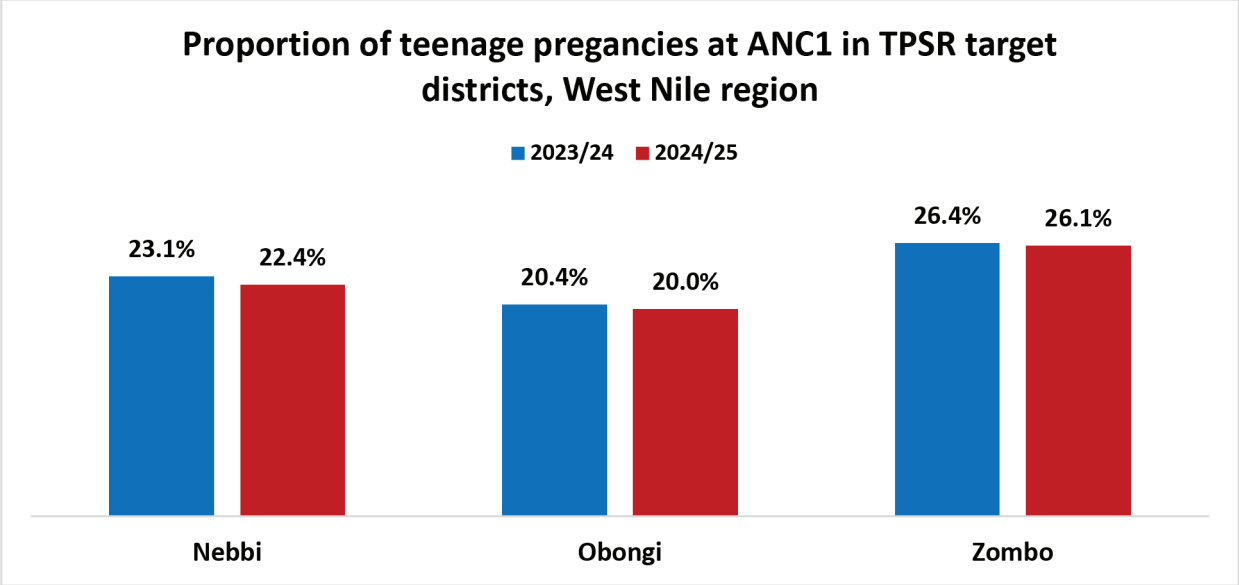


Teenage pregnancy in target districts of West Nile sub-region

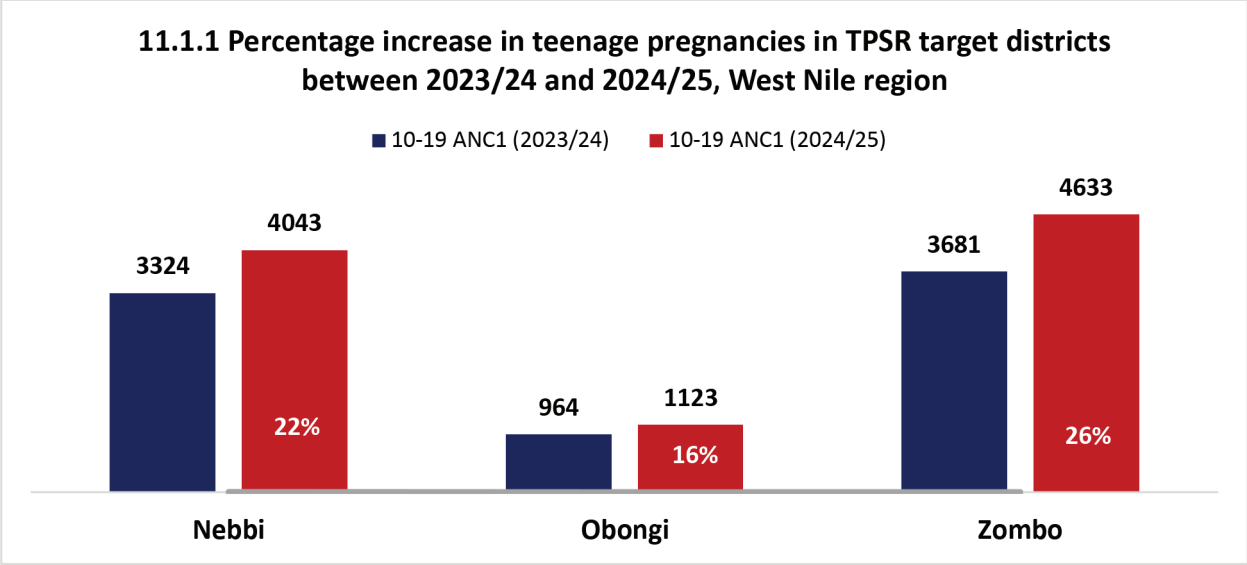
In West Nile region, between 2023/24 and 2024/25, the number of pregnant teenagers as a proportion of all ANC1 visitors reduced slightly across the three Districts of Nebbi (23.1% to 22.4%), Obongi (20.4% to 20%) and Zombo (26.4% to 26.1%). The range between the highest and lowest in 2024/25 was 6.1%

as per figure 11.1 below.

Figure 11.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of West Nile



While there was a slight variation in the proportion of teenage girls of all ANC1 visitors, there was a percentage increase in the absolute number of teenagers getting pregnant with Zombo having the biggest percentage increment of 26%, Obongi 16% and Nebbi 22% increment in teenage pregnancies. It should be noted however that based on the DHIS2 data, Obongi contributes less absolute numbers to the teenage pregnancy statistics in the TPSR districts of West Nile region.

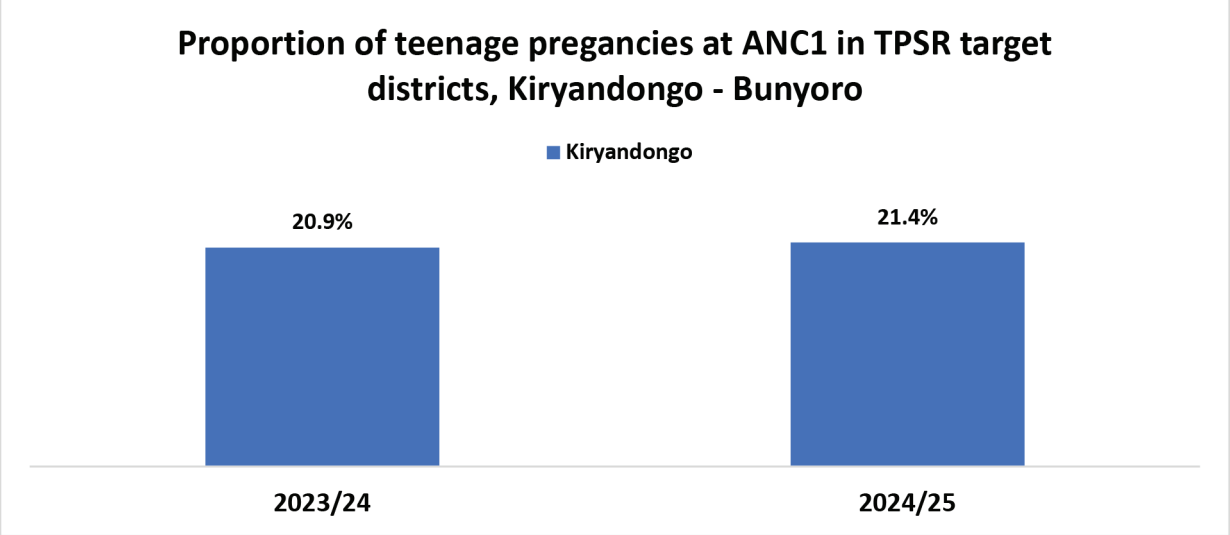


Teenage pregnancies in target districts in Bunyoro sub-region

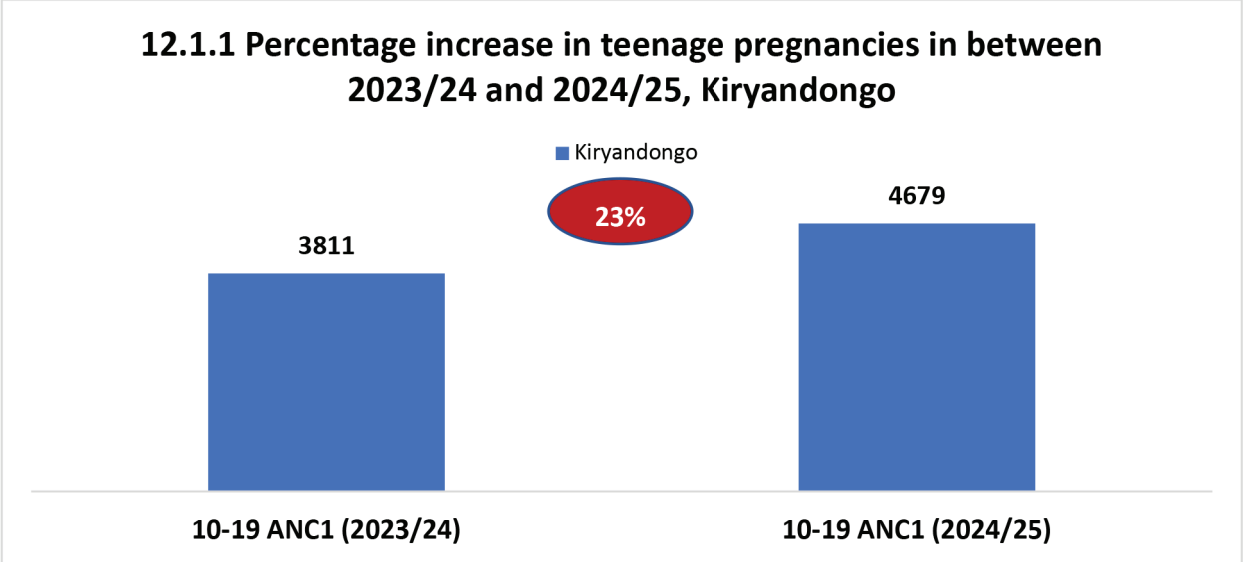
In Bunyoro sub region, the TPSR identified one District i.e. Kiryandodo to be part of the first phase of the TPSR engagement. The District experienced a slight increase of 0.5% in the proportion of pregnant teenagers 10-19 years, visiting health facilities for ANC1. This is still high in light of the 14% National target.

We illustrate this in figure 12.1 below.

Figure 12.1: Proportion of teenage pregnancies at ANC1 in TPSR target districts of West Nile



Like most regions and districts, a focused comparative analysis of the changes in the number of teenagers getting pregnant in Kiryandongo indicates a percentage increase (23%) in the number of pregnant teenagers. This shows that while the proportion of all ANC1 visits may not be changing significantly, the absolute numbers are increasing rapidly.



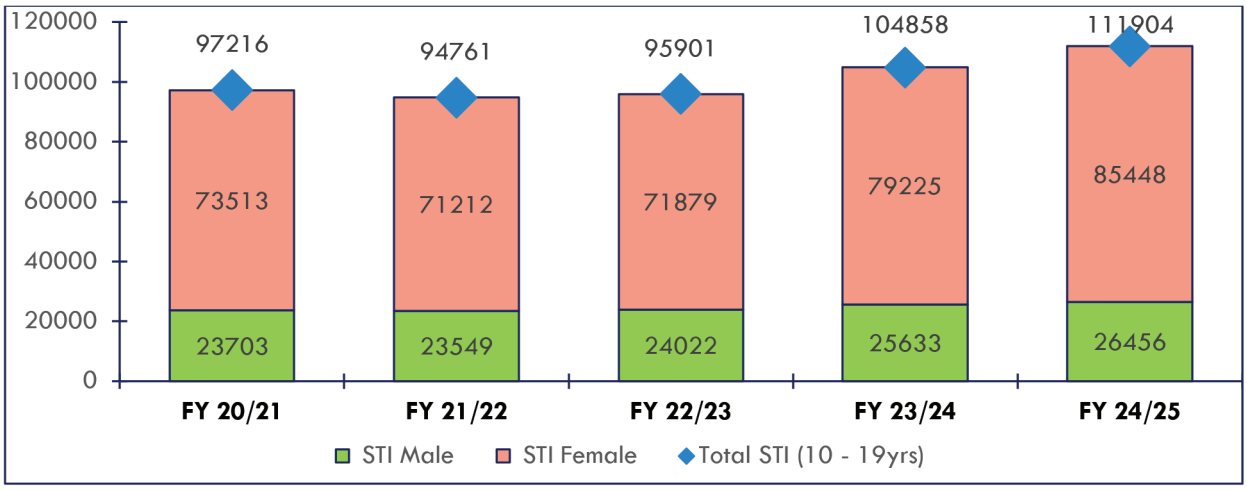
Other teenage pregnancy and child marriage adjacent indicators

Sexually Transmitted Infections (STIs) among adolescents

Sexually transmitted infections among adolescents serve as a critical indicator of sexual health vulnerabilities and risky behaviors that are intrinsically linked to teenage pregnancy and child marriage. Elevated STI rates reflect inadequate life skills education, limited access to youth-friendly health services, and power imbalances that compromise young people's ability to negotiate safe sexual practices. Adolescents who experience early marriage or pregnancy face heightened STI risks due to age-disparate relationships, limited contraceptive negotiation power, and reduced agency over their sexual and reproductive health decisions.

At the National level, there has been a percentage increase in STI infections among adolescents of 7%, from 104,858 in 2023/24 to 111,904 in 2024/25. This is illustrated in figure 13 below.

Figure 13: Sexually Transmitted Infection among 10 – 19 years by Sex



The graph above shows Sexually Transmitted Infection (STI) cases among adolescents in Uganda over five periods, reveals a negative upward trajectory. This significant net increase highlights a growing public health crisis, indicating that STI transmission is rising and underscoring an urgent need for enhanced prevention and treatment interventions within the country. Females were more affected than the male adolescents across the different financial years.

At the regional level, while some regions, such as Acholi, Ankole, and Bunyoro, demonstrated relative stability with only minor fluctuations, others experienced dramatic increases. The most pronounced surges were observed in West Nile, where rates rose from 18.4% to 25.5%, and in Busoga and Bukedi, which saw increases of over five percentage points. This indicates that the National rise in STIs is not uniform but is being driven disproportionately by specific geographic areas.

Conversely, Kampala reported a substantial decrease in its STI rate, falling from 17.5% to 15.4%. Despite this positive trend in the capital, the overall situation is concerning, as regions like Bugisu, Karamoja, and Kigezi all saw their rates climb by at least four percentage points over the period.

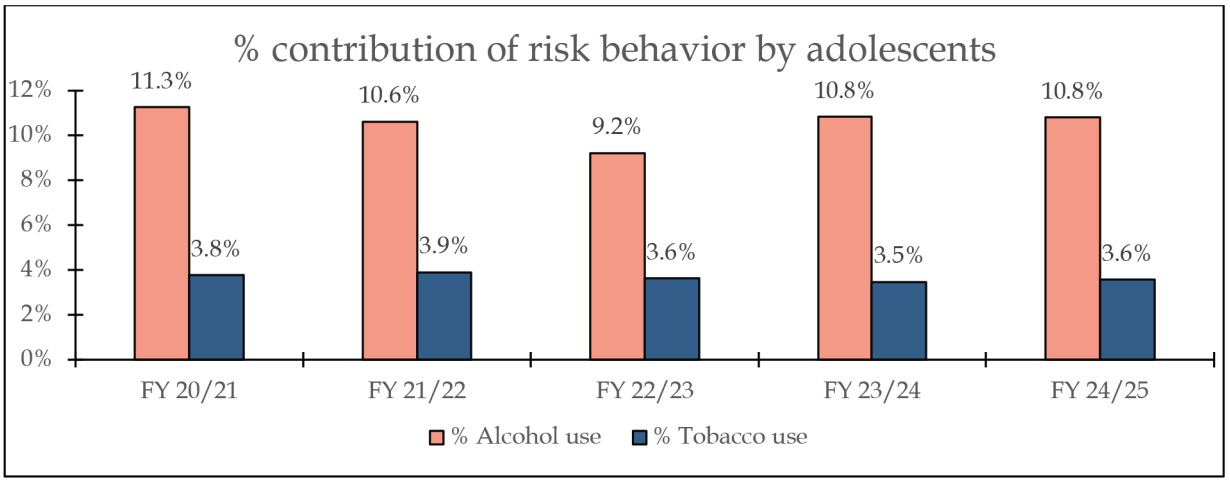
Table 3: Percentage contribution of adolescents to National sexually transmitted cases by region

Region	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Acholi	19.8%	19.6%	18.8%	19.7%	20.5%
Ankole	12.8%	13.8%	15.4%	14.7%	14.6%
Bugisu	20.8%	23.5%	27.1%	26.9%	26.5%
Bukedi	18.7%	20.9%	22.6%	25.9%	25.8%
Bunyoro	15.9%	16.2%	16.5%	15.3%	16.2%
Busoga	20.4%	19.9%	21.4%	23.4%	24.6%
Kampala	17.5%	17.8%	17.4%	17.5%	15.4%
Karamoja	13.4%	13.8%	13.9%	17.0%	17.9%
Kigezi	9.9%	11.5%	11.9%	13.5%	13.8%
Lango	18.8%	19.0%	20.4%	20.9%	20.6%
North Buganda	17.8%	17.6%	19.9%	20.1%	20.2%
South Buganda	15.7%	15.4%	17.6%	17.2%	16.9%
Teso	17.7%	19.2%	19.5%	21.4%	20.3%
Tooro	18.9%	18.1%	21.4%	19.2%	20.2%
West Nile	18.4%	18.3%	21.8%	23.5%	25.5%
National	17.0%	17.4%	19.0%	19.4%	19.5%

The persistent and sharp increases in many regions, particularly in the East and North, highlight the urgent need for targeted public health interventions to address the growing STI burden outside of the central urban area.

Risky Behaviours among adolescents

Figure 14: Percentage contribution of Adolescents to total cases of reported risky behaviors



The proportion of adolescents engaged in alcohol use among the total OPD cases with risky behaviors started at 12.0%, peaked at 11.3% in FY 21/22, and then generally declined, stabilizing at 10.8% for both FY 24/25 and FY 25/26. In contrast, the contribution of tobacco use was consistently lower, beginning at 4.0% and remaining relatively stable within a narrow range of 3.5% to 3.9% throughout the entire period. Overall, alcohol use represented a significantly higher share of adolescent risk behaviors compared to tobacco use, with both showing a general trend of slight decline or stabilization in the most recent years.

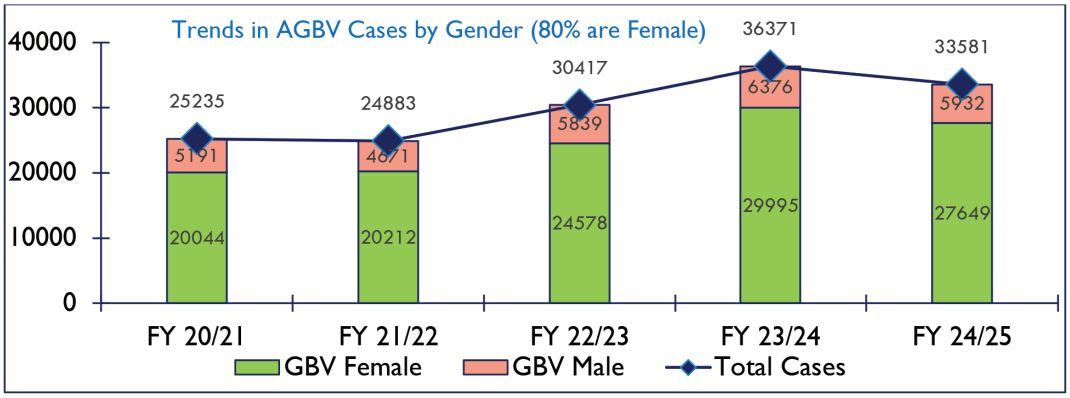
Table 4: Percentage contribution of Risk behavior by region

Region	% Alcohol use			% Tobacco use		
	FY 22/23	FY 23/24	FY 24/25	FY 22/23	FY 23/24	FY 24/25
Acholi	11.6%	12.0%	16.0%	10.8%	4.4%	5.5%
Ankole	6.7%	7.0%	7.7%	1.7%	1.7%	1.8%
Bugisu	15.2%	16.8%	15.7%	3.1%	1.5%	4.3%
Bukedi	9.8%	12.1%	7.3%	2.7%	2.0%	1.1%
Bunyoro	8.7%	8.3%	6.4%	3.7%	3.2%	3.2%
Busoga	9.6%	12.0%	12.5%	7.0%	3.8%	3.8%
Kampala	7.8%	9.0%	8.9%	2.8%	2.9%	3.0%
Karamoja	13.0%	13.5%	13.0%	5.5%	4.7%	5.1%
Kigezi	6.9%	6.4%	6.5%	1.2%	1.0%	1.2%
Lango	10.3%	11.0%	9.2%	2.2%	2.1%	2.5%
North Buganda	9.2%	7.7%	7.1%	3.0%	2.5%	2.8%
South Buganda	7.4%	6.4%	8.5%	1.8%	2.0%	1.6%
Teso	22.8%	18.3%	17.2%	1.3%	2.9%	2.1%
Tooro	8.9%	8.5%	7.9%	2.2%	2.0%	1.5%
West Nile	3.4%	9.6%	10.8%	1.7%	4.2%	3.6%
National	9.2%	10.8%	10.8%	3.6%	3.5%	3.6%

The percentage contribution of risk behaviours varies significantly by region over the three fiscal years, with alcohol use consistently representing a higher risk factor than tobacco use Nationally. The Teso region reported the highest levels of alcohol use, despite a notable decrease from 22.8% to 17.2%, while regions like Acholi and West Nile showed substantial increases in alcohol consumption, with Acholi reaching 16.0% and West Nile more than tripling to 10.8% by FY24/25. In contrast, tobacco use was generally lower and more stable, with Acholi and Busoga having some of the highest rates, peaking at 5.5% and 7.0% respectively in the periods shown, whereas most other regions, such as Ankole and Kigezi, maintained consistently low tobacco use below 2%. Nationally, alcohol use increased from 9.2% to 10.8%, while tobacco use remained relatively steady, indicating that alcohol is the more prevalent and growing risk behaviour across most regions

Adolescent Gender Based Violence

Figure 15: Trends in Adolescent Gender Based Violence by Gender



The figures consistently show that females experience approximately 80% of reported GBV cases, with the number of females (e.g., 30,417, 29,995) vastly outnumbering males (e.g., 5,839, 5,932) in the recorded periods. Gender-Based Violence (GBV) among adolescents in Uganda is a worsening and girls are more affected. This stark disparity highlights that adolescent girls and young women in Uganda bear the overwhelming burden of gender-based violence.

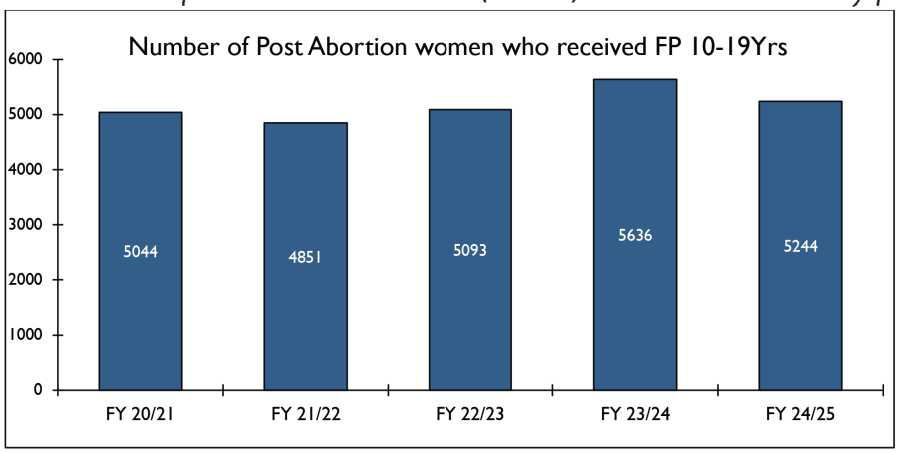
Table 5: Trends of Gender Based Violence cases for adolescents by region

Region	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Acholi	894	1073	998	1066	1012
Ankole	1614	1797	1397	1697	1326
Bugisu	4241	4594	6023	7366	7139
Bukedi	2170	1994	2883	4215	3097
Bunyoro	730	697	856	552	787
Busoga	2123	2100	3212	5867	5470
Kampala	656	941	2182	1889	1530
Karamoja	591	886	634	1096	751
Kigezi	736	1000	968	1575	1147
Lango	901	860	1157	1639	1325
Teso	653	685	1010	913	631
Tooro	1579	1484	1399	1477	1619
West Nile	1269	1493	1525	1872	2040
South Buganda	2353	2296	2036	1390	1776
North Buganda	4725	2983	4137	3757	3931
Total	25235	24883	30417	36371	33581

Based on regional data from FY 2020/21 to FY 2024/25, GBV cases in Uganda are not uniformly distributed, with certain regions consistently reporting significantly higher caseloads than others. The regions of Bugisu, Busoga, and North Buganda are persistent hotspots, with Bugisu showing a particularly sharp increase, rising from 4,241 to 7,139 cases. Similarly, Busoga more than doubled its caseload over the period, reaching 5,470 cases. In contrast, regions like Bunyoro, Karamoja, and Teso consistently reported comparatively lower numbers. The total National figures show a fluctuating but overall increasing trend, peaking in FY 23/24 at 36,371 cases, indicating that GBV remains a widespread and growing challenge across the country, concentrated in specific high-burden areas

Post abortion care/FP among women aged 10 – 19

Figure 16: Trends of post abortion women (10-19) who received Family planning



In the past five- FYs, there are fluctuation but generally high volume, underscore that a substantial number of young women in Uganda require medical care following an abortion and are being reached with contraceptive services to prevent subsequent unintended pregnancies. This highlights the critical role of post-abortion care programs in Uganda, which aim to provide immediate contraceptive counseling and methods to adolescents after an abortion procedure.

By integrating family planning into post-abortion care, we are able to reduce adolescent pregnancy, ultimately helping to break the cycle of repeat abortions and improve the reproductive health outcomes for this vulnerable population

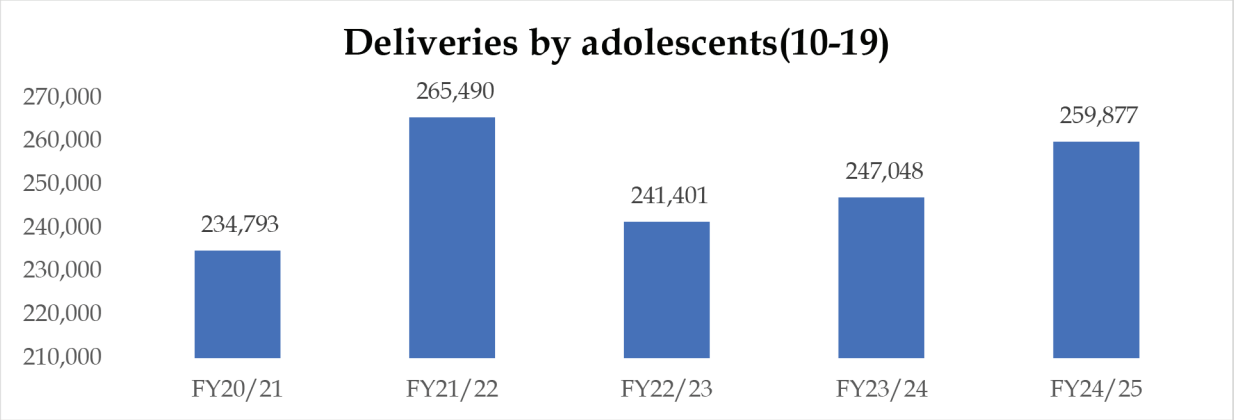
Table 6: Trends of Post Abortion family planning uptake by region

Region	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25
Acholi	332	348	394	330	548
Ankole	226	177	319	453	224
Bugisu	374	411	404	446	301
Bukedi	561	465	394	511	654
Bunyoro	141	148	134	118	83
Busoga	616	705	818	1134	1123
Kampala	501	339	376	320	295
Karamoja	72	57	42	51	68
Kigezi	45	68	42	28	36
Lango	312	466	443	498	491
Teso	185	192	324	269	213
Tooro	301	238	274	264	191
West Nile	387	360	342	232	187
South Buganda	484	417	461	590	503
North Buganda	507	460	326	392	327
Grand Total	5044	4851	5093	5636	5244

Based on the provided data on post-abortion family planning across regions from FY 20/21 to FY 24/25, Busoga consistently reported the highest number of cases, with a significant and steady increase from 616 to 1,123, peaking in FY 23/24. Other regions with notably high figures include Bukedi, which saw a resurgence to 654 in FY 24/25, and South Buganda, which remained consistently high, peaking at 590. In contrast, regions like Karamoja, Kigezi, and Bunyoro consistently reported the lowest numbers, with Bunyoro showing a declining trend to a low of 83. The National total fluctuated over the five-year period, starting at 5,044, dipping in FY 21/22, and reaching its peak of 5,636 in FY 23/24 before a slight decrease to 5,244 in the most recent fiscal year, indicating varied regional performance against the overall National trend

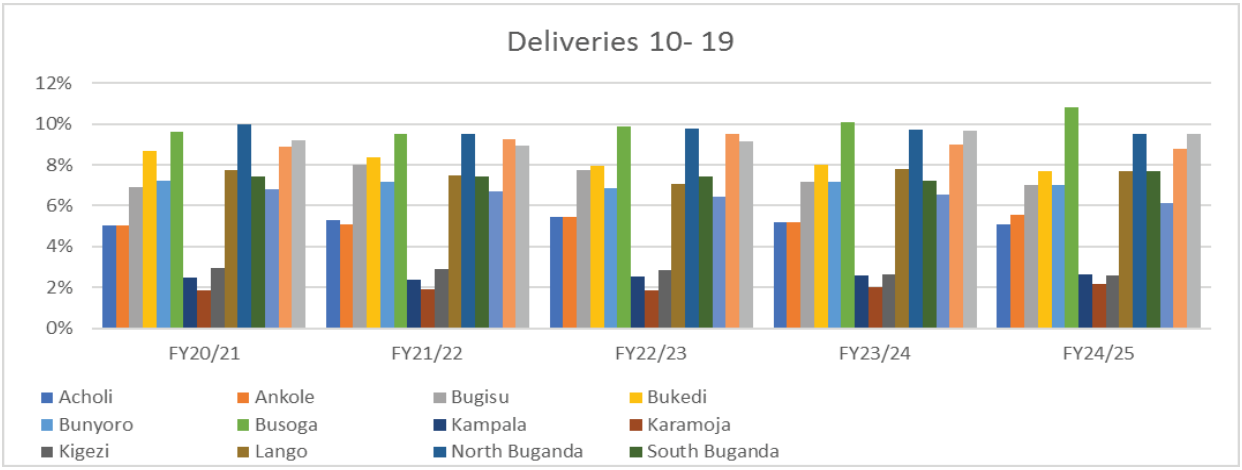
Adolescent deliveries in Health Facilities

Figure 17: Trends in deliveries for Adolescents (10-19 years)



Based on the data provided, adolescent deliveries in Uganda present a significant and persistent public health challenge across a 15-region dataset from FY20/21 to FY24/25. The National total started at 234,793 deliveries and showed a notable increase to 265,490 in FY21/22, before experiencing a dip in the middle years and rising again to 259,877 in FY24/25

Figure 18: Trends of deliveries by Adolescents (10-19 years) by region



The data reveals persistent regional disparities in the proportion of all deliveries that are attributed to adolescents across Uganda. Over the five-year period, regions like Busoga and North Buganda consistently bear the heaviest relative burden, with a steady 10% of all deliveries in those regions being to adolescent mothers. This means that in these areas, one in every ten women giving birth is a teenager, a rate substantially higher than the National average and highlighting them as critical hotspots for intervention. Other regions such as West Nile and Tooro also show consistently high percentages, maintaining a 9-10% share throughout the period.

Promising practices / what is working to prevent teenage pregnancies

Uganda's fight against teenage pregnancy has yielded a wealth of innovative, evidence-informed interventions emerging from districts and communities across the country. These promising practices demonstrate that preventing teenage pregnancy requires more than resource availability, i.e. it demands creativity, cultural sensitivity, multi-sectoral coordination, and sustained community engagement. From youth-friendly health services that double contraceptive uptake rates, to talking compounds where adolescents openly discuss taboo topics, to parenting groups that reduce school dropout by 53%, districts have pioneered solutions tailored to their unique contexts while offering replicable models for National scale-up. This synthesis presents the most impactful interventions across health, education, community mobilization, cultural engagement, and justice sectors—capturing what is working on the ground and providing actionable insights for adaptation and expansion. These practices collectively illustrate that teenage pregnancy prevention is achievable when communities are empowered, adolescents are centered, and traditional systems are transformed from barriers into enablers of change.

Table 8: Promising practices to be expanded across the 30 high burden Districts

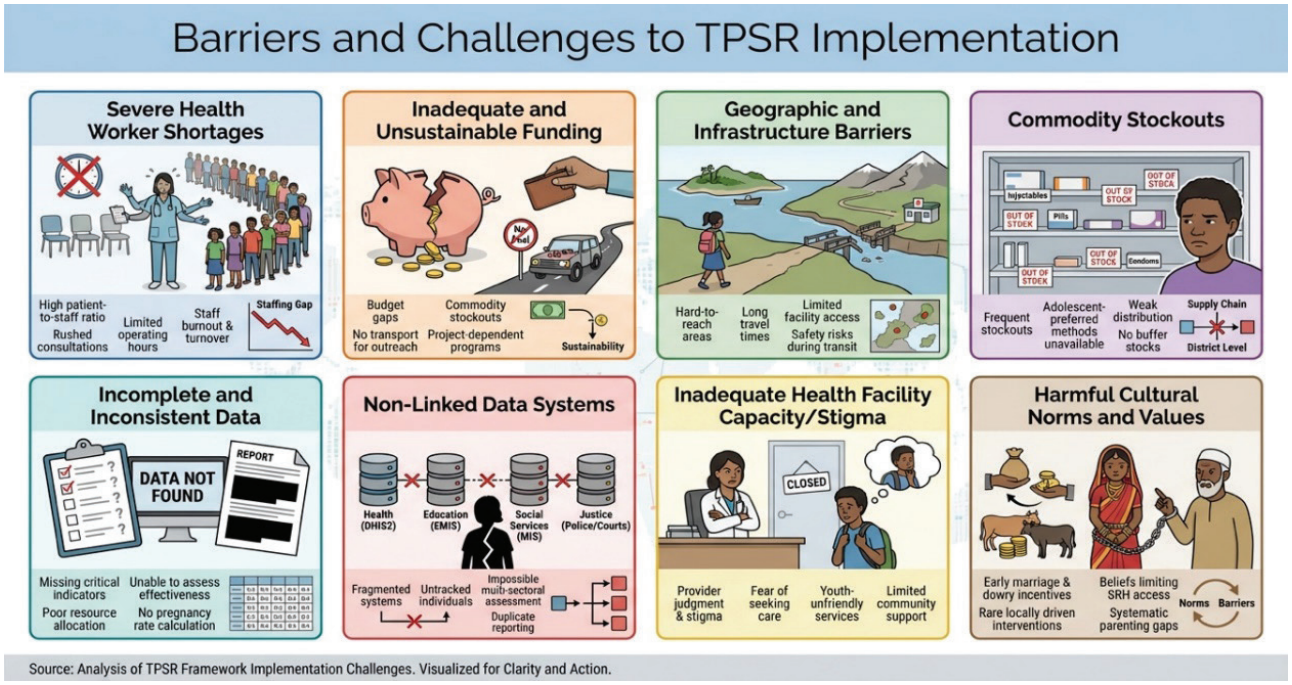
Intervention Category	Specific strategy	Description	Target demographic
Health Service	Youth-friendly health services	Private consultation spaces, trained non-judgmental providers, free services, convenient hours, and peer educator presence.	Adolescents
	Post-Abortion Care (PAC) and Family Planning (FP) Integration	Mandatory immediate counselling, removal of consent barriers (parental/spousal), commodity security, and tracking as a quality indicator.	Post-abortion women and adolescents
	Group-Based Antenatal Care (GANC)	Weekly designated adolescent clinic days, cohort-based enrollment, WhatsApp groups, and same-day multi-service delivery.	Pregnant adolescents
	CUAMM "Don't Stop Me Now" Project	Recreational materials, trained peer educators, free anti-violence hotline, door-to-door VHT visits, and transport support for survivors.	Adolescents and community members
	Improvised youth-friendly services with separate clinic days	Practical low-cost model, separate clinic days, age-segregated service provision, and stigma-free environments.	Youth

Intervention Category	Specific strategy	Description	Target demographic
School-based	Talking Compounds	Safe spaces for taboo topics, teacher training in facilitation, student-led discussions, and peer-to-peer learning.	Teenagers and students
	Formalisation of Senior Woman and Man Teacher roles	Official appointment letters, clear mandates, accountability for data collection, and SRH/GBV orientation.	Students (via teachers)
	Debate for Development competitions	Leveraging competitive spirit, student-led discourse, research requirements, and media coverage.	Students and adolescents
	Digital sexuality education (Journey Plus curriculum)	Early intervention (ages 9-14), engaging digital format, standardized content, and teacher training.	Learners aged 9-14 years
Data-driven and Governance	Five-year longitudinal trend data tracking	Evidence-based decisions, impact evaluation, and trajectory assessment.	Frontline officers, District-wide population
Family-based	Parenting groups	Monthly peer-led learning, addressing root causes of poor parenting, and opening family conversations about sexuality.	Parents and teenagers
Community-based	Parenting groups	Peer learning and replicability of the Lamwo model.	Parents
	Para-social worker engagement and community dialogues	Case management, referrals, surveillance, and utilisation of educated unemployed youth.	Adolescents
Cultural and community mobilization	Drama group performances	Overcoming literacy barriers, emotional impact through storytelling, and cultural resonance.	General public
Justice/Legal	Coordination of documentation and case follow-up	Coordination between police, health facilities, and prosecutors.	Sexual violence survivors and perpetrators
Male Engagement	Male Action Groups and Young Fathers support	Training and peer accountability.	Men and young fathers
	Real Fathers for adolescents approach (SDI partnership)	Quarterly men's conferences, challenging harmful masculinities, and addressing male responsibility.	Fathers, couples and men
Cultural	Alur Kingdom one-day traditional marriage ceremony policy	Reducing economic incentives for early marriage and traditional authorities as change agents.	Families and traditional communities
Religious/ School-based	Religious leader assembly sessions in Anglican schools	Normalising sexual and reproductive health conversations from faith perspectives and leveraging trust in religious authority.	Students

Barriers and challenges to the implementation of the TPSR framework

Despite the promising practices and innovations emerging across Uganda's districts, significant systemic challenges continue to undermine the effectiveness and sustainability of teenage pregnancy prevention efforts. These barriers ranging from still some weaknesses in the multi-sectoral coordination, siloed capacity building programs, severe health worker shortages and inadequate funding to fragmented data systems and harmful cultural norms, fundamentally constrain even the most well designed interventions. Understanding these challenges is critical for developing realistic, comprehensive solutions that address root causes rather than symptoms. The following constraints represent the most persistent obstacles reported across districts, requiring urgent National attention and coordinated multi-sectoral responses to ensure sustainable progress in teenage pregnancy prevention.

The figure 18 below is an illustration of the barriers:



Source: Analysis of TPSR Framework Implementation Challenges. Visualized for Clarity and Action.

Lessons learnt from early implementation

The early implementation phase of teenage pregnancy prevention interventions across Uganda's districts has yielded crucial insights that challenge conventional approaches and illuminate pathways toward more effective programming. These lessons emerge not from theoretical frameworks but from the lived realities of implementation—from districts that achieved remarkable reductions despite resource constraints, from well-funded initiatives that failed to produce results, and from communities that transformed social norms while others conducted meetings without measurable impact.

The patterns are clear and consequential; i.e. success demands multi-sectoral integration rather than siloed efforts, community-level action rather than facility-only approaches, implementation fidelity rather than design sophistication, and data-driven adaptation rather than rigid program replication. Districts like Lamwo, Namayingo, and Omoro demonstrate what becomes possible when these principles align, while the struggles of others reveal the costs of fragmented coordination, weak data systems, and purely reactive responses. These lessons are not merely academic observations but actionable imperatives for districts, implementing partners, and National stakeholders committed to translating political will and financial investment into tangible reductions in teenage pregnancy rates. Below is a summary of the most critical insights from implementation

experience, each grounded in specific evidence from district-level practice and each offering clear implications for future programming.

Table 9: Implementation systems, timing and fidelity learning matrix

	Sector and/or System lever	Early prevention	Late response	Lessons
1	Leadership & Governance	Leadership champions prevention before crisis and response	Reactive coordination by local leaders after spikes	Local leadership commitment matters more than NGO partner density
2	Coordination	Strategic, data-driven, resourced coordination	Performative meetings, case discussions only	Coordination without data and resources has no impact
3	Community Systems	Parenting groups, talking compounds, drama groups	One-off community dialogues	Community platforms are the most cost-effective and scalable
4	Education System	Life skills (9–14 yrs), flexible re-entry pathways	School re-entry after dropout	Prevention is cheaper and more effective than re-entry
5	Health System	Youth-friendly services and commodity security	Emergency ANC, post-abortion care and FP	Weak systems negate adolescent-specific interventions
6	Justice System	Deterrence through fast, certain prosecution	Long cases, impunity	Justice delays actively undermine prevention
7	Gender & Male Engagement	Early male norm transformation	Post-violence response	Male engagement is essential yet neglected or unfunded
8	Data Systems	Routine tracking data is used for quick decision-making	Missing or unusable data	Data enables everything; absence collapses accountability

Based on the above matrix, teenage pregnancy and child marriage prevention works well when multiple sectors/systems act together, when interventions occur early, and when implementation is done with high fidelity and driven by data.

At the implementation level, early lessons are pointing to some design and implementation principles, in relation to what works and what does not. These are vital, and will be tested for confirmation in the coming implementation period before wide scale adoption and adaptation.

Design and implementation: What works and what doesn't work lessons matrix

	Design and implementation principle	What works	What does not work
1	Sectoral approach	Integrated multi-sector action	Single-sector interventions
2	Delivery level	Community-based, peer-led	Facility-only, adult-led
3	Timing	Pre-sexual debut (9–14)	Post-pregnancy response
4	Scale & cost	Low-cost, high reach	High-cost, low coverage
5	Implementation	High fidelity, supervision	Same design, poor execution
6	Data use	Local data for quick decisions	Data reported upward only
7	Sustainability	Embedded in systems	Parallel partner projects
8	Context	Locally adapted	Rigid replication
9	Family based and fatherhood oriented	Transforming fathers/father figures has ripple effects on gender equity, education and GBV	Parenting approaches that are generic and untested

Recommendations

1. **Strengthen localized data use and surveillance:** Roll out the TPSR surveillance system Nationally after field pretesting in Kamuli and Lamwo. Train district focal persons (DHO, DEO, DCDO) and establish monthly reporting with quarterly analysis. Deploy the TPSR dashboard to all 30 target districts, then scale to 176 districts. Integrate with existing systems (DHIS2, EMIS, CWMIS) and establish quality assurance protocols. Provide data tools for hard-to-reach areas, create public dashboards for accountability, and conduct quarterly review meetings. Target 95% data completeness, 90% quality scores, and village-level pregnancy tracking in all districts.

2. **Influence school environments through talking teachers and compounds:** Establish teenage pregnancy talking compounds in all schools, replicating Omoro's low-cost success model. Document implementation processes and train Education officials as master trainers who cascade to head teachers and senior teachers. Provide minimal materials (flip charts, markers, signage) and monitor through quarterly utilization reports. Create peer learning networks where successful schools mentor others. In addition, support teachers with SRHR information talking points to integrate in their school routine .

3. **Adapt and spread a tested adolescent parenting approach:** Building on the parenting group networks, and basing on Lamwo and Otuke's replicable results (53% dropout reduction, six-fold school re-entry improvement), the TPSR secretariat should work with technical experts and local organizations to tailor an adolescent fatherhood approach to different contexts. Further, document the 40-member group model with monthly meetings and standardized curriculum. Train CDOs as facilitators to establish at least one group per parish. Link groups to Village Savings and Loan Associations for sustainability and integrate with nutrition, and violence prevention programs.

4. **Youth-Friendly Health Services:** Scale youth-friendly services to all Health Center IIs and IIIs, building on evidence that 69% coverage correlates with doubled family planning uptake. Provide adolescent-appropriate materials, establish weekly designated clinic days, integrate multiple services (family planning, STI screening, HIV testing, menstrual hygiene), offer flexible hours, and eliminate parental consent requirements for postpartum family planning.

5. **Roll out Education for Health and Life Skills**: Fast-track the National Framework on Education for Health and Life Skills curriculum in TPSR target districts. The MoES should train all senior teachers, address policy barriers through coordinated advocacy with religious leaders and parents, provide teaching materials, establish school-health facility linkages, and monitor through routine inspections.

6. **Male Engagement and Social Norms Change:** Strengthen male engagement through action groups, Real Fathers Program, and quarterly men's conferences. Engage male champions to model positive masculinity. Partner with cultural institutions (Buganda, Busoga, Acholi, Lango, others) to develop cultural charters on child marriage, establish age-verification for marriage certificates (18+ requirement), reform bride price practices, and integrate prevention messaging into cultural ceremonies.

Conclusions.

Uganda's teenage pregnancy and child marriage crisis 1,047 girls becoming pregnant daily, 34% married before 18 represents a profound threat to human capital development and National transformation aspirations. This analysis identified promising practices spanning health (youth-friendly services, group ANC, post-abortion care integration), education (talking compounds, debate competitions, digital CSE), community (parenting groups, para-social workers, male action groups, drama mobilization), cultural (traditional authority engagement, kingdom policies), and justice (enhanced prosecution, forced marriage rescue operations) sectors. Each innovation demonstrates feasibility, affordability, and of its potential for impact – not theoretical interventions. However, these are implemented in silos and small scale, which must be addressed.

We note that persistent implementation challenges threaten progress, but these are not insurmountable. They are systemic challenges requiring systemic solutions through systems change and systems strengthening, community-led action, justice sector accountability, economic empowerment at scale, and sustained political commitment.

Each of those 1,047 represents an individual adolescent whose life trajectory is being altered, educational opportunity destroyed, health endangered, economic potential limited, and rights violated. Behind the statistics are daughters, sisters, students, future mothers, potential leaders whose voices must drive collective response. Their participation in designing, implementing, and monitoring interventions is not optional but essential for effectiveness, relevance, and sustainability.

The question is not whether Uganda can achieve the National target of 15% teenage pregnancy rate by 2030 and ultimately reductions to 10%, the question is whether – using the TPSR framework, we will summon the collective political will, mobilize the necessary resources, maintain the strategic focus, and demonstrate the sustained commitment required to translate evidence into action at scale.

The pathway forward is clear. Uganda possesses the TPSR multi-sectoral framework, National Framework on Education for Health and Life Skills, the Parish development model, the tried out interventions (documented in 28 districts across 9 regions), the technical capacity (implementing partners, trained government staff), and the political will (Presidential attention, ministerial commitment, district engagement). What remains is systematic implementation at scale with quality assurance, adequate financing, sustained coordination, and relentless focus on evidence-based decision-making.

Annexes

Annex 1: ANC disparity matrix

The regional disparities highlight gaps in adolescent-friendly services and access barriers. Strengthening outreach in low-performing regions and replicating best practices from high-performing regions remains critical.

Region	FY20/21			FY21/22			FY22/23			FY23/24			FY24/25		
	ANC-1	Teenagers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teenagers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teenagers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teenagers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teenagers (10-19 yrs)	%age of teenagers attending ANC 1
Acholi	83380	18219	22%	92628	21119	23%	92543	19747	21%	100011	19929	20%	99371	19647	20%
Ankole	130552	18789	14%	134144	19330	14%	132184	17621	13%	137296	17865	13%	150043	19944	13%
Bugisu	91711	21987	24%	94683	22777	24%	96572	21595	22%	106265	23676	22%	115087	24674	21%
Bukedi	106575	26912	25%	103186	25850	25%	103802	23868	23%	112227	25464	23%	114473	25321	22%
Bunyoro	133309	28869	22%	130895	28928	22%	126952	26393	21%	136279	28593	21%	152136	33623	22%
Busoga	209089	45997	22%	203642	45546	22%	208694	44324	21%	218972	46610	21%	228553	47719	21%
Kampala	111552	8405	8%	111990	9154	8%	116162	8928	8%	115899	9055	8%	111776	8758	8%
Karamoja	47552	6854	14%	49660	7644	15%	53978	7233	13%	55378	7539	14%	59360	8468	14%
Kigezi	61995	9530	15%	62896	9675	15%	61034	8501	14%	61745	8752	14%	64402	9393	15%
Lango	125037	32991	26%	119682	32043	27%	126199	29433	23%	124447	29359	24%	125840	29373	23%
North Buganda	208456	37440	18%	207599	37699	18%	202030	35510	18%	216678	37158	17%	228650	38022	17%
South Buganda	204638	31859	16%	202535	31471	16%	198046	29436	15%	210737	30415	14%	230260	32305	14%
Teso	98579	23137	23%	99594	23750	24%	107220	22246	21%	108902	22555	21%	112707	22991	20%
Tooro	139491	28660	21%	148507	31670	21%	150310	30024	20%	157870	31109	20%	164508	32483	20%
West Nile	143862	29921	21%	146790	31497	21%	143746	30890	21%	154256	33387	22%	171443	35638	21%

Across all regions, the total number of women attending their first antenatal care (ANC-1) visit increased steadily from FY2020/21 to FY2024/25, showing overall improvement in service utilization. However, the proportion of teenagers (10–19 years) among ANC-1 attendees remained largely unchanged or slightly declined over time. Regions such as Bukedi, Lango, and Bugisu consistently recorded the highest teenage ANC-1 proportions (21–27%), while Kampala had the lowest at about 8% throughout the five-year period. Regions like Acholi, Busoga, Bunyoro, and Tooro maintained moderate teenage attendance rates of 20–22%, showing minimal fluctuation. In contrast, Ankole, Karamoja, and Kigezi had relatively low teenage proportions (13–15%), with little year-to-year variation.

Overall, while the absolute numbers of both total ANC-1 clients and teenagers increased in most regions, the percentage of teenage ANC-1 attendance either plateaued or showed a marginal decline, indicating that adolescent engagement in maternal health services has not improved at the same pace as general ANC utilization. This suggests that targeted adolescent-friendly strategies are still needed, especially in high-burden regions such as Bukedi and Lango, to address persistent barriers to early antenatal care uptake among teenage mothers in Uganda's urban and regional settings.

Deep dive in TPSR Districts

Region	District	FY20/21			FY21/22			FY22/23			FY23/24			FY24/25		
		ANC-1	Teen-agers (10-19 yrs)	%age of teenag-ers at-tending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1
Acholi	Amuru District	11449	2831	25%	13288	3335	25%	12025	2778	23%	13429	2924	22%	13767	2930	21%
	Lamwo District	7700	1544	20%	8624	1909	22%	10003	1996	20%	9431	1859	20%	9558	1764	18%
	Omoro District	8664	2369	27%	9697	2745	28%	9126	2294	25%	10015	2369	24%	9700	2328	24%
Bugisu	Manafwa District	8457	2191	26%	9758	2449	25%	8393	1996	24%	7665	1833	24%	8922	1915	21%
	Namisindwa District	11015	3087	28%	11708	3447	29%	10777	2779	26%	12230	3179	26%	12271	3251	26%
	Sironko District	13579	3290	24%	13016	3165	24%	15463	3701	24%	14469	3434	24%	14849	3385	23%
Bukedi	Budaka District	14446	3769	26%	13582	3395	25%	13977	3231	23%	14975	3232	22%	14923	3115	21%
	Butaleja District	15484	3863	25%	14319	3639	25%	13539	3080	23%	14405	3403	24%	15358	3520	23%
	Butebo District	6336	1553	25%	5931	1468	25%	5880	1230	21%	6735	1456	22%	6426	1335	21%
Bunyoro	Kiryandongo District	18569	4098	22%	18031	4073	23%	17609	3740	21%	18238	3811	21%	18890	4023	21%

Region	District	FY20/21			FY21/22			FY22/23			FY23/24			FY24/25		
		ANC-1	Teen-agers (10-19 yrs)	%age of teenag-ers at-tending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1	ANC-1	Teen-agers (10-19 yrs)	%age of teenagers attending ANC 1
Busoga	Bugiri District	21108	5335	25%	20246	5092	25%	21344	5056	24%	23841	5697	24%	24095	5709	24%
	Kamuli District	30509	6530	21%	29920	6436	22%	29835	6225	21%	28558	5753	20%	28530	5565	20%
	Luuka District	11563	2541	22%	10620	2336	22%	11165	2346	21%	11216	2584	23%	10495	2376	23%
	Namayingo District	12842	3512	27%	12870	3631	28%	13982	3717	27%	14600	3891	27%	14481	3780	26%
	Namutumba District	12356	2987	24%	12005	2691	22%	12045	2570	21%	13643	3056	22%	14719	3201	22%
Lango	Amolatar District	10012	2681	27%	8595	2332	27%	8980	2099	23%	9648	2318	24%	10418	2615	25%
	Apac District	10782	2647	25%	11486	2863	25%	13960	3181	23%	12848	2804	22%	13296	2820	21%
	Dokolo District	11833	3328	28%	10668	2888	27%	12315	2873	23%	10792	2435	23%	10802	2507	23%
	Kole District	13992	4171	30%	14625	4479	31%	13265	3694	28%	12338	3310	27%	12830	3399	26%
	Kwania District	10462	3018	29%	11844	3417	29%	10975	2612	24%	12296	3078	25%	11405	2632	23%
	Lira City	14041	2515	18%	14220	2532	18%	14394	2224	15%	14193	2208	16%	14562	2205	15%
	Lira District	10502	2964	28%	8635	2471	29%	8146	1892	23%	8965	2219	25%	9163	2217	24%
	Otuke District	8254	2135	26%	6810	1879	28%	7770	1717	22%	7251	1618	22%	7757	1850	24%
	Oyam District	22813	6466	28%	22245	6637	30%	22719	6125	27%	23921	6583	28%	23420	6235	27%
Teso	Kapelebyong District	5587	1364	24%	5772	1414	24%	6158	1263	21%	6028	1211	20%	6104	1239	20%
	Soroti City	8519	1614	19%	8670	1656	19%	9464	1562	17%	8521	1380	16%	9008	1361	15%
	Soroti District	8568	2251	26%	8011	2087	26%	8671	1938	22%	9434	2167	23%	9575	2234	23%
Tooro	Bundibugyo District	10673	3059	29%	13249	3740	28%	13138	3589	27%	14979	3624	24%	16368	4457	27%
	Ntoroko District	3913	1053	27%	4096	1132	28%	4197	1090	26%	4087	1005	25%	4607	1146	25%
West Nile	Nebbi District	15405	3767	24%	14450	3571	25%	13647	3296	24%	14365	3324	23%	15392	3420	22%
	Obongi District	5150	984	19%	5236	1012	19%	5173	1035	20%	4715	964	20%	4755	938	20%
	Zombo District	12397	3441	28%	13041	3598	28%	12947	3583	28%	13961	3681	26%	14438	3850	27%
National		386980	96958	25%	385268	97519	25%	391082	90512	23%	401792	92410	23%	410884	93322	23%

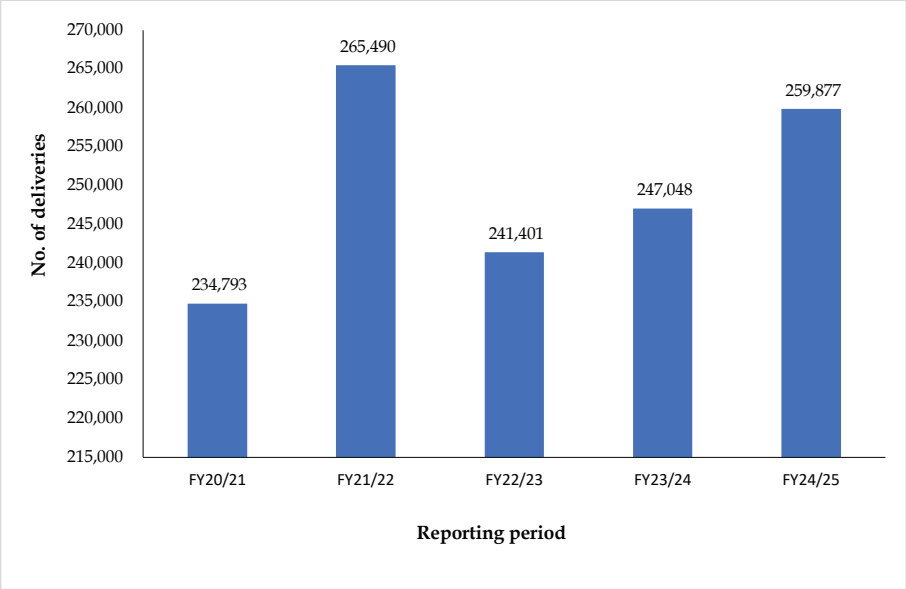
From FY2020/21 to FY2024/25, total ANC-1 attendance across the TPSR districts showed a consistent upward trend, reflecting improvement in access to maternal health services. However, the proportion of teenagers (10–19 years) attending ANC-1 declined slightly from 25% in FY2020/21 to 23% in FY2024/25. Districts such as Namisindwa (Bugisu), Kole and Oyam (Lango), and Zombo (West Nile) consistently recorded

the highest teenage ANC proportions (26–31%), indicating persistent adolescent pregnancies despite improvements in overall ANC coverage. On the other hand, urban or semi-urban areas such as Lira City, Soroti City, and Kampala maintained the lowest teenage proportions (15–19%), possibly due to greater access to education and adolescent health information.

Regionally, Bukedi, Lango, and Bugisu stood out with teenage ANC attendance consistently above 23%, while Ankole, Karamoja, and Kampala remained below 15%. The gradual decline in teenage ANC-1 proportions despite increased total ANC attendance suggests that the rise in overall service utilization is being driven largely by adults, not adolescents. This pattern highlights an ongoing challenge in engaging teenage mothers in antenatal services, especially in rural and high-burden districts. To address this, region-specific adolescent reproductive health strategies—particularly in Lango, Bugisu, and Bukedi—are needed to reduce teenage pregnancies and improve timely ANC initiation among adolescents

Annex 2: Adolescent child deliveries graph

Figure 1: Trends in deliveries among adolescents over the last 5 years



The number of adolescent deliveries has remained high over the last five years, with fluctuations observed. Deliveries rose from 234,793 in FY2020/21 to a peak of 265,490 in FY2021/22, before dropping to 241,401 in FY2022/23. A steady increase followed, reaching 247,048 in FY2023/24 and 259,877 in FY2024/25.

Deliveries among adolescents by region

Region	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25
Acholi	11,838	14,044	13,120	12,811	13,266
Ankole	11,816	13,540	13,159	12,777	14,400
Bugisu	16,250	21,289	18,664	17,729	18,258
Bukedi	20,442	22,176	19,188	19,733	20,064
Bunyoro	17,017	19,101	16,578	17,703	18,250
Busoga	22,537	25,325	23,925	24,899	28,088
Kampala	5,853	6,367	6,148	6,387	6,785
Karamoja	4,375	5,065	4,451	4,996	5,582
Kigezi	6,970	7,686	6,856	6,511	6,739
Lango	18,215	19,924	17,001	19,300	20,034
North Buganda	23,515	25,220	23,622	24,037	24,755
South Buganda	17,501	19,694	17,990	17,911	20,045
Teso	15,943	17,780	15,573	16,149	15,924
Tooro	20,923	24,574	23,026	22,258	22,905
West Nile	21,598	23,705	22,100	23,847	24,782
National	**234,793**	**265,490**	**241,401**	**247,048**	**259,877**

Overall, the total number of **facility deliveries** across all regions in Uganda increased steadily from **234,793 in FY2020/21 to 259,877 in FY2024/25**, indicating continued improvements in maternal health service utilization and institutional delivery coverage. Most regions showed gradual growth with minor year-to-year fluctuations. **Busoga, North Buganda, and Tooro** consistently recorded the **highest delivery volumes**, each surpassing 22,000 deliveries by FY2024/25, reflecting both large catchment populations and stronger facility delivery uptake. **Bukedi, West Nile, and Lango** also maintained strong and relatively stable figures throughout the five-year period. In contrast, **Kampala and Karamoja** reported the lowest delivery numbers, remaining under 7,000 and 6,000 respectively, suggesting possible underreporting, smaller populations, or higher reliance on private or non-facility births in these areas.

Trends across the five years show a general upward trajectory, although a slight **dip occurred in FY2022/23** in most regions before recovery in subsequent years. This temporary decline could be attributed to residual impacts of the COVID-19 pandemic, mobility restrictions, or health system disruptions. By FY2024/25, nearly all regions had rebounded, with **Busoga, South Buganda, and Ankole** achieving their highest delivery counts over the period. The consistent rise in total institutional deliveries underscores progress toward safer motherhood and reduced maternal and neonatal mortality, though persistent **regional disparities**—particularly in **Karamoja, Kigezi, and Kampala** highlight the need for targeted interventions to strengthen access and equity in skilled birth attendance

Deliveries for adolescents among TPSR districts

Region	District	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25
Acholi	Amuru District	1,380	1,657	1,390	1,354	1,249
	Lamwo District	1,014	1,144	1,129	1,210	1,122
	Omoro District	1,145	1,421	1,388	1,376	1,329
Bugisu	Manafwa District	1,632	2,831	1,933	1,475	1,524
	Namisindwa District	2,381	3,790	3,062	2,772	2,764
	Sironko District	2,242	2,797	2,450	2,337	2,457
Bukedi	Budaka District	3,354	3,366	2,806	2,739	2,399
	Butaleja District	3,066	3,259	2,474	2,545	2,531
	Butebo District	957	1,003	836	889	810
Bunyoro	Kiryandongo District	2,399	2,580	2,327	2,370	2,388
Busoga	Bugiri District	2,637	2,707	2,726	3,193	3,750
	Kamuli District	3,478	3,663	3,377	3,187	3,081
	Luuka District	937	996	980	1,179	1,109
	Namayingo District	1,238	1,633	1,707	1,713	2,021
	Namutumba District	1,231	1,470	1,242	1,414	1,743
Lango	Amolatar District	1,119	1,394	1,288	1,639	1,637
	Apac District	1,585	1,535	1,567	1,728	1,648
	Dokolo District	1,836	1,889	1,384	1,573	1,694
	Kole District	1,931	2,579	2,109	2,063	2,234
	Kwania District	1,822	1,982	1,627	1,911	2,040
	Lira City	1,813	2,138	1,737	1,906	1,940
	Lira District	1,087	1,284	1,191	1,358	1,380
	Otuke District	898	931	719	810	1,035
	Oyam District	4,495	4,489	3,907	4,587	4,633
Teso	Kapelebyong District	842	828	702	778	801
	Soroti City	1,409	1,639	1,480	1,384	1,303
	Soroti District	1,357	1,379	1,183	1,376	1,153
Tooro	Bundibugyo District	2,327	2,787	2,433	2,272	2,885
	Ntoroko District	678	757	680	632	757
West Nile	Nebbi District	3,156	3,361	3,010	3,298	3,508
	Obongi District	616	670	641	711	733
	Zombo District	2,238	2,405	2,186	2,359	2,149
	TPSR Districts	***8,300***	***66,364***	***57,671***	***0,138***	***1,807***

Across the TPSR districts, the total number of deliveries by teenagers fluctuated slightly over the five-year period, increasing from 58,300 in FY2020/21 to 61,807 in FY2024/25. Most districts registered small year-to-year variations, with overall upward trends observed in regions such as Busoga, Lango, and West Nile, while others like Bukedi and Bugisu recorded slight declines in later years. Districts such as Oyam (Lango) and Nebbi (West Nile) consistently had the highest deliveries, maintaining figures above 3,000–4,000 per year. In contrast, districts like Kapelebyong, Obongi, and Ntoroko maintained comparatively low numbers

Bukedi and Bugisu experienced noticeable drops between FY2021/22 and FY2022/23, which may indicate temporary disruptions in service delivery or reporting.

Annex 3: Adolescent GBV matrix

Region	District	FY2020/21			FY2021/22			FY2022/23			FY2023/24			FY2024/25		
		Abortion due to GBV	Abortion due to GBV (10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV (10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV (10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV(10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV(10-19)	%age contribution of Teenager to abortion due to GBV
Acholi	Amuru	7	0	0%	8	6	75%	5	1	20%	9	1	11%	2	0	0%
Acholi	Lamwo	8	2	25%	7	0	0%	11	2	18%	0	0		3	1	33%
Acholi	Omoro	4	0	0%	13	1	8%	6	2	33%	7	1	14%	4	0	0%
Bugisu	Manafwa	8	2	25%	3	0	0%	0	0		28	0	0%	0	0	
Bugisu	Namisindwa	6	0	0%	1	1	100%	5	3	60%	0	0		12	5	42%
Bugisu	Sironko	13	8	62%	23	5	22%	12	7	58%	13	3	23%	12	4	33%
Bukedi	Budaka	65	17	26%	109	45	41%	88	37	42%	45	27	60%	113	46	41%
Bukedi	Butaleja	1	1	100%	14	2	14%	14	4	29%	4	1	25%	15	1	7%
Bukedi	Butebo	0	0		0	0		0	0		0	0		22	7	32%
Bunyoro	Kiryandongo	11	7	64%	37	14	38%	0	0		26	6	23%	61	25	41%
Busoga	Bugiri	35	8	23%	13	5	38%	34	16	47%	5	2	40%	3	0	0%
Busoga	Kamuli	109	34	31%	5	1	20%	18	8	44%	40	13	33%	117	43	37%
Busoga	Luuka	10	6	60%	2	1	50%	4	0	0%	53	15	28%	45	25	56%

Region	District	FY2020/21			FY2021/22			FY2022/23			FY2023/24			FY2024/25		
		Abortion due to GBV	Abortion due to GBV (10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV (10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV (10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV(10-19)	%age contribution of Teenager to abortion due to GBV	Abortion due to GBV	Abortion due to GBV(10-19)	%age contribution of Teenager to abortion due to GBV
Busoga	Namayingo	13	7	54%	5	1	20%	32	10	31%	12	2	17%	1	1	100%
Busoga	Namutumba	5	1	20%	0	0		1	1	100%	3	3	100%	4	0	0%
Lango	Amolatar	6	1	17%	4	0	0%	1	0	0%	10	4	40%	13	5	38%
Lango	Apac	1	0	0%	3	0	0%	42	10	24%	362	169	47%	0	0	
Lango	Dokolo	12	0	0%	10	5	50%	16	4	25%	2	1	50%	4	0	0%
Lango	Kole	3	1	33%	9	3	33%	8	2	25%	8	5	63%	9	7	78%
Lango	Kwania	6	0	0%	10	5	50%	1	1	100%	2	0	0%	23	11	48%
Lango	Lira City	18	2	11%	56	12	21%	21	3	14%	6	1	17%	9	2	22%
Lango	Lira	1	0	0%	0	0		8	1	13%	4	0	0%	38	14	37%
Lango	Otuke	2	2	100%	0	0		0	0		0	0		0	0	
Lango	Oyam	31	8	26%	27	11	41%	5	0	0%	26	5	19%	19	3	16%
Teso	Kapelebyong	2	2	100%	0	0		2	0	0%	0	0		11	2	18%
Teso	Soroti City	4	1	25%	4	1	25%	7	1	14%	5	3	60%	2	0	0%
Teso	Soroti	1	0	0%	0	0		3	0	0%	1	0	0%	4	2	50%
Tooro	Bundibugyo	24	9	38%	1	1	100%	3	0	0%	4	2	50%	13	3	23%
Tooro	Ntoroko	6	1	17%	3	0	0%	0	0		0	0		8	1	13%
West Nile	Nebbi	1	0	0%	22	8	36%	1	0	0%	3	1	33%	38	20	53%
West Nile	Obongi	8	0	0%	0	0		3	0	0%	5	1	20%	1	0	0%
West Nile	Zombo	9	4	44%	10	4	40%	2	0	0%	0	0		4	1	25%

Over the past five financial years, the burden of abortions attributed to gender-based violence has continued to manifest across multiple districts, with adolescents aged 10–19 years contributing a considerable proportion of the reported cases. While the overall number of GBV-related abortions fluctuates by district and region, the data show a persistent vulnerability among teenage girls who experience violence leading to unintended pregnancies and unpost abortions.

Regional Overview: Across regions, **Bukedi, Busoga, and Lango** consistently recorded higher numbers of abortions linked to GBV. In **Bukedi**, Budaka District stands out, reporting a steady increase in both total cases and adolescent contribution rising from 26% in FY2020/21 to 41% in FY2024/25. **Busoga** sub-region, particularly Kamuli and Luuka, demonstrates similarly high teenage contributions, with Luuka reaching 56% in FY2024/25, suggesting deep-rooted challenges related to adolescent sexual violence and limited access to reproductive health services.

In **Lango**, an alarming trend is observed in Apac District, where GBV-related abortions rose sharply to 362 cases in FY2023/24, with adolescents contributing nearly half (47%) of these cases. This points to the intersection between GBV, teenage pregnancy, and limited empowerment of adolescent girls in the sub-region. Kole and Kwania also exhibit rising trends, with teenage contributions reaching 78% and 48% respectively in FY2024/25—among the highest Nationally.

Emerging Patterns and Concerns: Although some districts such as Namisindwa, Namutumba, and Otuke recorded relatively lower absolute numbers, the proportion of adolescent involvement often surpassed 50%, emphasizing that even in low-burden settings, teenagers remain disproportionately affected. The data also highlight year-to-year inconsistencies, likely reflecting variations in reporting, community awareness, or access to care following GBV incidents.

Conversely, **West Nile** and **Acholi** sub-regions display moderate but persistent teenage involvement, with Nebbi reporting a steady increase culminating at 53% in FY2024/25. The occurrence of abortion due to GBV in these regions underscores ongoing risks faced by young girls amid humanitarian settings and post-conflict vulnerabilities.

Overall, teenage girls (10–19 years) contribute between **20–50%** of all abortions due to GBV in many districts, demonstrating the strong link between gender-based violence, unintended adolescent pregnancy, and unpost abortion practices. These trends signal the urgent need for integrated responses that combine **GBV prevention, adolescent sexual and reproductive health education, psychosocial support, and legal protection**.

There is also a need to strengthen **community-based reporting systems**, ensure **availability of adolescent-friendly services**, and enhance **linkages between GBV response units and reproductive health programs** at district and facility levels. Targeted interventions in high-burden districts such as Budaka, Kamuli, Luuka, Apac, and Kole are critical to reversing this trend and protecting adolescent girls from avoidable reproductive health consequences of violence.

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