



**BUDGET ANALYSIS STUDY  
FOR FAMILY  
PLANNING/SEXUAL AND  
REPRODUCTIVE HEALTH  
(FP/SRH)  
FY2022/23-2023/24**

**NATIONAL AND SUB-NATIONAL LEVEL**



## ACKNOWLEDGEMENT

This report would not have been a success without the support of Mityana and Kassanda District Health Offices and the various health officials stewarding the health departments in these districts. Action 4 Health Uganda (A4HU) also appreciates the consultant, Samasha Medical Foundation, who spearheaded the research process and the production of this report finalized in September 2025.

Action 4 Health Uganda is an implementing partner under the TeamUp Uganda program in Mityana and Kassanda Districts.



### Implemented by:



### Financed by:



## Table of Contents

Definitions of Key Terms .....	iv
List of Acronyms .....	vi
Executive Summary.....	vii
<i>Chapter 1: Introduction</i> .....	1
1.1 Family Planning/Sexual and Reproductive Health Financing in Uganda.....	1
1.2 FP/SRH Financing as Reflected in National Policies.....	2
1.3 Rationale for the Budget Analysis Study.....	3
1.4 Objectives of the Study.....	4
1.5 Scope of the Study .....	4
<i>Chapter 2: Approach and Methodology</i> .....	5
2.1 Approach .....	5
2.2 Methodology.....	5
2.2.1 Study Design .....	5
2.2.2 Sample Selection .....	6
2.2.3 Study Preparations and Data Collection Process .....	6
2.2.4 Data Collection.....	6
2.2.5 Data Collection Tools.....	7
2.2.6 Ethical Considerations .....	7
2.2.7 Data Management and Analysis.....	7
<i>Chapter 3: Study Findings</i> .....	9
3.1 Health Sector Financing.....	9
3.2 Ministry of Health Budget.....	10
3.3 Donor Contributions to the Health Sector.....	10
3.4 GoU FP/RH Allocation and Spending.....	11
3.4.1 FP/SRH Commodities Allocation and Expenditure .....	12
3.4.2 FP/SRH Programs Allocation and Expenditure .....	13
3.5 Cross-Sectoral Linkages .....	16
3.6 District FP/SRH Allocation and Expenditure.....	17
3.7 Family Planning Budget Composition.....	20
3.8 FP/RH Budget Summary .....	20
3.9 Subcounty FP/SRH Budget Allocation and Expenditure .....	21

<i>Chapter 4: Findings from Key Informant Interviews</i> .....	23
a) The Local Government Budget Process/Cycle.....	23
b) Role in the Budget Process .....	23
c) Documents that Guide the Budgeting Process .....	24
d) Involvement of Civil Society in the Budget Process.....	24
e) The District FP/SRH Budget.....	24
f) Cross-sectoral Linkages.....	24
<i>Chapter 5: Findings from Health Facility Assessments</i> .....	26
<i>5.2 Community Perspectives</i> .....	29
3.5.1 Sub-counties Sampled for Community Perspectives .....	29
<i>Chapter 6: Recommendations and Conclusion</i> .....	33
National level.....	33
Sub-national level .....	34
References.....	35

## List of Figures and Tables

Figure 1: A4HU/DSW's Budget Monitoring Methodology.....	5
Figure 2: Health Sector Budget Allocations.....	9
Figure 3: Ministry of Health Budget.....	10
Figure 4: Donor Contributions to the Health Budget.....	11
Figure 5: Reproductive Health Budget Allocations and Expenditures (Commodities) .....	12
Figure 6: Donor support to the RMNCAH Program 2023/24.....	16
Figure 7: Ministry of Education and Sports Budget Allocations to SRH-related Activities .....	17
Figure 8: Local Government Budget Cycle .....	23
Figure 9: Availability of FP/SRH Services .....	26
Figure 10: Availability of FP/SRH Commodities .....	27
Figure 11: Delivery of Adolescent-Responsive Health Services .....	28
Figure 12: Demographic Characteristics.....	29
Table 1: Health Facilities Assessed.....	6
Table 2: Vote sourcing for FP/SRH Resources .....	11
Table 3: FP Commodities Allocations and Expenditures .....	12
Table 4: Donor Allocations to Family Planning Commodities.....	13
Table 5: Expenditure on FP Commodities .....	13
Table 6: Reproductive Health Budget Allocations (Programs) .....	14
Table 7: FP/SRH Budget Allocations and Expenditure.....	14
Table 8: Allocation and Spending at Regional Referral Hospitals .....	15
Table 9: Kassanda District Allocation and Expenditure to FP/RH in Selected Districts .....	18
Table 10: Mityana District Allocation and Expenditure to FP/RH in Selected Districts .....	19
Table 11: Composition of the District Family Planning Budget Allocations.....	20
Table 12: District FP/RH Budget .....	21
Table 13: Subcounty FP/SRH Budget Allocation and Expenditure .....	21
Table 14: FGD Challenges and Proposed Recommendations .....	32

## Definitions of Key Terms

<b>Term</b>	<b>Definition</b>
Comprehensive Sexuality Education (CSE)	Age-appropriate, scientifically accurate information on sexuality and health.
Contraceptive Prevalence Rate (CPR)	% of women of reproductive age (15–49) using any contraceptive method at a given time.
Family Planning (FP)	Regulation of fertility through contraceptive methods to promote maternal and child health.
Family Planning Commodities	Health products and medical supplies used to prevent unintended pregnancies, space or limit childbirth, and support reproductive health.
Family Planning Programs	Coordinated interventions, policies, and activities aimed at delivering FP services, enhancing awareness, promoting behavior change, training personnel, and ensuring method availability and uptake.
FP2030	Global partnership tracking progress toward universal access to modern contraception by 2030.
Informed Choice	Individuals receive full info and voluntarily choose preferred method. Core to rights-based FP.
Method Mix	Distribution of contraceptive users by method type. Assesses choice and responsiveness.
Modern Contraceptive Methods	Includes IUDs, implants, injectables, pills, condoms, sterilization. Approved methods for FP2030 tracking.
Modern Contraceptive Prevalence Rate (mCPR)	Proportion of women of reproductive age (usually 15–49) currently using modern contraceptive methods such as pills, injectables, implants, IUDs, condoms, or sterilization.
Off-budget support	Financial transactions often excluded from government budget and often difficult to control
On-Budget support	Funding sources that occur through the official government budget management system
Out-of-Pocket Expenditure (OOP)	Share of health spending that households pay directly at the time of service, excluding prepayments and insurance. High OOP can signal poor financial protection.
Service Delivery Points (SDPs)	Locations providing FP services; health facilities, clinics, pharmacies, outreach sites.

<b>Term</b>	<b>Definition</b>
SRHR (Sexual and Reproductive Health and Rights)	Human rights related to sexuality, reproduction, and bodily autonomy.
Total Health Expenditure (THE)	Aggregate expenditure on health from public, private, and donor sources, expressed as either absolute value or percentage of GDP. Includes all health-related services and infrastructure
Total Market Approach (TMA)	Coordination across public, private, and NGO actors to expand FP access and equity.
Unmet Need for Family Planning	Percentage of women of reproductive age who want to delay or stop childbearing but are not using any method of contraception. Includes unmet need for spacing and limiting.
Youth-Friendly Services	A holistic, youth-friendly health-care package of services tailored for young people. These include: <ul style="list-style-type: none"> <li>• Universal access to accurate SRH information</li> <li>• A range of safe and affordable contraceptive methods</li> <li>• Sensitive counseling</li> <li>• Quality obstetric and antenatal care for all pregnant women and girls</li> <li>• The prevention and management of STIs, including HIV</li> </ul>

## List of Acronyms

A4HU	Action 4 Health Uganda
COCs	Combined oral contraceptives
CSO	Civil Society Organization
DCIP	District Family Planning Costed Implementation Plan
DHO	District Health Officer
DLG	District Local Government
ECP	Emergency Contraceptives
FP	Family Planning
FP CIP	Family Planning Costed Implementation Plan
FY	Financial Year
FGD	Focus Group Discussion
GoU	Government of Uganda
HDPs	Health Development Partners
IEC	Information Education and Communication
IUD	Intrauterine Device
KIIs	Key Informant Interviews
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MDAs	Ministries Departments and Agencies
mCPR	modern Contraceptive Prevalence Rate
NMS	National Medical Store
NWR	Non-Wage Recurrent
OOP	Out of Pocket Payments
PHC	Primary Health Care
PIAP	Programme Implementation Action Plan
POPs	Progestin only pills
PNFP	Private Not for Profit
QPPU	Quantification and Procurement Planning Unit
RH	Reproductive Health
RMNCAH	Reproductive Maternal New-born Child and Adolescent Health
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UCREPP	Uganda Covid 19 Response and Emergency Preparedness Project
URMCHIP	Uganda Reproductive Maternal Child Health Services Improvement Project
UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shillings
USAID	United States Agency for International Development
USD	United States Dollars
VHTs	Village Health Teams
WRA	Women of Reproductive Age

## Executive Summary

Access to voluntary family planning and sexual reproductive health (FP/SRH) services is essential for safe motherhood, healthy families, and sustainable development. Uganda has improved access to contraceptives, with the modern contraceptive prevalence rate among married women rising from 37.6% in 2020 to 41.2% in 2024. However, the country's health financing heavily relies on donors, posing a risk amid aid cuts. Sustainable, domestic financing strategies are urgently needed to ensure continuity and resilience service delivery.

To support evidence-based advocacy, A4HU and partners through the TeamUp project commissioned Samasha to conduct the budget analysis study on FP/SRH allocations and expenditures for FY2022/23 and FY2023/24. One of the key components of the TeamUp Uganda project is budget analysis as a source of evidence for budget advocacy with a focus on tracking government commitments, budget allocations, and expenditures on Family Planning and Sexual Reproductive Health and Rights.

The study covered FY2021/22 and FY2022/23 and was conducted during May-July 2025 at national level and sub-national level in two (2) districts of Mityana and Kassanda. The study focused on SRH and FP as its health themes. The methodology used was the A4HU/DSW's budget monitoring methodology that tracks government commitment, budget allocations and expenditures related to FP/SRH using bottom-up approach.

### Key findings

The largest proportion of funding for FP/SRH is financed by the MoFPED and allocated through two vote functions, i.e., Vote 014 Ministry of Health that covers program implementation and National Medical Stores Vote 116 for procurement, warehousing and distribution of FP commodities.

#### a) Government of Uganda FP Allocations and Expenditures

For two consecutive financial years (FY 2021/22 and 2022/23), the RH supplies budget remained unchanged at UGX 20.46 billion. In FY 2023/24, the allocation increased to Ugx 25.11 billion due to intensified advocacy efforts which later increased to Ugx 32.5 billion in FY2024/25. However, data on FP/SRH expenditures, particularly on programs remains limited and difficult to disaggregate. This highlights the need for improved reporting to ensure transparency and accountability in FP/SRH spending.

#### b) Other Actors' FP/SRH Allocation and Expenditure

The donors have over the years invested and continue to dedicate resources in FP/SRH. Funding for FP commodities is largely from USAID, UNFPA, and UCREPP for the period assessed. contributed UGX 75.8 billion towards RMNCAH programs. However, it was difficult to disaggregate the allocation to FP/SRH except for UNFPA.

#### c) Cross-sectoral Linkages

FP/SRH integration in the Human Capital Development (HCD) programme is clearly evident in the health and education sectors that incorporate objectives on FP/SRH. The Ministry of

Education and Sports (MoES) allocated UGX 0.355 billion in FY 2022/23, and UGX 0.177 billion in FY 2023/24 toward initiatives including menstrual health programs, implementation of the National School Health Policy, and social dialogues on SRH. However, execution of these budgets has been limited. In FY 2022/23, only 13.4% of the allocated funds was spent while no expenditures were recorded in FY2023/24.

At the district level, the DHO collaborates with the Education department in implementation of school health programs which provides entry points. However, there is no dedicated budget of FP/SRH from the departments, but these components are incorporated informally or addressed only when partners provide support. There is need to redefine and enhance integration of FP/SRH within cross-sectoral frameworks with clear budgeting provisions.

#### d) District Level FP/SRH Funding

The National FP-CIP II (FY2020-21-FY2024/25) provides guidance for increased knowledge, awareness and access to FP/SRH interventions at local government level. This study revealed that Mityana has a District FP Costed Implementation Plan (2024/25-2029/30), while Kassanda does not have one. In addition, these two districts did not have explicit budgets for implementing FP programs. The key informant interviews and discussions revealed that FP activities are integrated within PHC budget and could not easily estimate how much is spent on FP/SRH. It was also noted that most of the FP/SRH activities in the districts were financed through Results Based Financing funds in FY 2021/22-2022/23. However, there was reduced commitment of funds to FP/SRH activities due to close out of URMCHIP in FY2023/24.

#### e) Participation in FP/SRH budget processes

There is active participation of civil society in the national and local government planning and budget conferences where they advocate for health to be prioritized. The participation and engagement of adolescents and youth representatives is still wanting.

There was no involvement of the participants in any health-related budgeting processes at the district. Most participants were unfamiliar with the budgeting process, with only Community Development Officers (CDOs), Parish Development Committee members, and local council representatives actively participating. Participants expressed a desire for greater involvement, particularly in advocating for FP/SRH-related needs, especially adolescents and young people.

#### f) Youth Perspectives on FP/SRH

Youth highlighted that health facilities lack confidential, respectful, and non-judgmental services. Strong cultural and religious beliefs caused fear of disclosure to parents and other family members thus discouraging utilization among unmarried youth. Low awareness and limited access to accurate FP/SRH information, coupled by misinformation from peers, social media and some community leaders. There is need for ongoing sensitization and behavior change communication, with FP/SRH messages packaged in an age-appropriate and culturally sensitive manner to effectively reach and resonate with young people.

#### g) Challenges in financing of FP/SRH services.

- Lack of FP specific budget lines in the district budgets.
- Poor execution of the cross-sectoral health budgets.
- Limited domestic resource allocation by needs.
- Minimal community and youth participation and engagement in local government budgeting processes.

### **Recommendations**

There is need to intensify advocacy efforts for FP/SRH budget transparency at the national level including;

- a) Implementation of Universal Health Coverage through fast-tracking the National Health Insurance (NHIS) 2024 Bill.
- b) Mainstreaming off-budget FP/RH financing into national budgets.
- c) Revision and update of the Budget Monitoring Methodology and tools.
- d) Advocating for District Local Governments to allocate funds from their local revenues towards provision of FP/SRH services.

At the sub-national level;

- a) To mainstream FP/SRH interventions in district workplans and budgets.
- b) To strengthen community participation in planning and budgeting processes.
- c) To create and support implementation District male engagement plans.

## Chapter 1: Introduction

### 1.1 Family Planning/Sexual and Reproductive Health Financing in Uganda

Access to voluntary family planning and sexual reproductive health (FP/SRH) services is vital for safe motherhood and healthy families. Family planning is fundamental to improving reproductive health outcomes and the economic, social, and environmental dimensions of sustainable development. Uganda has made significant progress with respect to improving access to contraceptive services. The modern contraceptive prevalence rate (CPR) among married women of reproductive age (15-49 years) increased from 37.6% in 2020 to 41.2% in 2024<sup>1</sup>.

However, despite significant progress, challenges persist. The mCPR across age groups has not changed substantially, and demand satisfaction has stagnated at 62% over the last two years. Many rural and underserved communities still lack access to comprehensive family planning services. Stigma and misinformation about contraception and negative perceptions of family planning compound this issue. Uganda's high rates of adolescent pregnancy (24%) highlight the urgent need for tailored interventions that empower youth. The unmet need for modern contraception, particularly among vulnerable groups, remains a critical issue. Uganda currently has a population of over 45.9 million. The Uganda Demographic and Health Survey 2022 reveals that 2 out of every 10 married women in Uganda desire to use contraception but lack access to the necessary services. This situation is exacerbated by entrenched gender inequality, harmful practices, and limited access to services.

The reproductive health financing landscape in Uganda is complex, characterized by a mix of government allocation, significant donor dependence, and substantial private sector payments. According to the latest National Health Accounts (NHA) of FY 2020/21, contributions during that period were as follows; Health Development Partners (HDPs) at 45.4%, Private sector (mainly household out-of-pocket and voluntary health insurance schemes) at 29% and Government at 25.6%. Furthermore, Uganda spends approximately US \$5.46 (Ugx 19,972) per capita on reproductive health, which is below the WHO-recommended US \$86 needed for essential health services.<sup>4</sup> A key vulnerability in Uganda's health financing landscape is its heavy dependence on external donor funding. However, future projections warn of a significant decline in donor contributions given the current aid cuts, a shift that could severely undermine the delivery of essential services unless the country adopts more sustainable, homegrown financing strategies. These high OOP costs expose households to catastrophic health expenditures, particularly among the poorest and most vulnerable populations and contribute to health-related financial hardship and inequity.

---

<sup>1</sup> Track20, 2024., *Uganda Progress 2023* <https://track20.org/Uganda>

<sup>2</sup> PMA 2024., *Phase 4 cross-sectional survey*

<sup>3</sup> Uganda Bureau of Statistics (UBOS). 2024. *National Population and Housing Census, 2024*.

<sup>4</sup> World Health Organization (WHO). (2025). *Global Health Expenditure Database*. Geneva: WHO.

## 1.2 FP/SRH Financing as Reflected in National Policies

Access to FP/SRH services, information and education globally is underpinned by the International Conference on Population and Development 1994 (ICPD), SDG3 specifically target 3.7, FP2030 Commitments and the UN Global strategy on mothers', children's and adolescents' health 2016-2030 recognizing the importance of meeting the people's reproductive health needs including unmet need for FP. Uganda has since worked to establish policies; strategies and guidelines aimed at improving these health outcomes. These frameworks are grounded in the country's demographic realities, health system challenges, and long-term development aspirations.

Human capital development is a key pillar of Uganda's long-term transformation agenda. Uganda's Vision 2040 identifies human capital development as one of the fundamentals that need to be strengthened to accelerate the country's transformation and harnessing the demographic dividend, the accelerated economic growth possible when fertility declines sharply and more of the population is working age and employed in well-paying jobs. Growing government commitment and investment in family planning can result in a sustained decline in fertility that leads to manageable numbers of children per family and lasting changes in a population's age structure which in turn can affect economic development opportunities. Complementing this vision, the Third National Development Plan (NDP III) (2020/21–2024/25) underscores Human Capital Development (HCD) as a national priority, recognizing reproductive health and family planning as essential components for accelerating socio- economic transformation. The HCD Programme aims to reduce fertility rates, improve maternal and child health and expand access to health services—objectives that are directly linked to robust FP/SRH programming and financing.

There is high-level political good-will and commitment to increase funding for health. To support the financing of these priorities, the Second National Health Financing Strategy (NHFS II, 2019/20–2029/30) outlines the vision for achieving universal health coverage (UHC) through sustainable, equitable and efficient health financing mechanisms. The strategy identifies key areas for reform, including increased domestic resource mobilization, reduced out-of-pocket expenditures, and better pooling and allocation of resources—factors that are critical to sustaining FP/SRH services, especially considering declining donor support.

The National Financing Strategy for FP services (2019) highlights innovative mechanisms which can enhance availability and uptake of SRH, especially FP in an equitable and sustainable manner—with emphasis on responsiveness to the needs of hard-to-reach population subgroups. It lays out the specific financing mechanisms for resource mobilization, pooling and purchasing, considering the delivery differentiated family planning services to cater for all.

The RMNCAH Sharpened Plan and Investment case (2021/22-2025/26) seeks to identify and use innovative financing mechanisms to improving efficiencies through integration and increasing domestic resource mobilization; regular resource tracking of national, district expenditure and reducing off-budget financing of RMNCAH services that currently stands at 79% (UGX 129 billion).

The National FP Costed Implementation Plan II (2020/21–2024/25) provides a detailed roadmap for scaling up FP services. The FP-CIP II aligns with global initiatives like FP2030 and the Sustainable Development Goals (SDGs) and sets targets for increased modern contraceptive use, reduced unmet need, and greater government financing for FP commodities and services. These policies and strategies ultimately create an enabling policy environment. However, implementation gaps, fragmented financing and limited accountability mechanisms, particularly at the sub-national level continue to hinder the realization of Uganda’s FP/SRH goals.

### 1.3 Rationale for the Budget Analysis Study

TeamUp Uganda is a multi-sectoral approach to development cooperation that applies a comprehensive approach to addressing complex challenges faced by young people by integrating socio-economic, health, educational, water, agriculture, and infrastructural aspects to reach 50.000 in-school and out-of-school youth between the ages of 12-35 years plus their families in Mityana and Kassanda Districts in Central Uganda. One of the key components of the TeamUp Uganda project is budget analysis as a source of evidence for budget advocacy with a focus on tracking government commitments, budget allocations, and expenditures on FP/SRH.

Subsequently, A4HU with her partners have over the years conducted annual budget analysis at district and national levels as entry points for ongoing engagements with national and subnational decision-makers to influence budgetary allocation for FP and SRH as well as track expenditures of the allocated budgets towards FP/SRH. Previous findings are published in reports, fact sheets and infographics targeting various audiences. The last analysis was conducted during the fiscal year 2021/22. It is against this background that A4HU contracted Samasha to undertake a new round of budget analysis covering the fiscal years 2022/23 and 2023/24. This study is therefore expected to provide actionable insights and recommendations to improve budget allocation and expenditures on FP/SRH.

---

<sup>5</sup> Initiated by the Federal Ministry for Economic Cooperation and Development of the German government (BMZ) and managed as well as co-financed by three German-based foundations, namely: Deutsche Stiftung Weltbevölkerung (DSW), Hanns R. Neumann Stiftung (HRNS) and Siemens Stiftung

#### 1.4 Objectives of the Study

The main objective of the study was to provide a comprehensive analysis of financial allocations and expenditures on FP/SRH programs for fiscal years 2022/23 and 2023/24 at the national and sub-national level.

Specifically, to;

- a) Establish annual budget allocations at the national and sub-national level for FP/SRH
- b) Explore the expenditure in government ministries, departments, and agencies for FP/SRH programs.
- c) Provide recommendations that will inform evidence-based policy advocacy towards increasing FP/SRH financing at the national and sub-national level.

#### 1.5 Scope of the Study

The study focused on SRH and FP as its health themes. It was conducted at the national and district levels to ensure a comprehensive analysis of FP budget allocations and expenditure tracking for FY 2022/23 and FY 2023/24. At the national level, the study engaged key institutions, including the Ministry of Health (MoH), relevant agencies, departments, and other line ministries involved in health financing and policy implementation. This provided insights into national budgetary commitments, policy frameworks, and expenditure trends related to FP/SRH services.

At the district level, the study focused on District Health Offices, selected health facilities within sub-counties and community members. This enabled the assessment of how FP funds are allocated, utilized, and experienced at the service delivery level. Additionally, community engagement ensured that the perspectives of service users, including youth and marginalized groups are captured to provide a holistic view of FP financing effectiveness.

##### About the districts

**Mityana district** is located in the central region of Uganda and administratively divided into 2 counties, 10 sub-counties, and 4 Town Councils. According to the NPHC 2024 report, the total population count is 407,386 with 197,040 male and 1210,346 as female of which 19.5% are within the 15-24 age group. Mityana has a total of 73 health facilities, of which 36 is government-owned, 24 PNFP and 13 by private sector. The teenage pregnancy rate stands at 17% while the unmet need for FP is at 24.1%.

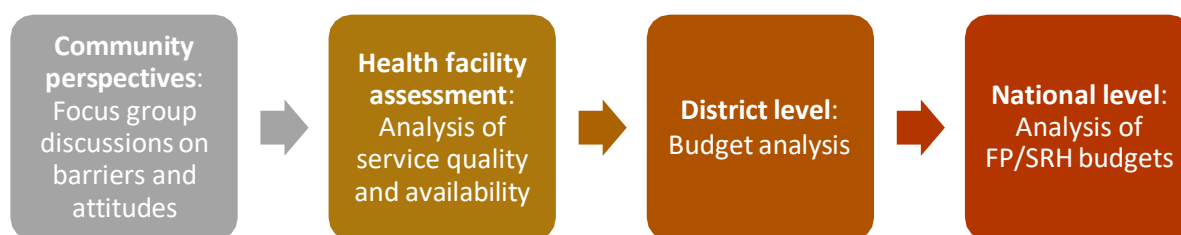
**Kassanda district** is located in the central region of Uganda and administratively divided into 9 parishes, 12 sub-counties, and 03 Town Councils. According to the NPHC 2024 report, the total population count is 314,008 with 153,298 males and 160,710 as females of which 19.3% are within the 15-24 age group. Kassanda has a total of 35 health facilities, of which 21 is government-owned and 10 PNFP and 4 by private sector.

## Chapter 2: Approach and Methodology

### 2.1 Approach

Samasha committed to using a rigorous, highly participatory and evidence-driven approach. We adapted the A4HU/DSW's budget monitoring methodology developed in 2014. This monitoring methodology focuses on tracking government commitments, budget allocations, and expenditures related to FP/SRH using a bottom-up approach, as shown in Figure 1 below. The methodology integrates community voices, health system realities, and policy landscape to deliver a comprehensive analysis.

Figure 1: A4HU/DSW's Budget Monitoring Methodology



### 2.2 Methodology

#### 2.2.1 Study Design

This was designed as a cross-sectional descriptive study using qualitative and quantitative methods. The dual approach enabled the triangulation of data from multiple sources, thereby strengthening validity and enriching the results. The study involved key informant interviews with health facility staff, selected national-level informants and a review of available policy and financing reports. Respondents at the HF were the in-charges, MCH focal persons, and delegated midwives. At the national level, these included program managers and technical experts from key ministries, including the Ministry of Health (Reproductive and Infant Health division), the Ministry of Education and Sports (MoES), and the Ministry of Finance, Economic Planning and Development (MoFPED).

The qualitative component included Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) at both national and sub-national levels. These were used to capture nuanced perspectives from various stakeholders, including community members, health workers, program managers, and policymakers. The FGDs focused on community-level attitudes, experiences, and knowledge regarding FP/SRH, while the KIIs provided expert insight into planning, budgeting, and implementation processes.

The quantitative component utilized validated structured assessments at selected health facilities to determine service availability, stock levels, and workforce capacity for delivering FP/SRH services. Data was also gathered through document reviews of national and district-level policies, budget plans, and expenditure reports to assess the alignment between commitments and actual financing.

This mixed-methods study design enabled a holistic understanding of the status of FP/SRH, integrating financial tracking with service delivery realities and community experiences.

### 2.2.2 Sample Selection

- *Participant selection*

The selection of the KIIs and FGD respondents was guided by the A4HU team in collaboration with the TeamUp Uganda youth structures and champions.

- *Selection of Health Facilities*

The consultant, in consultation with the A4HU team sought to have an inclusive representation to ensure a diverse range of public and private-not-for-profit (PNFP) facilities in the 2 districts. In each district, high-volume HC IIIs and IVs with high FP uptake were selected. A total of 10 health facilities were sampled including non-project supported facilities. Bearing in mind that TeamUp is currently supporting 2 sub-counties in Kassanda and

10 in Mityana, we were deliberate to focus on 5 sub counties per district for more representative sample as shown in Table 1 below.

*Table 1: Health Facilities Assessed*

District	Sub-county	Health facility	Ownership	TeamUp - supported
Mityana	Maanyi	Maanyi HCIII	Gov't	Yes
	Kakindu	Mwera HCIV	Gov't	Yes
	Bulera	Bulera HCIII	Gov't	Yes
	Kikandwa	Kikandwa HCIII	Gov't	Yes
	Central Division	Lulagala HCIII	PNFP	No
Kassanda	Kassanda Town Council	Kassanda HCIV	Gov't	Yes
	Bukuya Town Council	Bukuya HCIII	Gov't	Yes
	Kiganda	Musozi HCIII	Gov't	Yes
	Myanzi	Kasaana HCII	Gov't	No
	Kassanda Town Council	Makonzi HCII	PNFP	No

### 2.2.3 Study Preparations and Data Collection Process

Samasha held pre-field consultations with A4HU team to clarify on the sampling strategy and consensus on data tools. The research assistants were identified from the TeamUp district champions and oriented for 2 days on the different data collection tools.

### 2.2.4 Data Collection

Data was collected by trained data collectors with thorough understanding of the tools (Refer to Annex 1). Due diligence in data collection and management was observed. Each district team had a designated team leader who supervised field data collection and undertook

immediate review of data collected to ascertain accuracy, completeness, and consistency. This was done at the end of every day of data collection. Data entry and analysis was conducted at Samasha premises.

#### 2.2.5 Data Collection Tools

*Document Review:* A systematic review of existing policy frameworks, budget commitments and implementation performance. This included national documents such as those from the Ministry of Health, National Medical Store, Ministry of Education and Sports, Ministry of Finance and district-level documents such as approved annual workplans, approved annual budgets and budget performance reports from Mityana and Kassanda. This helped trace FP/SRH resource flows on FP/SRH commodities, Programs (service delivery, outreaches, and policy alignment across level).

*Focus Group Discussions (FGDs):* Samasha engaged community members to examine the state of FP/SRH services within their distinct socio-cultural contexts. A total of six FGDs were conducted across two districts, three sub-counties per district, to capture diverse perspectives. The FGDs involved women, men, young people, and members of vulnerable populations, enabling a nuanced understanding of community-level knowledge, attitudes, and experiences related to FP/SRH.

*Health Facility Assessments:* Health facility assessments were conducted in 10 purposively sampled facilities to evaluate the availability and quality of FP/SRH services, FP stock availability, and human resource capacities to deliver these services. This quantitative data provided insight into health system readiness and service delivery capacity.

*Key Informant Interviews (KIIs):* To complement the community and facility-level findings, we conducted Key Informant Interviews with relevant officials at national and district levels to establish the processes of prioritization and resource allocations for FP/SRH and confirm the information collected. Out of the 12 key informants reached, only 10 responded to the consultant team (Refer to Annex 2).

#### 2.2.6 Ethical Considerations

Official approval for this study was sought and granted by the TeamUp lead, A4HU alongside the Chief Administrative Officers (CAOs) and District Health Officers (DHOs) for Kassanda and Mityana districts. Throughout the data collection process, explicit consent was diligently sought from all participants, and their contributions were handled with confidentiality.

#### 2.2.7 Data Management and Analysis

Quantitative data on FP/SRH budget and health facility data was entered, cleaned and analyzed using Microsoft Excel. To ensure accuracy and prevent misrepresentation of FP funding and spending, verification was done with the relevant officials. Qualitative data obtained from Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were transcribed, manually coded and analyzed using a deductive/focused thematic approach. Verbal consent was sought from respondents of the study. Transcribed interviews and discussions were thoroughly reviewed to identify recurring themes, patterns and key insights

related to FP access and service delivery, challenges in FP/SRH financing, cross-sectoral linkages, attitudes and perceptions.

To enhance the credibility and transparency of the qualitative findings, illustrative quotes were systematically selected from the transcripts. Selection was guided by three criteria: (i) relevance to the identified theme, (ii) clarity and richness of expression, and (iii) representation of diverse participant categories. These quotes were used to exemplify key themes and provide authentic participant voices while maintaining confidentiality.

### 2.2.8 Challenges Faced During the Study

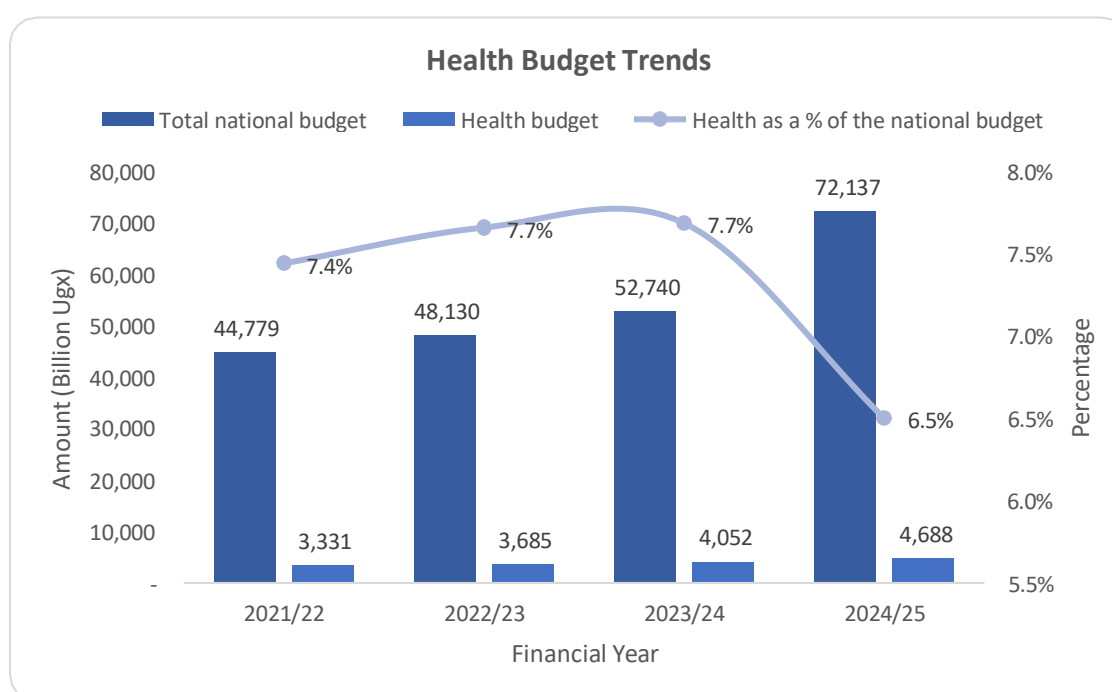
- Accessing data on FP/SRH allocations, releases, and expenditures at the district and sub county level proved challenging as these funds are integrated within broader Primary Health Care (PHC) budget lines rather than reported as standalone items or explicitly highlighted in MDA budgets. The limited access of data may have led to partial interpretation of financial flows and underrepresentation of district and sub- county variations. To minimize the impact of data access challenges, we triangulated information from multiple sources, including Key Informant Interviews, Focus Group Discussions, available budget documents, and workplans, to validate findings. Where data gaps persisted, we clearly noted these and avoided overgeneralization, ensuring that interpretations remained grounded in the available data.
- Response rate: The study could not obtain data from 02 heavily critical organizations (USAID and Enabel). At local government levels, some DHOs, most In-Charges of health facilities and records officers were not available at the time the data team visited the districts. To mitigate for non-response, we compensated for these gaps by using secondary data sources to supplement missing information. However, the absence of these perspectives may have limited the diversity of insights captured.
- The timing of the budget study made it difficult to interact with strategic respondents at the district level as they were engaged in financial year reviews (June -July 2025). To mitigate this, Samasha scheduled follow-up calls and virtual interviews. We recommend that future budget analysis studies be scheduled after the financial year reporting preferably between October and December of the new financial year.

## Chapter 3: Study Findings

### 3.1 Health Sector Financing

Public spending in the health sector occurs at both national and local government levels. At the national level, this is aligned to the HCD programme as per the NDP III objectives. This allocation is spread across 30 Vote lines<sup>6</sup>. However, there is still no single vote exclusive to FP/SRH. While there's no FP/SRH vote, allocated resources to FP/SRH are embedded in other votes. In absolute terms, the government allocation to the health sector has been on a steady increase since the 2021/22 financial year. However, the increase has not been fast enough to match the increase in total budget resulting in the country continuing to miss the target against international spending benchmarks. The health sector budget increased from UGX 3,331 billion in 2021/22 to UGX 4,688 billion in 2023/24, indicating a 40.7% increase. However, the spending is consistently below the Abuja Declaration which stipulates a 15% target for health spending, standing at 7.7% in FY2023/24. Figure 2 below shows the trend in the approved budget.

Figure 2: Health Sector Budget Allocations



Source: MoFPED MTEF, Annual Budget Performance Reports (2022-2024)

<sup>6</sup> MoH Headquarters, Uganda AIDS Commission, Uganda Blood Transfusion Services (UBTS), Health Service Commission, Butabika Hospital, Mulago Hospital, Uganda Cancer Institute, Uganda Heart Institute, National Medical Stores and KCCA.

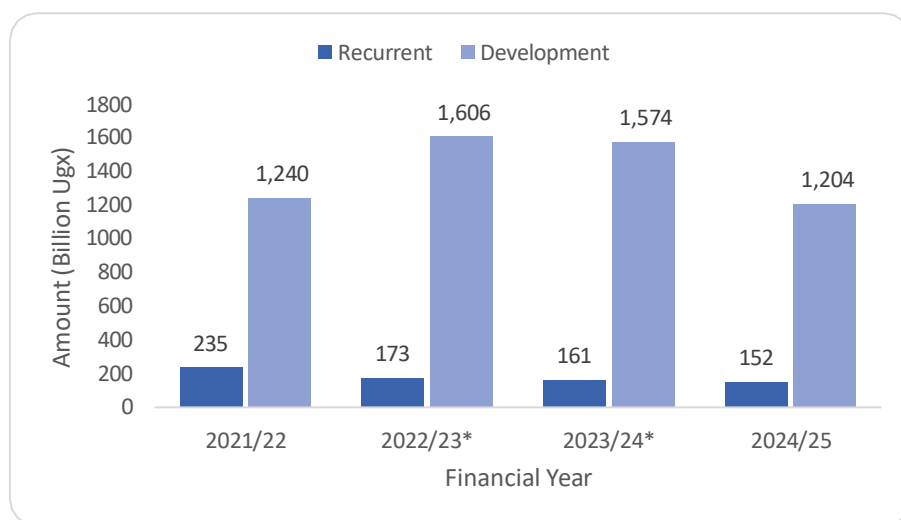
At the Local Government level, spending is mainly through conditional grants which include PHC Salaries, PHC Non-Wage, District Hospitals, PHC NGO Hospital Non-wage, NGO Wage Subvention, and PHC Development and Regional Referral Hospitals.

### 3.2 Ministry of Health Budget

In Uganda, the health system is generally financed through two main modalities which are on-budget and off-budget. The financing to these modalities comes through a variety of stakeholders who include the Government of Uganda, private sector, households and Health Development Partners (HDPs).

The majority of health sector spending is through the Ministry of Health. This is mainly due to the Ministry of Health being the principal recipient of external health sector financing. This is followed by expenditures through Local Government, National Medical Stores (NMS) and Referral Hospitals. Out of the total health sector budget, 34.7% (1,277.99 billion) and 42.8% (1,735.346 billion) was allocated to the Ministry of Health in FY 2022/23 and 2023/24, respectively, as shown in Figure 3 below. Total Recurrent budget was 172.653 billion and Development budget was 1,606.3 billion. GoU contribution to the Development budget accounts for only 5%, indicating a strong reliance on external financing sources.

Figure 3: Ministry of Health Budget

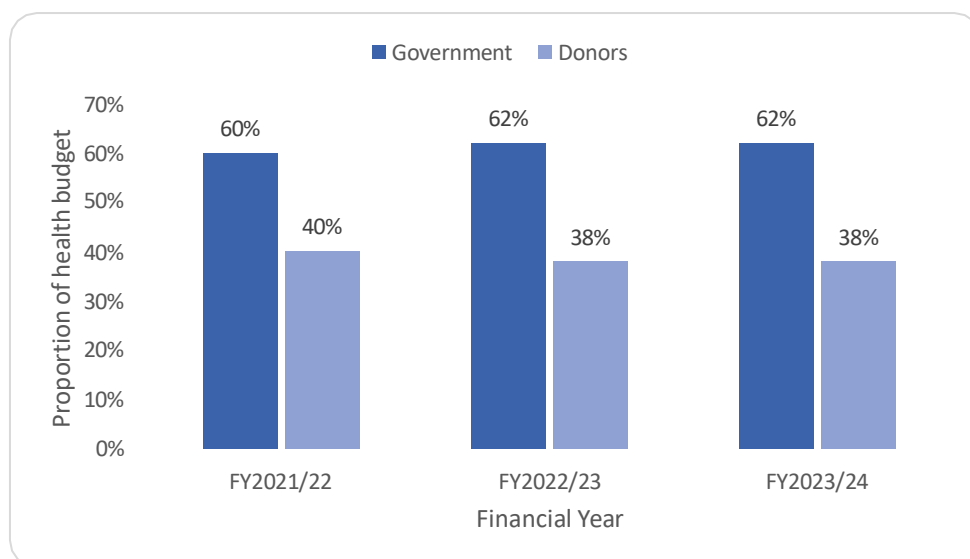


Source: MoFPED-Approved Budget Estimates FY 2021/22-2023/24

### 3.3 Donor Contributions to the Health Sector

While financing of the health sector is predominantly from GoU sources, external financing remains very significant contributor to total health sector financing. It is important to note that external financing for the health sector is predominantly through off-budget avenues that mostly target direct interventions in communities. In FY2022/23, the external financing was at 37% and 38% in FY 2023/24, having increased from 19% of the total health budget in FY2021/22 as shown in the Figure 4 below.

Figure 4: Donor Contributions to the Health Budget



Source: MoFPED Annual Budgets and Performance Reports (2022-2024)

### 3.4 GoU FP/RH Allocation and Spending

We assessed the percentage of the national health budget allocated for FP/SRH. MoFPED allocates funding for reproductive health (RH) through two main votes, that is Vote 014: Ministry of Health for FP/SRH related programs under NMS Vote 116 Output 320093 Reproductive Health supplies for the procurement, warehousing, and distribution of reproductive health commodities mainly Injectables, Mama Kits and Misoprostol. In addition to the 2 votes, FP/SRH resources can be traced in other votes summarized in the table 2 below.

Table 2: Vote sourcing for FP/SRH Resources

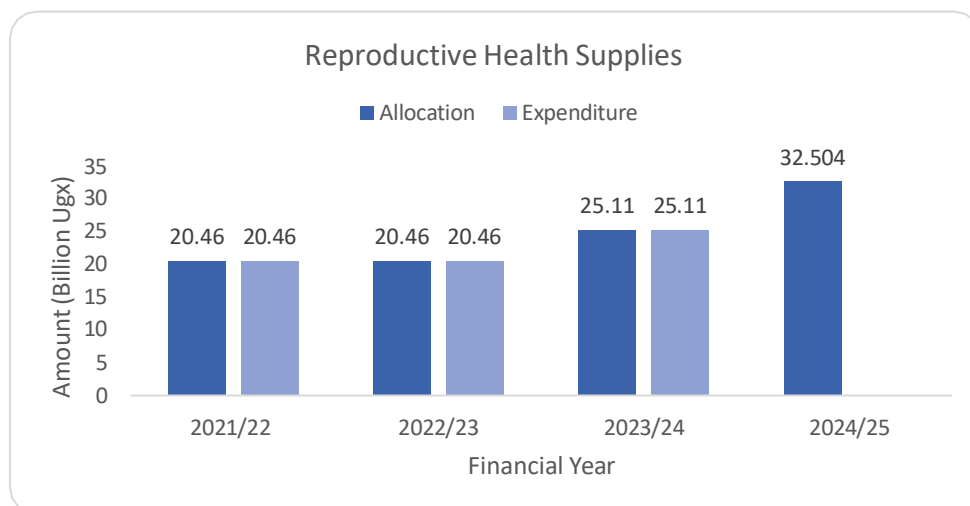
Vote	Description	Budget Output	Notes
014	Ministry of Health	320076, 320051	For FP Programs
116	National Medical Store (NMS)	320093	For procurement, storage and distribution of FP commodities
018	Ministry of Gender, Labour and Social Development (MoGLSD)	320145 320146	Response to Gender-based violence  Youth and Children
401, 416, 417, 418, 420	National Referral Hospitals	No budget output	Mulago, Naguru NRH, Kiruddu NRH, Kawempe NRH, Mulago Specialized Women and Neonatal Hospital
403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 419	Regional Referral Hospitals	320034	14 RRHs under budget output Prevention and Rehabilitation Services

Source: Samasha's Compilation

### 3.4.1 FP/SRH Commodities Allocation and Expenditure

For two consecutive financial years (FY 2021/22 and 2022/23), the RH supplies budget remained unchanged at UGX 20.46 billion as shown in Figure 5 below. The allocation rose to UGX 25.11 billion, reflecting a 22.7% increase. With advocacy efforts from civil society (RMNCAH CSO Platform, FPBAG and CSBAG), accelerated investment in 2024/25 was observed, with a 29.5% jump, bringing the allocation to UGX 32.504 billion.

Figure 5: Reproductive Health Budget Allocations and Expenditures (Commodities)



Source: MoFPED- NMS Approved Budget Estimates, and Vote Performance Reports

In FY2022/23, the entire RH supplies budget of Ugx 20.46 billion was used to procure Mama Kits. However, UGX 10,376,393,430 was acquired from the Global Financing Facility (GFF) to procure family planning commodities. This allocation rolled over from FY 2021/22 because funds were not disbursed then as delayed shipments from FY 2020/21 came in. In FY2023/24, UGX 3 billion was allocated and spent on family planning commodities (Depo Provera, Sayana Press, and Implanon NXT) out of the total RH commodity budget of UGX 25.11 billion as illustrated in Table 3 below.

Table 3: FP Commodities Allocations and Expenditures

Family Planning Commodities	2022/23	2023/24	2024/25
Allocation	2,752,359,000	2,960,523,750	5,053,965,000
Expenditure	2,752,359,000	2,960,523,750	No data

Source: Annual Health Sector Performance Report 2023/24, Ministry of Health-Pharmacy Division Quantification Planning and Procurement Unit presentation

With Uganda's FP2030 commitment to increase the contraceptives budget, as a result of advocacy efforts, 5 billion shillings was allocated to family planning commodities out of the 32.5 billion RH commodities budget in FY 2024/25. However, it was difficult to get the disbursements of this allocation

### 3.5 Donor Support to FP/SRH Commodity Budget

Analysis showed that donors continued to invest in FP/RH commodities as highlighted in the Table 4 below. Funding for FP commodities was mainly from USAID, UNFPA under the Global Health Supply chain program (GHSC) and UCREPP.

Table 4: Donor Allocations to Family Planning Commodities

Donor	FY 2022/23	FY 2023/24	FY 2024/25
UNFPA	6,396,818	4,477,157	4,590,746
USAID/PEPFAR	6,600,000	8,397,738	4,316,981
Global Fund (Condoms)	2,879,326	3,555,783	1,793,517
Total	25,876,144	16,430,678	10,701,244

Source: Global Health Supply Chain Annual Reports, FY2023 and FY2024, QPPU presentations

The availability of a reliable supply of high-quality contraceptives is essential in ensuring that FP demand is met at all levels. Based on the data collected from institutions that provide FP contraceptives and were able to respond to the survey, the most funded contraceptives were implants and injectables in both FY 2022/23 and FY 2023/24 as shown in Table 5 below.

Table 5: Expenditure on FP Commodities

Commodity Type	2020	2021	2022	2023
Combined Oral Contraceptives	1,666,800	3,150,720	36,000	960,048
Copper-bearing Intrauterine Devices	132,900	236,700	–	90,600
Emergency Oral Contraceptives	457,356	781,784	575,200	365,400
Hormonal Intrauterine Devices	–	–	840	3,180
Implantable Contraceptives	551,740	643,200	941,996	990,160
Injectable Contraceptives	5,916,900	6,693,700	4,805,900	4,680,200
Personal Lubricants	1,760,000	–	4,189,000	–
Progestogen Only Pills	465,120	–	552,240	285,840
Standard Days Method	–	–	45,750	–
Syringes and Accessories	412,000	–	3,464,400	145,000
Grand Total	11,362,816	11,506,104	14,611,326	7,520,428

Source: Reproductive Health Vis Interchange accessed 07<sup>th</sup> June, 2025

#### 3.4.2 FP/SRH Programs Allocation and Expenditure

The RH programs under Vote 014 (Ministry of Health), Department of Reproductive and Child Health received a total allocation of UGX 127.58 billion in FY 2022/23. Out of this allocation, 3% (2.81 billion) was government of Uganda allocation and 97% (124.768 billion) was external financing through the URMCHIP as indicated in Table 3 above. However, in FY 2023/24, the allocation to URMCHIP significantly declined to UGX 1.2 billion, due to the project's phase- out. In response, the Government of Uganda increased its contribution to RH programs by 7%, indicating a shift toward sustainability through domestic financing.

Table 6: Reproductive Health Budget Allocations (Programs)

Department	Budget Output	Description	FY2022/23			FY2023/24		
			Allocation (Billion)	Release (Billion)	Expenditure (Billion)	Allocation (Billion)	Release (Billion)	Expenditure (Billion)
007: Reproductive and Child Health	320076	Reproductive and Infant Health Services	2.58	2.163	2.142	2.781	2.781	2.746
	320051	Adolescent and School Health Services	0.12	0.112	0.11	0.12	0.12	0.12
<b>Total allocation to RCH</b>			<b>2.811</b>	<b>2.374</b>	<b>2.351</b>	<b>3.012</b>	<b>3.012</b>	<b>2.977</b>
003: Health Education Promotion and Communication	Project 1440	Uganda Reproductive Maternal & Child Health Services Improvement Project	124.768	124.768	104.804	1.2	1.2	1.2

Source: MoFPED-Ministry of Health Approved Budget Estimates and Vote Performance Reports

Out of the 2.81 billion GoU allocation to RH programs under Reproductive and Child Health Division in FY 2022/23, only 1.4% (Ugx 39,056,200) was allocated to family planning programs. *Table 7: FP/SRH Budget Allocations and Expenditure*

FP Programs	2022/23	2023/24
Allocation	39,056,200	No data
Expenditure	39,056,200	No data

Source: MOH Integrated Annual Workplan for Reproductive and Child Health Department FY 2022/23, Annual Vote Performance Reports (2022/23-2023/24).

At national level, the study also considered funds allocated and spent on FP to deliver on the “number new and old FP users” indicator at the Regional Referral Hospitals. It is important to note that although the approved quarterly workplans and performance reports included family planning outputs, for example “3,300 family planning users attended to (New and Old)”, no specific budget allocations are made to support these services and this made it difficult to trace the actual expenditure on FP/SRH services.

Table 8: Allocation and Spending at Regional Referral Hospitals

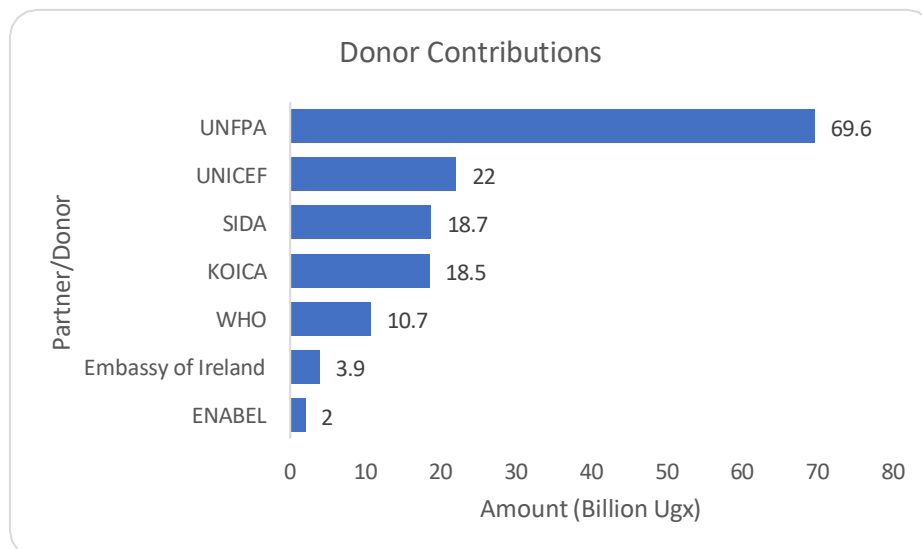
Vote Name	Total Budget Allocation (billion)		FP/SRH Allocation (billion)		FP/SRH Expenditures
	2022/23	2023/24	2022/23	2023/24	
Mulago National Referral Hospital	98.304	129.078	0	0	No data
Mulago Specialized Women and Neonatal Hospital	26.268	33.031	0	0	No data
Naguru National Referral Hospital	11.778	13.435	0	0	No data
Kiruddu National Referral Hospital	26.364	27.441	0	0	No data
Kawempe National Referral Hospital	16.365	22.737	0	0	No data
Arua Regional Referral Hospital	17.444	14.833	0	0	No data
Fort Portal Regional Referral Hospital	11.92	13.563	0	0	No data
Gulu Regional Referral Hospital	16.618	16.262	0	0	No data
Hoima Regional Referral Hospital	16.383	15.084	0	0	No data
Jinja Regional Referral Hospital	20.918	23.708	0	0	No data
Kabale Regional Referral Hospital	12.511	12.678	0	0	No data
Masaka Regional Referral Hospital	13.551	12.209	0	0	No data
Mbale Regional Referral Hospital	22.30	18.902	0	0	No data
Soroti Regional Referral Hospital	12.486	12.508	0	0	No data
Lira Regional Referral Hospital	17.025	18.709	0	0	No data
Mbarara Regional Hospital	19.952	18.813	0	0	No data
Mubende Regional Referral Hospital	10.030	13.371	0	0	No data
Moroto Regional Referral Hospital	10.836	12.815	0	0	No data
Entebbe Regional Referral Hospital	7.798	11.928	0	0	No data

Source: MoFPED; Ministerial Policy Statements, Approved Budget Estimates, Annual Vote Performance Reports 2022/23-2023/24

### 3.4.3 Donor Support to FP/SRH Programs Budget

In FY 2023/24, donors contributed UGX 75.8 billion to RMNCAH programs. It was not possible to disaggregate how much was allocated to FP/SRH for most of the donors except UNFPA, whose entire allocation was for sexual and reproductive health programs as shown in the figure below.

Figure 6: Donor support to the RMNCAH Program 2023/24



Source: Health Sector off-budget tracking report, 2023/24

### 3.5 Cross-Sectoral Linkages

The health and education sectors are foundational pillars of Human Capital Development (HCD) as outlined in Uganda's Third National Development Plan (NDP III). The NDP III targets to reduce unmet need for family planning from 28 to 10%, increase CPR from 35% to 50%, and reduce the teenage pregnancy rate from 25% in 2016 to 15 percent<sup>7</sup>.

The Ministry of Health has a specific budget output dedicated to Adolescent and School Health Services, which reflects its commitment to addressing the unique health needs of young people. This output typically supports interventions such as the establishment of youth-friendly corners in health facilities, the provision of sexual and reproductive health education, and the promotion of healthy lifestyles among in-school and out-of-school adolescents. It also enables cross sectoral collaboration with the education sector to implement school health interventions and deliver integrated health services within school settings.

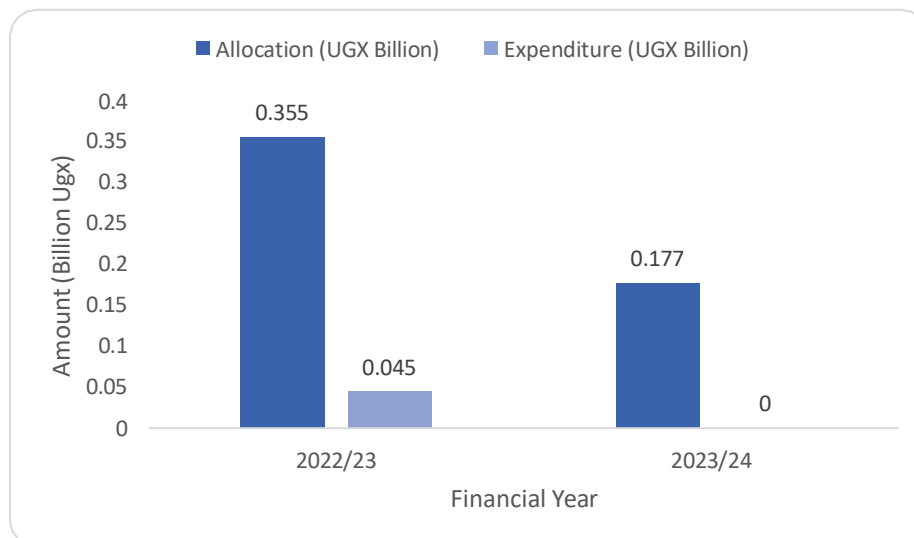
In FY 2022/23, the MoES allocated UGX 0.355 billion and UGX 0.177 billion in FY 2023/24 (as seen in Figure 7) toward initiatives including menstrual health programs, implementation of the National School Health Policy, and social dialogues on SRH.<sup>8</sup> However, execution of these

<sup>7</sup> [uganda\\_ndp-3-finale.pdf](#)

<sup>8</sup> [PBS | Admin - CG Vote Reports](#)

budgets has been limited. In FY 2022/23, only 13.4% of the allocated funds was spent. No expenditures were recorded in FY 2023/24 due to the pending cabinet approval of the National School Health Policy which delayed the program.

Figure 7: Ministry of Education and Sports Budget Allocations to SRH-related Activities



Source: MoES Ministerial Policy Statements, Annual Budgets, FY 2022/23-FY 23/24

Despite the critical role of education in shaping adolescent health outcomes, the Ministry of Education and Sports (MoES) does not have a dedicated budget line for FP/SRH. While some related issues such as menstrual health management are addressed, they are typically embedded within broader cross-cutting themes of gender and equity and HIV/AIDS, rather than prioritized as standalone interventions.

Furthermore, the Ministry of Gender, Labour, and Social Development (MoGLSD) and the Ministry of Water and Environment are among the lead implementing agencies for the HCD programme. However, a review of their budgets revealed that there is no disaggregated funding for FP/SRH-related activities, despite their critical roles in influencing social determinants of health.

### 3.6 District FP/SRH Allocation and Expenditure

The health sector at sub national level is financed through budget allocations from the Central government, Local Revenue, and external sources/partners. The Government of Uganda, through Ministry of Finance, Planning, and Economic Development (MoFPED), channels allocations to the local government health sector via distinct grants namely;

1. Health Development Conditional Grant
2. Health Non-wage Conditional Grant
  - Primary Health Care-Non-Wage Recurrent (Government)
  - Primary Health Care-Non-Wage Recurrent (PNFP)
  - Primary Health Care-DHO Allocation
3. Health Wage Conditional Grant

[District FP Costed Implementation Plans](#) Uganda is implementing its second FP Costed Implementation Plan (2020/21-FY 2024/25 that provides guidance that should ideally be domesticated at local level. This study found that only 1 of the 2 districts sampled had a district FP-CIP. Mityana was funded by A4HU to revise and develop its FP-CIP II. Kassanda, despite being a TeamUp project district, did not have an FP-CIP.

The Mityana District FP Costed Implementation Plan II (2024/25-2029/30) indicates a total financing need of UGX 800,685,000 to deliver family planning services in the next 5 years.<sup>9</sup> However, there hasn't been any commitment by the district to prioritize allocation of funds to family planning.

To effectively implement FP/SRH programs, it's imperative for the districts to have budgets. The team observed that none of the districts had explicit budgets for FP for the reporting period as shown in Table 7 below.

*Table 9: Kassanda District Allocation and Expenditure to FP/RH in Selected Districts<sup>10</sup>*

Reproductive Health Item	2022/23		2023/24		Comment
	Allocation	Expenditure	Allocation	Expenditure	
Family Planning	1,120,000	1,120,000	891,000	891,000	
Adolescent Reproductive Health	77,700,000	77,000,000	75,359,000	75,359,000	74,000,000 was on-budget support from UNICEF for adolescent and school health services
Maternal, New-born and Child Health	2,467,000	2,000,000	No data	No data	
<b>Total RH Budget (Ugx)</b>	<b>81,284,000</b>	<b>80,120,000</b>	<b>2,250,000</b>	<b>2,250,000</b>	

*Source: A4HU Budget Analysis Study Report, Local Government Approved Budget Estimates*

In FY 2022/23, the reproductive health budget was UGX 2.7 million, with UGX 2.4 million spent on family planning. The sharp decline in RH allocations was largely due to the conclusion of the Results-Based Financing (RBF) support from the URMCHIP.

<sup>9</sup> <https://a4huganda.org/wp-content/uploads/2025/05/Mityana-DLG-2nd-FP-CIP-2024-2025-to-2029-2030.pdf>

<sup>10</sup> The allocation data was based on the approved district health work plans and not health facility specific budget allocations from Primary health care grants

Table 10: Mityana District Allocation and Expenditure to FP/RH in Selected Districts<sup>11</sup>

RH Item	2022/23		2023/24	
	Allocation	Expenditure	Allocation	Expenditure
Family Planning	2,700,000	2,403,000	7,052,000	7,052,000
Adolescent Reproductive Health	No data	No data	8,648,000	8,648,000
Maternal, New-born and Child Health	No data	No data	2,560,000	2,560,000
<b>Total RH Budget</b>	<b>2,700,000</b>	<b>2,403,000</b>	<b>18,260,000</b>	<b>18,260,000</b>

Source: A4HU Budget Analysis Study Report 2023

Discrepancies between allocation and expenditure was driven by unforeseen costs, such as vehicle repairs and rising fuel expenses for outreach activities. In FY 2023/24, UGX 18.3 million was allocated to RH, with approximately UGX 7 million earmarked for family planning as shown in Table 3 above.

Family Planning at the district level is funded through Maternal and Child Health. The FP commodities are funded and procured through the National Medical Stores for government owned facilities and Joint Medical Stores for Private Not for Profit facilities, which deliver them to health facilities through an established ordering and delivery schedule. The health facilities integrate FP/SRH expenditure in the Primary Health Care grant in integrated outreaches during which information, counselling and family planning and other SRH services are offered.

The Health Department operates based on a quarterly work plan, which outlines priority activities and corresponding budget allocations for each quarter. Disbursement and use of funds are tracked against these work plans, and implementation is monitored through routine reporting and supervision mechanisms to ensure accountability and service delivery efficiency. The funds are disbursed directly to the health facilities and performance reports submitted to the DHO. While there was no clear budget line, the District Planner and DHO affirmed that FP activities are integrated in the overall health sector budget. It was also noted that most of the FP/SRH activities in the districts were financed through Results Based Financing funds in FY 2021/22-2022/23. However, there was reduced commitment of funds to FP/SRH activities due to close out of URMCHIP in FY2023/24.

While Kassanda District received on-budget support from UNICEF, it was not possible to disaggregate the portion specifically allocated to family planning activities, as the funding was broadly categorized under Adolescent and School Health Services. Additionally, the Primary Health Care (PHC) allocation does not provide a clear line item or breakdown for family planning interventions, making it difficult to track actual allocations and expenditures.

---

<sup>11</sup> The allocation data was based on the approved district health work plans and not health facility specific budget allocations from Primary health care grants

### 3.7 Family Planning Budget Composition

Table 11: Composition of the District Family Planning Budget Allocations.

District	Item	FY 2021/22	FY 2022/23	FY 2023/24
Kassanda	Capacity Building	0	0	0
	Service delivery	1,703,360	0	0
	Advocacy and community Mobilization	2,980,880	515,200	891,000
	Commodities	37,899,760	604,800	0
	Others	0	0	0
	<b>Total FP Budget</b>	<b>42,584,000</b>	<b>1,120,000</b>	<b>891,000</b>
Mityana	Capacity Building	0	0	0
	Service delivery	0	0	0
	Advocacy and community Mobilization	0	891,000	2,679,760
	Commodities	15,901,630.00	1,809,000	1,198,840
	Others	0		3,173,400
	<b>Total FP Budget</b>	<b>17,867,000</b>	<b>2,700,000</b>	<b>7,052,000</b>

Source: A4HU Budget Analysis Study Report 2023

In Kassanda district, FP budget allocations shifted over the years. In FY 2021/22, 89% was allocated to commodities, 7% to advocacy/community mobilization, and 4% to service delivery. In FY 2022/23, 54% went to advocacy/community mobilization and 46% to service delivery, with no allocations to commodities or capacity building. In the FY 2023/24, 100% of the FP budget is directed to service delivery. In Mityana, advocacy/community mobilization dominated FP allocations, 89% in FY 2021/22 and 67% in FY 2022/23. The remainder in FY 2021/22 (11%) went to commodities, while in FY 2022/23, 33% supported service delivery. FY 2023/24 shows a more diversified allocation: 45% to "others," 38% to advocacy, and 17% to commodities. In both districts, capacity building remains the least funded component.

### 3.8 FP/RH Budget Summary

The TeamUp team was desirous to better understand the percentage allocation against the national health budget. From the Table 10 below, it was observed that;

- Both districts experienced modest increases in their health budgets.
  - Kassanda: From UGX 5.0 billion to 5.55 billion (+11%)
  - Mityana: From UGX 12.14 billion to 12.43 billion (+2%)
- Health continues to receive a stable 18% share of Kassanda's total budget and 35% in Mityana, indicating health remains a priority sector in both districts.
- FP as a percentage of the district health budget remains extremely low in Kassanda at 0.02%, with no improvement across years. Mityana improved its FP share in the health budget from 0.02% to 0.06%, though still far below recommended levels.

Both districts allocated less than 1% of their health budgets to FP/SRH, far below recommended levels, pointing to a major gap in financial prioritization for FP/SRH services.

Table 12: District FP/RH Budget

Description	Kassanda district (UGX)		Mityana District (UGX)	
	FY 2022/23	FY 2023/24	FY 2022/23	FY 2023/24
Family planning Budget	1,120,000	891,000	2,700,000	7,052,000
RH Budget	81,284,000	76,250,000	2,700,000	18,260,000
District PHC Budget	376,467,754	795,030,749	767,283,498	11,881,371,457
Health Budget	5,004,417,863	5,549,205,520	12,143,857,995	12,431,011,734
District Total Budget	27,156,280,151	31,058,741,662	34,724,866,473	35,974,252,824
Percentage allocation to Health from district Total Budget	18%	18%	35%	35%
Percentage allocation to FP from health Budget	0.02%	0.02%	0.02%	0.06%
FP as a percentage of the RH budget	1.4%	1.2%	100%	38.6%
Percentage allocation to RH from the health budget	1.62%	1.47%	0.02%	0.15%

Source: Author's computations

### 3.9 Subcounty FP/SRH Budget Allocation and Expenditure

The Local Government (LG) budget is composed of two components: The Higher Local Government (district) budget and the Lower Local Government (subcounty) budget. Notably, only the Higher Local Government receives a designated health budget. They instead receive funds through the health facilities (PHC non-wage current grant).

Table 13: Subcounty FP/SRH Budget Allocation and Expenditure

District	Subcounty	Total Allocation		FP/SRH Allocation	
		FY 2022/23	FY 2023/2024	FY 2022/23	FY 2023/24
Kassanda	Myanzi	45,561,000	42,279,000	0	0
	Kassanda Town Council	65,931,000	52,573,000	0	0
	Bukuya	30,164,000	28,367,000	0	0
	Makokoto	23,153,000	22,021,000	0	0
	Nalutuntu	51,844,000	48,137,000	0	0
	Kassanda	45,698,000	42,401,000	0	0
	Kiganda	23,428,000	22,265,000	0	0
	Kitumbi	46,523,000	43,255,000	0	0
	Kalwana	64,806,000	59,974,000	0	0
	Bukuya Town Council	51,539,000	61,698,000	0	0
	Kiganda	71,349,000	86,699,000	0	0
	Kamuli	16,264,000	21,288,000	0	0
	Kijjuna	28,528,000	43,133,000	0	0
Mbirizi	11,291,000	32,028,000	0	0	

Mityana	Bbanda	10,678,000	27,869,000	0	0
	Bbanda Town Council	27,198,000	55,333,000	0	0
	Bulera	30,094,000	97,017,000	0	0
	Butayunja	43,956,000	38,505,000	0	0
	Kakindu	20,941,000	61,758,000	0	0
	Maanyi	23,160,000	67,417,000	0	0
	Namungo	58,063,000	62,680,000	0	0
	Kalangaalo	30,579,000	95,704,000	0	0
	Kikandwa	29,816,000	82,636,000	0	0
	Ssekanyoyi	18,167,000	43,440,000	0	0
	Ssekanyoyi Town Council	42,811,000	92,437,000	0	0
	Zigoti Town Council	33,300,000	96,855,000	0	0
	Malangala	16,572,000	50,218,000	0	0
	Busunju Town Council	38,571,000	144,004,000	0	0

*Source: MoFPED: Local Government Approved Budget Estimates, District Approved Work Plans 2022/23-2023/24*

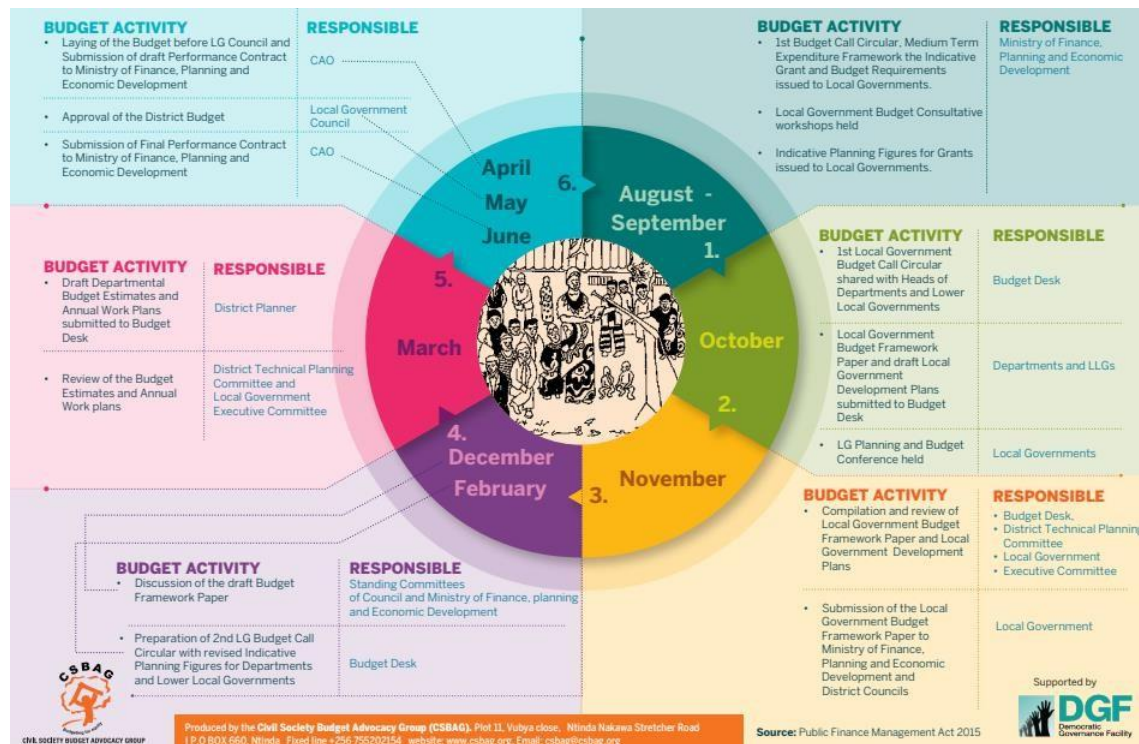
A review of the Local Government budgets in the study districts revealed a growing trend in allocations made to sub counties. However, these did not include direct health budget allocations at the subcounty level. Instead, funds were allocated to health facilities located within the sub counties. As a result, there were no funds directly allocated or spent on FP/SRH activities from the sub county budget, as illustrated in Table 13 above.

## Chapter 4: Findings from Key Informant Interviews

### a) The Local Government Budget Process/Cycle

Districts are the main implementers of basic services in Uganda. Local Governments/ districts therefore have discretionary planning and budgeting powers, but their plans and budgets need to align with national priorities and policies. Consequently, the local government budget cycle fits into the national budgeting cycle. It starts in September/October and ends in June as summarized in the figure 8 below.

Figure 8: Local Government Budget Cycle



Source: Civil Society Budget Advocacy Group (CSBAG)

### b) Role in the Budget Process

District Planners coordinate the district budgeting process that is a bottom-up approach. The process starts from the village level where the Parish Development Committees (PDCs) engage the communities to gather their needs that are then taken to the sub county level. At subcounty level, budget conferences are convened to prioritize needs. The health facility incharges, Community Development Officers (CDOs), District Planners, Local Council Chairpersons participate in these conferences to articulate the health needs and provide guidance in prioritization process respectively. At district level, the planning departments coordinates compilation of departmental priorities. They are responsible for drafting departmental budget estimates and annual work plans and submit them to the budget desk. The draft estimates and workplans then goes to the District Executive and Technical Planning Committees for review and finally to the District council for approval. Once the budget is approved, the Chief Administrative Officer (CAO) submits the final performance contract to the Ministry of Finance Planning and Economic Development.

### c) Documents that Guide the Budgeting Process

This entire budget process is rigorously guided by key national frameworks, including the Local Government Act, Cap 243, Local Government Development Planning Guidelines, the Sector Grant and Budget Guidelines for Local Governments, Primary Health Care Grant and Budget Guidelines issued by the central government and the Ministry of Health. For instance, annually, Local Governments make a budget provision for Primary Health Care (PHC) Non- Wage Recurrent (NWR) Grant that are transferred directly to health facilities from Ministry of Finance Planning and Economic Development (MoFPED). These guidelines are issued by the Ministry of Health (MoH) to provide guidance on the policies and principles for budgeting for the PHC NWR funds at the facility level and the various eligible expenditures for the grant.

The allocation of resources to the different departments such as Health, Environment, Community Services, Education, and others is primarily determined by the Indicative Planning Figures (IPFs) received from the Ministry of Finance, Planning, and Economic Development (MoFPED), which set the financial ceilings for each sector.

### d) Involvement of Civil Society in the Budget Process

At both the subcounty and district level, civil society organizations participate in local government planning and budget conferences to advocate for health and other issues to be prioritized. However, the participation and engagement of adolescents and youth representatives is still wanting and can be strengthened for meaningfulness and inclusivity.

### e) The District FP/SRH Budget

A review of a few quarterly work plans revealed no specific budget allocations for FP/SRH activities. Feedback from district Maternal, Newborn, and Child Health (MNCH) focal persons indicated that FP/SRH activities are typically integrated within broader health interventions, rather than being treated as standalone priorities.

*“Family planning activities are embedded in other programs. it’s hard to isolate the budget.”-  
Female KII participant, Kassanda District*

Activities cited for integrating FP/SRH included support supervisions to the health facilities by the District Health Team (DHT), district performance review meetings, data verification exercises, Continuous Quality Improvement (CQI), refresher trainings for health workers. These activities served as platforms to assess service delivery performance, identify bottlenecks, and develop improvement plans.

### f) Cross-sectoral Linkages

The District Health Office collaborates with the Education Department to jointly implement school health programs, which serve as key entry points for promoting adolescent health. These programs typically include activities such as health education sessions, counselling services, and the dissemination of information on a range of health topics, including hygiene, family planning, and life skills.

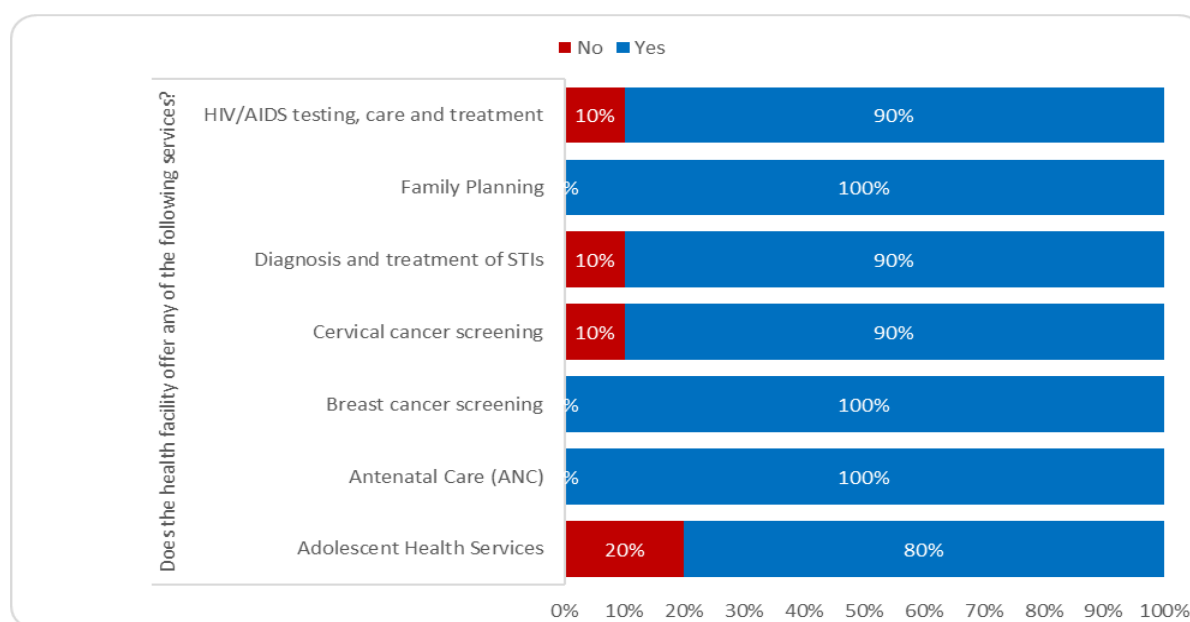
*“We work with the education department on joint school health programs, though most schools are faith-based, so we go under the broader umbrella of school health and address FP on a one-on-one basis.”-KII Male participant, Mityana District*

Despite this collaboration, there is no dedicated budget for FP/SRH within these joint activities from both departments. As a result, FP/SRH components are incorporated informally or addressed only when external partners provide support, which limits the consistency and scale of service delivery. This gap highlights the need for stronger integration of FP/SRH within cross-sectoral frameworks, accompanied by clear budgeting provisions to ensure that adolescent reproductive health is systematically addressed through both health and education platforms.

## Chapter 5: Findings from Health Facility Assessments

**Availability of FP/SRH Services** All the 10 sampled health facilities were providing family planning and other sexual and reproductive health services. Most facilities offered a broad range of family planning methods, including both short-term and long-term options (see Figure 10). 9 out of 10 health facilities (Mwera HCIV, Bulera HCIII, Kikandwa HCIII, Lulagala HCIII, Kassanda HCIV, Bukuya HCIII, Musozi HCIII, and Makonzi HCII) were offering HIV testing, care and treatment and STI diagnosis and treatment.

Figure 9: Availability of FP/SRH Services



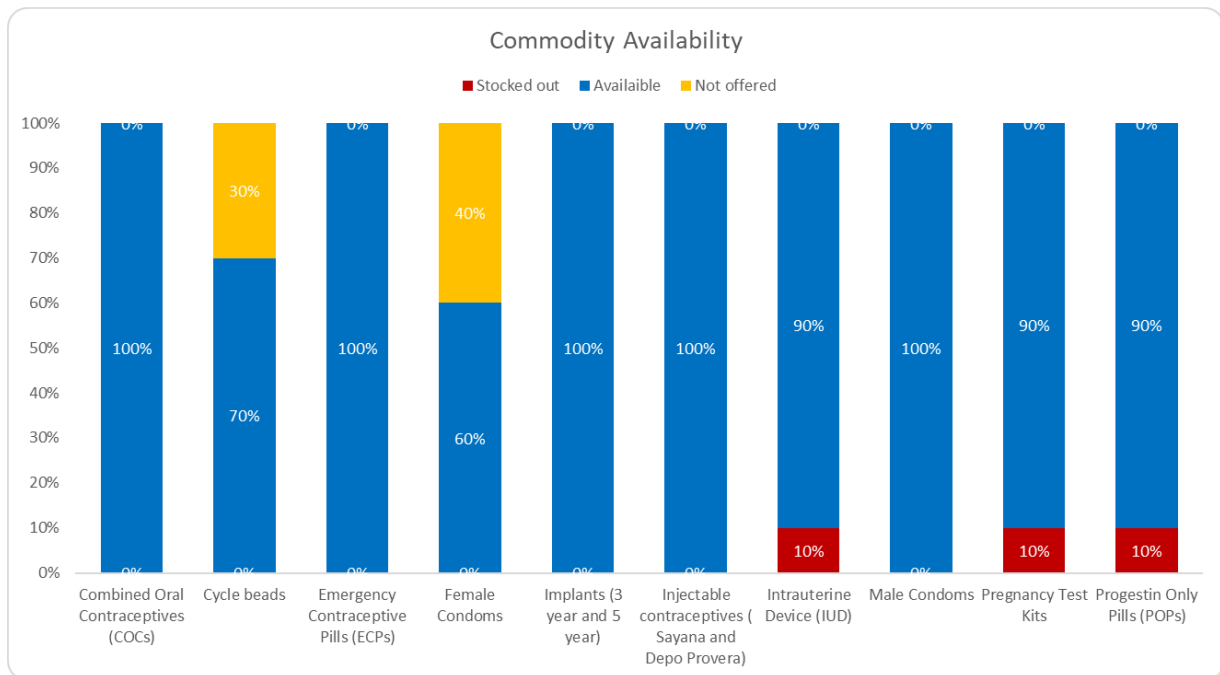
**Outreaches** To complement facility-based services, all the 10 health facilities were actively extending FP/SRH services into the community through regular integrated outreach, conducted either weekly or monthly to help improve access, especially for populations in hard-to-reach or underserved areas. 5 out of the 10 (Mwera HCIII, Musozi HCIII, Bukuya HCIII, Kasaana HCII, and Kassanda HCIV) conducted weekly outreaches, while the other 5 (Kikandwa HCIII, Lulagala HCIII, Musozi HCIII, Makonzi HCIII, and Bulera HCIII) conducted them on a monthly basis. The outreaches offered all FP methods (short and long-term). However, implants and intrauterine devices (IUDs) were not offered, as health workers cited challenges related to maintaining client privacy in outreach settings. Additionally, these outreaches are often disrupted by poor road conditions and lack of transport and equipment. One provider noted, “Bad roads that become slippery when it rains... you can’t even use a motorcycle.” Even when outreaches happened as scheduled, there was low turnout “By the time clients come, the health workers are already getting tired of waiting,” another staff member explained.

**Health facility staffing** Half of the facilities: Kasaana HII, Kassanda HCIV, Makonzi HCIII in Kassanda district and Bulera HCIII, Maanyi HCIII, and Mwera HCIV in Mityana district reported that their staff had received training in Family Planning and Sexual and Reproductive Health within the last two years. While the number of midwives and nurses appeared to be adequate, in Mityana District, two out of every three nurses or midwives at Health Centre IIIs and HCIVs

were seconded by an implementing partner (Baylor Uganda), highlighting a significant reliance on partner-supported human resources, particularly at higher-level facilities.

**Commodity Availability** Generally, family planning commodities were available, with 91% of the health facilities reporting availability on the day of assessment. There were observed stock outs for IUDs, attributed to expiry resulting from low demand. The 8 Government facilities (Mwera HCIV, Bulera HCIII, Kikandwa HCIII, Kassanda HCIV, Bukuya HCIII, Musozi HCIII, and Kasaana HCII) reported a rare occurrence of stock outs in the last 6 months, citing improvements in supply performance by NMS. Additionally, the PNFPs reported some stockouts in March and April 2025 because JMS didn't have stock.

Figure 10: Availability of FP/SRH Commodities

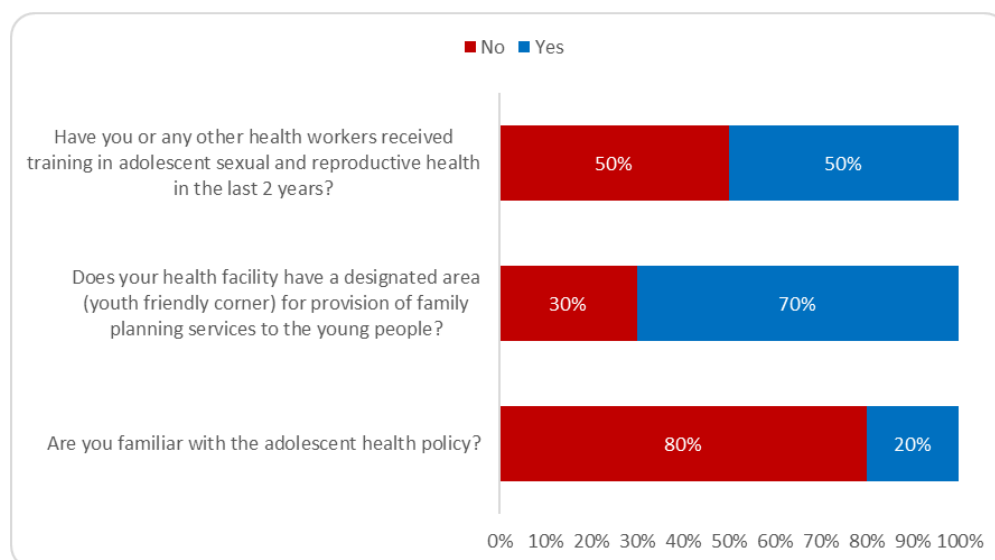


All assessed health facilities reported the availability of implants, injectables, and male condoms, reflecting a diverse contraceptive method mix. Oral contraceptive pills were also generally available, with only one out of the ten facilities experiencing a stock-out of Progestin-Only Pills. This overall availability suggests that clients have multiple options for family planning, which is essential for meeting varied preferences and improving contraceptive uptake. However, the reported stock-out, though limited, highlights potential supply chain vulnerabilities that could disrupt continuity of care and limit method choice for clients who prefer or require progestin-only pills.

**Adolescent Health Services** 8 out of the 10 health facilities assessed were offering adolescent-responsive services, and 70% had designated spaces or youth-friendly corners to provide these services in a more accessible and supportive environment for young people. The three health facilities that did not have youth friendly corners were Kikandwa HCIII, Maanyi HCIII, and Lulagala HCIII, all in Mityana district. However, only 50% of facilities (Mwera HCIV, Bulera HCIII, Lulagala HCIII, Maanyi HCIII, and Makonzi HCII) had staff trained specifically

in adolescent health services in the last 2 years, indicating a gap in capacity to effectively meet the unique needs of adolescents. All health facilities reported providing the full range of family planning methods to young people, with injectables being the most preferred option. However, feedback from health workers indicated a gradual shift, with more youth beginning to embrace long-term methods especially the implants. This shift was attributed to the increased effort by the health workers to provide comprehensive education on the entire method mix, and improved availability of the long-term methods.

Figure 11: Delivery of Adolescent-Responsive Health Services



Much as the adolescent health services and job aids were generally available, only 2/10 respondent HFs (Maanyi HCIII and Mwera HCIV) showed knowledge of the reproductive health Policy and Adolescent health Policy.

IEC materials on FP/SRH were observed in 7 out of 10 health facilities assessed, i.e., Bukuya HCIV, Kasaana HCII, Kassanda HCIV, Kikandwa HCIII, Makonzi HCII, Musozi HCIII, and Lulagala HCIII. However, 3 out of 5 health facilities in Mityana district (Bulera HCIII, Maanyi HCIII, and Kakindu HCIII) did not have FP IEC materials.

Regarding the challenges faced in delivery of FP/SRH services, the following were cited;

- Limited number of staff to offer some FP methods, especially the long-term methods
- Non-delivery of FP commodities ordered
- Inadequate funds to facilitate health workers who conduct outreaches in the communities
- Discontinuation of FP
- Lack of private spaces for counselling. 6/10 health facilities have private spaces to conduct counseling for FP clients. In Maanyi HC3, Mityana district, the FP clinic is hosted in the Maternity ward and clients do not receive privacy while being counselled.
- Long waiting times because of the small number of health workers

In response to the challenges identified by the community members, health workers acknowledged the issues raised from the community and suggested the following to address them;

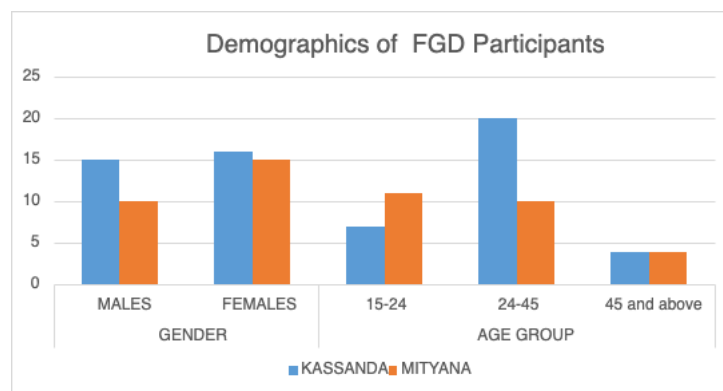
- Continuous sensitization of communities on family planning and its benefits
- Male involvement. The health workers advised us to use community dialogues to target men as opposed to community sensitization which usually attracts women
- Create safe spaces for adolescents to seek FP/SRH services
- Conduct regular trainings/ CMEs of health workers on delivery of adolescent health FP/SRH services

## 5.2 Community Perspectives

### 3.5.1 Sub-counties Sampled for Community Perspectives

Focus Group Discussions (FGDs) were conducted in six (06) sub counties of Bukuya Town Council, Myanzi, Kassanda Town Council for Kassanda District and Bulera, Maanyi, and Kakindu in Mityana to understand the community attitudes to FP/SRH, and barriers to access

Figure 12: Demographic Characteristics



and use of contraception. The FGDs were conducted with men, women and youth as summarized below in The discussions centered on getting perspectives to attitudes, explored the FP method mix, source of FP and causes of unmet need. It also explored the challenges faced in the community are the same or there are notable changes.

Good understanding of family planning as a means to space childbirth, control the number of children, and enhance household well-being. The respondents defined FP as a responsible decision to give birth only to the number of children one can support emotionally, financially, and physically. There were mixed feelings about FP. The proponents of FP cited improved maternal and child health and better opportunities to educate and care for fewer children. Some participants expressed aspirations for their children, emphasizing how FP enables them to invest in their future. A recurring sentiment was that FP empowers families to plan wisely and pursue personal goals without the burden of unplanned pregnancies.

*'Before, herbs were used, but now we are using modern FP methods' Respondent Maanyi S/C*

*'Now days, some parents give their sons condoms before they leave for school' Respondent, Bulera S/C*

Negative attitudes towards family planning stemmed primarily from cultural, religious, and personal beliefs. Men were frequently portrayed as resistant, particularly when they felt excluded from decision-making processes. Religious opposition was also evident, with some

participants stating that FP contradicts the divine will. Misconceptions about side effects included that FP causes infertility, fibroids, and once removed, someone is more likely to deliver by caesarean section than normal delivery. Notably, some men linked FP use to promiscuity and infidelity, further straining marital relationships. Another significant reason was the lack of information and knowledge about family planning. In Bukuya s/county, Kassanda district, the participants estimated that only 3 out of 10 men support their wives when getting SRH services.

**Sources of FP** FP/SRH services are primarily accessed through government health facilities, which offer free services. Village Health Teams (VHTs) also play a significant role in connecting communities to services. However, due to long queues at the government facilities, many women turn to private clinics despite the cost. Participants noted that injectables in private clinics cost between UGX 5,000 to 15,000, with implants sometimes reaching UGX 20,000.

*“Because of the long process, some people leave the government facility and go to clinics. It’s not until they get issues from those clinics that they come back to the health facility for treatment.” — FGD participant, Kakindu S/C*

**Method Mix** Injectables emerged as the most popular FP method across all sites, praised for their convenience, affordability, and discreetness. Implants and emergency contraceptive pills were also commonly used, particularly among the youth. On the other hand, IUDs, condoms, and tubal ligation faced resistance due to stigma, discomfort, and prevailing myths and misconceptions. Participants shared exaggerated fears of IUDs "disappearing" in the body or condoms causing irritation and noise. Female condoms were not popular due to concerns they might get stuck in the woman.

**Satisfaction with SRH services varied across communities** Positive feedback was given when services were available, staff were respectful, and waiting times were manageable. There has been a positive shift, with improved accessibility to family planning services for everyone. Sensitization efforts and solutions for managing side effects have improved, which encourages more women to participate in family planning. The number of outreach providers has also increased, broadening the spread of information. However, dissatisfaction was expressed over long distances to facilities, limited service hours, some clinics do not conduct necessary consultations or diagnoses, low male engagement, and recurring stock-outs. In some instances, participants reported being asked to pay unofficial fees or bring their own medical supplies at public health facilities.

**Causes of unmet need** The discussions revealed both direct and indirect causes of unmet need. The reasons cited were;

- Widespread misinformation about FP, e.g., fear of over bleeding, infertility, FP stops menstruation
- Fear of side-effects especially IUD might ‘disappear’ or cause cancer
- Partner resistance, as men are not supportive and disapprove of contraception- our wives have become barren
- Religious and cultural beliefs e.g. use of FP encourages promiscuity

In order to reduce the unmet need, the following suggestions were made;

- Need for increased community sensitization, especially from right-sources
- Conduct full medical assessments before administering FP method
- Increase participation of men and youth
- Use personal stories to address FP-related fears

Non-users often cited fear of side effects, misinformation, and lack of partner support.

*“They told me that using family planning would make me barren. I believed it because my neighbor hasn’t conceived again since she got it.” — Community youth, Myanzi S/C.*

Previous users frequently discontinued due to side effects like prolonged bleeding, poor counseling in private clinics or changes in fertility preferences. Encouragingly, attitudes toward FP are gradually shifting. Participants acknowledged greater acceptance among youth, who are increasingly accessing condoms, emergency contraceptives, and injectables. Parents and health workers are beginning to encourage young people to seek SRH services. However, challenges remain particularly in ensuring that private providers offer proper counselling before administering FP methods.

**Participation in FP/SRH Budget Processes** There was no involvement of the participants in any health-related budgeting processes at the district. Most participants were unfamiliar with the budgeting process, with only Community Development Officers (CDOs), Parish Development Committee members, and local council representatives actively participating. Participants expressed a desire for greater involvement, particularly in advocating for FP- related needs.

*“We are not involved. If only they involved us, we could talk about real needs. For example, they once prioritized procurement of dustbins in schools and hospitals, which were not as relevant as some of the health services we were missing.” — FGD participant Kassanda T/C*

**Youth Perspectives on FP/SRH** Youth consistently highlighted that health facilities often lack confidential, respectful, and non-judgmental services. Many reported discomfort interacting with health workers, citing fear of stigma and being judged for seeking family planning services.

The strong cultural and religious beliefs caused fear of disclosure to parents and other family members hence discouraging utilization, particularly among unmarried youth. Additionally, they indicated hesitation to discuss FP/SRH topics openly due to fear of backlash and being labelled promiscuous.

Youth also reported low awareness and limited access to accurate FP/SRH information outside the health facility. Misinformation from peers, social media, and some community leaders contribute to myths, fear, and mistrust around contraceptive use.

Overall challenges and recommendations from the FGDs are summarized in the Table 11 below

Table 14: FGD Challenges and Proposed Recommendations

Challenges faced	Recommendations
<ul style="list-style-type: none"> <li>• Commodity stockouts</li> <li>• Shortage of medical consumables (gloves, surgical blades, syringes)</li> <li>• Long distances to nearest facility</li> <li>• Unfriendly Health workers</li> <li>• Minimal participation in budgeting processes</li> <li>• Lot of misinformation on side-effects</li> <li>• Unsupportive partners</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen community engagement using VHTs</li> <li>• Provide community-based education</li> <li>• Increase male involvement</li> <li>• Construct HC III in Bukuya</li> <li>• Regular HW mentorships and FP trainings</li> <li>• Increase facilitation for VHTs/CHEWs</li> </ul>

## Chapter 6: Recommendations and Conclusion

Based on the evidence generated and the community voices in previous sections, the following recommendations are put forward.

### National level

#### ***Needed Initiatives to Increase Budget Allocation and Expenditure for FP/SRH***

Increasing resources for FP/SRH requires expansion of the health budget because at current level it is already overstretched with many competing health - related priorities. While the national policies prioritise FP/SRH, this is not reflected in the budgeting processes and workplans. Family Planning remains underfunded and often obscured within broader maternal and child health budgets. The Ministry of Finance and Ministry of Health should create a dedicated FP budget line within the national and district health budgets to allow for better visibility, prioritization, and accountability of FP investments. This will also support Uganda's commitment to the FP2030 targets. Other initiatives could include strengthening advocacy efforts to decision makers regarding the importance of RH/FP services for our national development plans. This could make more resources and budget-data including disbursements and expenditures, publicly available by respective offices.

#### ***Implementation of Universal Health Coverage (UHC) through Fast-Tracking the National Health Insurance (NHIS) 2024 Bill***

Health insurance coverage of 1% in Uganda is still very low to address issues of out-of-pocket expenditure and impoverishment due to health spending. It should be able to incorporate a wide range of RMNCAH services in the proposed healthcare benefits package and consider alternative innovative financing strategies, such as donations, investments, sin-taxes. This would ultimately reduce the high Out-of-pocket (OOP) payments and increase equity.

#### ***Mainstream Off-Budget FP/RH Financing into Sector Budgets***

As Uganda implements the HCD in aspiration of the Vision 2040 and Agenda 2063, transparency and improved efficiencies are critical in financial management. Most of the donor support to FP/RH is given as off-budget support. Most of the low budget absorption by districts was as a result of challenges brought about by partners. Mainstreaming these into the on-budget frameworks would go a long way in strengthening transparency, reducing duplication and alignment to national priorities (NDP III).

#### ***Revise and update the Budget Monitoring Methodology and Tools***

The DSW Budget Monitoring Methodology, developed in 2014, needs to be updated to reflect changes in policies, programs, and budgeting processes over the past decade. The current methodology does not adequately account for FP/SRH funding needs, nor does it integrate mechanisms for assessing value for money or the broader impact of FP/SRH investments. An updated methodology should highlight its cost-effectiveness as a development best-buy, and should be supported by a robust monitoring and evaluation (M&E) framework. This would

enable systematic tracking of both financial and programmatic performance, ensuring greater accountability and demonstrating the impact of FP/SRH financing.

#### Sub-national level

##### ***Mainstreaming of FP/SRH in District Workplans and Budgets***

The Ministry of Finance should ensure that there are clear family planning indicators in local government output budgeting tools to ensure that all local governments plan and budget for FP. Districts such as Kassanda currently lack FP CIPs, and Mityana has not committed funding for its CIP despite expressed prioritization of FP/SRH. To aggravate matters, there is poor planning and coordination between programmes and among sub-programmes within the HCD programme which would negatively affect alignment and efficiency.

##### ***Strengthen Participation in Planning and Budgeting Processes***

During the FGDs and district interviews, it was reported that there is weak participation of community members in FP/SRH planning and budgeting processes. This makes it difficult for them to amplify the needs of the community or even to participate in review/microplanning meetings and address context-specific barriers to access. Strengthened participation fosters ownership and governance by providing opportunities to voice concerns and facilitate dialogue.

##### ***Creation and Implementation of District Male Engagement Plans.***

Male participation and involvement in FP/SRH are not well conceptualized at district level. Men are seen as a barrier, or they can be seen as a support to increase the use of modern contraception, improved birth spacing, and decreased/healthier family size. It would be good to have men as users of FP, partners, users of family planning methods, partners, service providers, influencers and decision makers who promote dialogue amongst couples and religious leaders, stimulate conversations about the negative impacts of rigid gender roles, and actively address gender inequalities.

## References

1. Ministry of Health, 2024., Annual Health Sector Performance Report FY 2023/24
2. Ministry of Health, 2023., Annual Health Sector Performance Report FY 2022/23
3. Ministry of Health, 2022., Annual Health Sector Performance Report FY 2021/22
4. Ministry of Health, 2019., National Financing strategy for Family Planning, 2019-2025
5. MoFPED, 2024., Ministerial Policy Statement
6. RH Interchange, 2025., <https://www.rhsupplies.org/activities-resources/tools/rh-viz/tool/>
7. Ministry of Health, 2022., Annual Workplan FY 2023/24
8. Ministry of Health, 2023., Annual Workplan FY 2022/23
9. Ministry of Health., Consolidated Ministerial Policy Statements
10. MoFPED, 2023., Ministry of Health Budget Framework Paper FY 2018/19- FY2022/23
11. National Medical Stores, 2022., Annual Workplan FY 2022/23
12. National Medical Stores, 2023., Annual Workplan FY 2023/24
13. National Medical Stores, 2023., Procurement plans
14. Ministry of Health-RHI Department Workplan
15. Ministry of Health- TWG meeting minutes
16. MoFPED, 2023., Human Capital Development Performance Reports
17. UNICEF, 2023., Health Sector off-budget report FY 2023/24
18. MoH. 2022., Resource Mapping and Costing of the RMNCAH Sharpened Plan FY 2020/21-FY2024/25
19. Ministry of Health, Reproductive Child Health Division, 2022. Reproductive, maternal, newborn, child, adolescent and healthy aging: sharpened plan II, 2022/23–2027/28
20. Countdown to 2030., Uganda RMNCAH Profile <https://data.unicef.org/countdown-2030/country/Uganda/4/>

**Sample Activity Photos**



*L-R: Youth FGD session in progress at Myanzi subcounty and men's FGD session at Bukuya sub-county*



*FGD session in progress at Maanyi subcounty, Mityana*



*Family planning commodities available on the day of assessment at the FP clinic Mwera HCIV, Mityana district*

**Annex 1: Data tools used [Shared separately] Annex 2:****List of Respondents Contacted**

Name	Designation	District	Notes
Nalukwago Sharon	Planner	Kassanda	KII
Albert Kyagera	Planner	Mityana	KII
Barbra Nanyonjo	ADHO MNCH	Kassanda	KII
Winnie Nakimbugwe	District Health Educator	Mityana	
Dr. Kizza Jude	DHO	Kassanda	
David Muzira	District Community Development Officer (DCDO)	Mityana	
Mono Denis Sworo	Senior Health Educator-Mityana General Hospital	Mityana	
Dr. Kawooya Vincent	District Health Officer	Mityana	
Sr. Enzaru Betty	ADHO MNCH	Mityana	KII
Gonzaga Ssebulime	District Community Development Officer (DCDO)	Kassanda	
Nekesa Esther Ruth	District Health Educator	Kassanda	KII
Ssenyondo Francis Xavier	Ass. Chief Administrative Officer	Kassanda	
Dr. Chris Ebong		MOH-RH&I Division	KII
Aliyi Walimbwa	Senior Health Planner	MOH	
Clive Ainebyoona	Economist, Planning Department	MOH	KII
Bob Niwagaba	Health Budget Desk	MoFPED	KII
Sarah Taratwebirwe	Technical Officer	MOH-QPPU	KII
Uwikyeya Betty	Incharge	Mwera HC IV	KII
Diika Livingstone	Chief Finance Officer	Mityana	
Wekiye Nelson	Chief Finance Officer	Kassanda	

**Annex 3: FGD Participants**

District	Name	Sub county
Mityana	Nsamba Cornerious	Myanzi Sub county
Kassanda	Kanyike Venansio	Myanzi Sub county
Kassanda	Namuddu Fausta	Myanzi Sub county
Kassanda	Ssekyanzi Paul	Myanzi Sub county
Kassanda	Ssenyonga Charles	Myanzi Sub county
Kassanda	Ssengiri Brian	Myanzi Sub county
Kassanda	Ssegawa Rashid	Myanzi Sub county
Kassanda	Kikasi David	Myanzi Sub county
Kassanda	Walugembe Fred	Myanzi Sub county
Kassanda	Nankumbi Juliet	Myanzi Sub county
Kassanda	Kyakuhaire Esther	Myanzi Sub county
Kassanda	Nagawa Shamirah	Myanzi Sub county
Kassanda	Nabalunzi Florence	Myanzi Sub county

Kassanda	Namukwaya Justine	Myanzi Sub county
Kassanda	Nakanjako Justine	Kassanda Town Council
Kassanda	Ainembabazi Miria	Kassanda Town Council
Kassanda	Nambuya Joyce	Kassanda Town Council
Kassanda	Nakigozi Cissy	Kassanda Town Council
Kassanda	Namatovu Maria	Kassanda Town Council
Kassanda	Iradukunda Shallon	Kassanda Town Council
Kassanda	Nassunje Margaret	Kassanda Town Council
Kassanda	Nakimuli Aidah Elizabeth	Kassanda Town Council
Kassanda	Geresa Rehema	Kassanda Town Council
Kassanda	Nakazibwe Alice	Kassanda Town Council
Mityana	Katongole Akim	Bukuya Sub county
Mityana	Muyanja Joseph	Bukuya Sub county
Mityana	Waswa M	Bukuya Sub county
Mityana	Ssewanyana J	Bukuya Sub county
Mityana	Nsaali John	Bukuya Sub county
Mityana	Lule Yusufu	Bukuya Sub county
Mityana	Ssebagala Disan	Bukuya Sub county
Mityana	Onyango Denis	Bulera Sub county
Mityana	Kibuuka Edirisa	Bulera Sub county
Mityana	Nabakunja Norah	Bulera Sub county
Mityana	Kateregga Bria	Bulera Sub county
Mityana	Nakalembe Christine	Bulera Sub county
Mityana	Nalukenge Mary	Bulera Sub county
Mityana	Kabali Joel	Bulera Sub county
Mityana	Kaliisa Eric	Bulera Sub county
Mityana	Komugisha Moreen	Kakindu Sub county
Mityana	Nakimuli Sophia	Kakindu Sub county
Mityana	Nabuuma Catherine	Kakindu Sub county
Mityana	Najjuma Solome	Kakindu Sub county
Mityana	Baluku Josephat	Kakindu Sub county
Mityana	Wakusadi Eric	Kakindu Sub county
Mityana	Nansubuga Shamim	Kakindu Sub county
Mityana	Namuddu Betty	Maanyi Sub county
Mityana	Ssebulime Moses	Maanyi Sub county
Mityana	Tendo Samson	Maanyi Sub county
Mityana	Kasozi Livingstone	Maanyi Sub county
Mityana	Racheal Owomugisha	Maanyi Sub county
Mityana	Nakiranda Joan	Maanyi Sub county
Mityana	Nakayenga Oliver	Maanyi Sub county

Action 4 Health Uganda is an implementing partner under TeamUp Uganda program in Mityana and Kassanda Districts.



**Implemented by:**



**Financed by:**



Action 4 Health Uganda (A4HU)  
Plot 17, Lubowa Hill, Nazziba Rise  
P.O.BOX 120595 Kampala, Uganda  
Tel: +256 393 255 411  
Email: [info@a4huganda.org](mailto:info@a4huganda.org)  
[www.a4huganda.org](http://www.a4huganda.org)