Joint Appraisal (JA)

The Joint Appraisal (JA) is an **essential element of GAVI's regular monitoring and performance management (MPM).** The JA has evolved to align with GAVI 5.0 strategic shifts.

The JA is an **annual, country-led, multi-stakeholder** review/discussion that represents an important opportunity for countries to engage GAVI Alliance partners and other key stakeholders on annual progress of routine immunization programmes against national goals and objectives, and to discuss how GAVI support is contributing to this progress. Key stakeholders involved in the country's immunization programme should be represented at the Joint Appraisal, including civil society organisations (CSOs).

As an integrated part of GAVI's portfolio management process, the JA discussion should review **GAVI's contribution to immunization programme performance.** A key feature of the JA is the joint discussion focused on lessons learned to inform enhanced immunization performance with a focus on reaching zero-dose children and missed communities.

The modality of the Joint Appraisal exercise is tailored to the country context and may be scheduled taking into consideration other planning exercises such as EPI reviews or National Immunization Strategy Development.[1] The JA process will involve preparatory work to assemble and analyse data in advance of the discussion, exchange on the trends and their implications for the EPI program, and will conclude with the finalisation of a report and relevant deliberation outcomes and follow-up actions. At least one live discussion (in person or virtual) of the multiple stakeholders engaged in the Joint Appraisal should be organised.

The Joint Appraisal template is structured as follows

- **Section 1: Country situation**: overview of performance of GAVI support & discussion on progress and challenges faced over the preceding year.
- **Section 2: Looking forward**: planning for the upcoming year and summary of discussion points and follow-up actions.

Section 1 is where GAVI expects reporting against the Grant-linked Key Performance Indicators developed during HSS / EAF applications. For these indicators, results are to be analysed as (1) the absolute change in the indicator as a trend over time and; (2) the percent change in the indicator against the baseline value from the HSS or EAF application. Changes over time will be assessed against the end of grant target set during the application stage. Please ensure that sufficient data is provided to conduct such analyses, including the baseline values, targets, and sufficient annual data to infer trends.

The below set of cross-cutting questions should be considered to structure qualitative information:

Cross-cutting Questions

1. What factors have facilitated or impeded progress?
2. What promising practices and/or innovations have emerged?
3. What key contributions have partners made to drive performance?
4. What are the top risks that should be mitigated?

Section 1 forms the analytical foundation to structure the JA discussion with Section 2 summarising the outcome of the JA and follow-up actions.

The outcome of this Joint Appraisal will include a joint assessment of promising practices, perceived challenges and opportunities for GAVI investments, and should elaborate future actions with clear targets and assigned responsibilities which is owned by the full set of in-country stakeholders.

Section 1: Country situation: overview of performance of support & discussion on progress, challenges faced

A. Immunization Programme Performance – Zero-dose, Routine immunization coverage, Vaccine introductions, campaigns, and outbreak response

1. Learning Question: What progress has been made to reach zero-dose and under-immunized children with vaccinations?

Key indicators

Indicator	2019	2020	2021	2022	2023	2024	% Change, 2022-2024	% Change, 2023-2024
Number of zero-dose children at national level	62,165	95,444	48,709	98,947	83,478	84,010	-15%	+1%
Dropout from DTP1 to DTP3 at national level	3%	5%	6%	5%	4%	4%	-20%	+0%
Dropout from DTP1 to last routine dose of MCV at national level	9%	5%	7%	4%	5%	5%	+25%	+0%
Percent of health facilities that reported no stock-outs for the full year for DTP	NA	NA	NA	NA	NA	NA	NA%	NA%

Source: WUENIC, July 2025 release

Uganda has made measurable progress in reaching zero-dose and under-immunized children through deliberate and coordinated actions to strengthen immunization service delivery and the broader health system. This section highlights the actions undertaken by the Uganda National Expanded Programme on Immunization (UNEPI) across routine immunization, vaccination campaigns, and other targeted interventions; including health system strengthening initiatives; to improve access, reduce missed opportunities, and ensure that previously unreached children are progressively reached with immunization services.

Within this context, Uganda's immunization programme has expanded into a comprehensive vaccine portfolio comprising 14 antigens, reflecting sustained programmatic growth over the past three decades. In the last five years alone, the country has introduced Yellow Fever vaccine (YF), second doses of Measles–Rubella (MR2), Inactivated Polio Vaccine (IPV2), and the Hepatitis B birth dose, further strengthening protection across the life course. Most recently, in April 2025, Uganda introduced the malaria vaccine, with the largest malaria vaccine introduction globally to date, and marking a significant milestone in efforts to reach high-risk and previously underserved infant populations.

The country has consistently achieved high routine immunization coverage, particularly for antigens such as DPT-HepB-Hib, BCG, and polio, supported by a well-established immunization programme (Table 1). The significant improvement in the performance of new antigens seen in 2024 was due to the Big Catch up activity conducted in October and November of that year; with sustained improvements seen in 2025 (Figure 1).

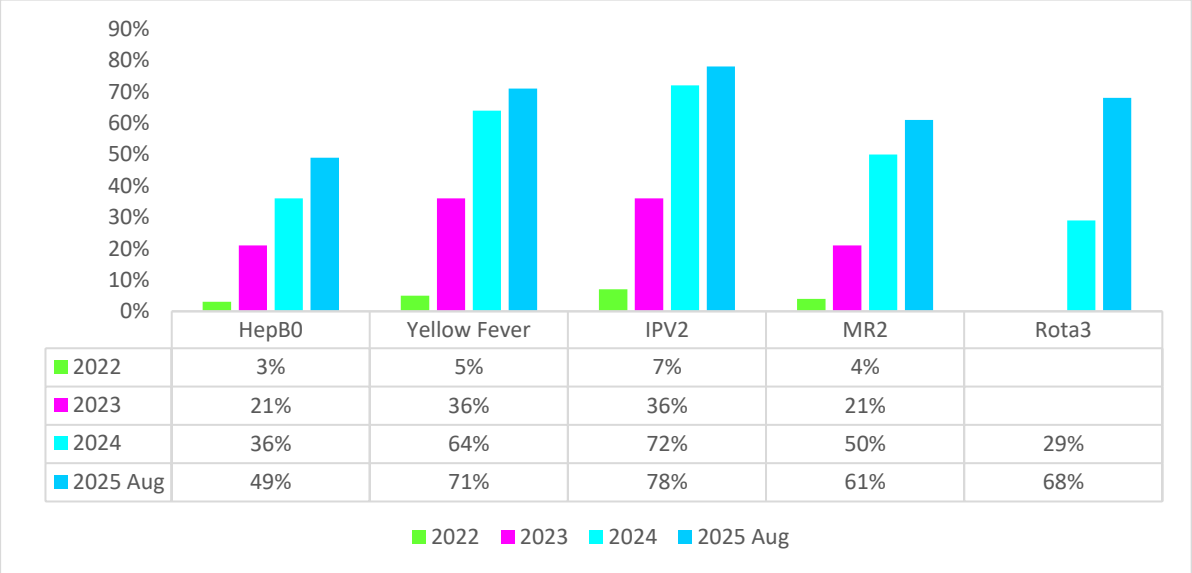
The country has maintained a polio-free status since 2006 when WHO certified the country as free from all indigenous wild polio virus, while demonstrating the capacity to rapidly respond to

outbreaks of vaccine-preventable diseases through supplemental immunization activities. Uganda immunization program proved resilient during the COVID-19 pandemic, maintaining essential vaccination services despite significant public health and system-wide disruptions. The Ministry of Health rapidly adapted service delivery by prioritizing routine immunization as an essential service, implementing infection prevention measures, and using outreach and mobile strategies to cater to children in hard-to-reach communities during lockdowns. Health workers were reoriented to safely deliver vaccines, while surveillance, cold chain operations, and vaccine supply systems were sustained to prevent stock-outs. As a result, Uganda was able to minimize declines in routine immunization coverage protecting children from vaccine-preventable diseases and reinforcing the country's reputation for a robust and adaptable immunization

Table 1: Performance of All antigens in RI Schedule, FY2018/19 – 2024/25

Antigen	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025
BCG	88%	79%	83%	85%	82%	82%	90%
Hep B zero dose					10%	36%	44%
DPT1	103%	92%	97%	98%	94%	98%	102%
DPT2	95%	87%	91%	92%	89%	94%	100%
DPT3	93%	85%	91%	92%	91%	94%	97%
IPV1	88%	73%	90%	91%	113%	122%	121%
IPV2					20%	60%	79%
MR1	87%	80%	90%	91%	94%	92%	107%
MR2					29%	41%	51%
Yellow fever					20%	52%	78%
PCV 1	100%	92%	97%	99%	94%	97%	101%
PCV 2	94%	87%	91%	93%	90%	93%	99%
PCV 3	92%	85%	91%	93%	91%	94%	96%
Polio 0	74%	72%	77%	79%	68%	71%	76%
Polio 1	103%	98%	97%	98%	96%	98%	106%
Polio 2	94%	97%	91%	93%	91%	93%	98%
Polio 3	92%	84%	91%	93%	90%	95%	97%
Rotavirus 1	96%	90%	94%	94%	92%	95%	104%
Rotavirus 2	88%	84%	87%	86%	87%	88%	98%
Rota3							57%
HPV1	115%	95%	96%	105%	157%	176%	169%
HPV2	65%	38%	56%	56%	74%	123%	NA
Td2+_Preg Women	75%	58%	64%	58%	62%	63%	66%
Td2+_Non Preg Women	6%	3%	5%	3%	6%	11%	25%

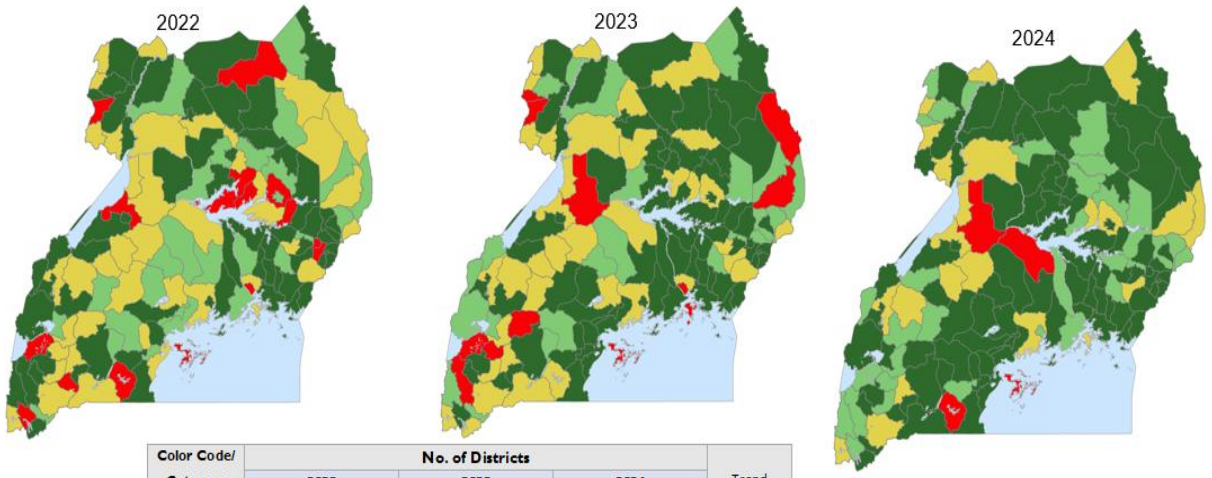
Figure 1: New Vaccines Coverage:



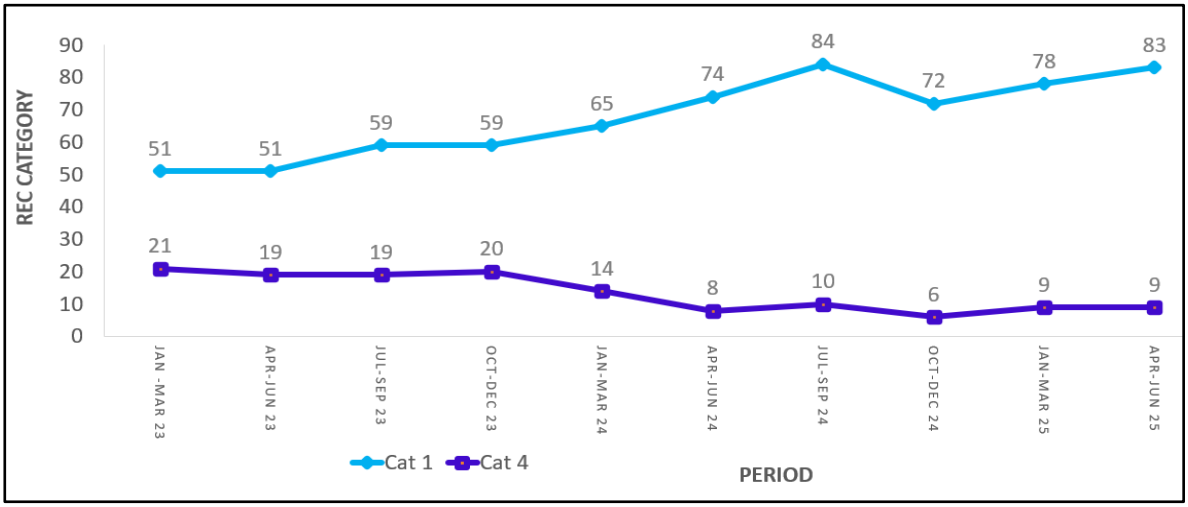
	HepB0	Yellow Fever	IPV2	MR2	Rota3
2022	3%	5%	7%	4%	
2023	21%	36%	36%	21%	
2024	36%	64%	72%	50%	29%
2025 Aug	49%	71%	78%	61%	68%

The standard assessment of the country and districts using the Reach every child/Reach every district (RED/REC) categorization, has shown progressive improvement at sub-national level with more districts transitioning into Category 1 status. The maps below show the progress. This improvement is attributed to increased access through more health facilities onboarding vaccination, continuous targeted support supervision of districts with improved microplanning to accurately identify zero dose and under immunized children, and carrying out targeted interventions. The capacity building of district biostatisticians to use district specific data analytics has greatly supported this exercise. In addition, the implementation of the Ministry of Health's integration strategy, has improved access opportunities.

Figure 2: EPI RED/ REC Categorization, 2022 - 2024



Color Code/ Category	No. of Districts			Trend
	2022	2023	2024	
Cat 1	63	74	86	
Cat 2	27	23	34	
Cat 3	40	37	22	
Cat 4	16	12	4	



Source DHIS2

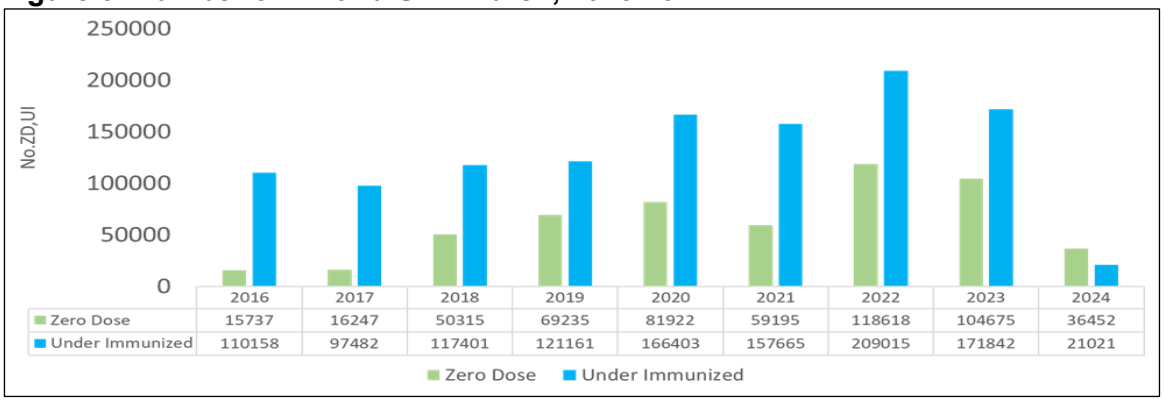
The country over the years has increased access to immunization services through increment in number of vaccinating health facilities from 4313 in 2024 to 4563 in 2025. This increment also led to the rise in the number of outreach sessions as shown in the table below:

Table 2: Number of Vaccinating Health facilities:

Year	No.Vaccinating Health Facilities	No.Outreach (OR) Sessions Conducted	No.Children receiving DPT1 in OR
2020	4313	135372	485340
2021	4368	166159	570656
2022	4387	158331	557167
2023	4455	165553	600329
2024	4557	172776	746559
2025 Aug	4563	155580	624494

In spite of the above strengths, there are still pockets of zero dose(ZD) and under immunized(UI) children across the country for various reasons. However, significant progress in reducing the number of ZD and UI children has been made. According to WUENIC 2024 estimates, the number of ZD children reduced by 15% in the past 3 years (2022-2024). Compared with administrative data, the number of ZD children increased gradually from 15,737 in 2016 to a peak of 118,618 in 2022, before declining to 36,452 in 2024, representing a 69% reduction from the 2022 peak as shown in the figure below. This reduction is attributed to intensified efforts to reach previously unimmunized and under-immunized children affected by the COVID pandemic during the Big Catch-up in November 2024.

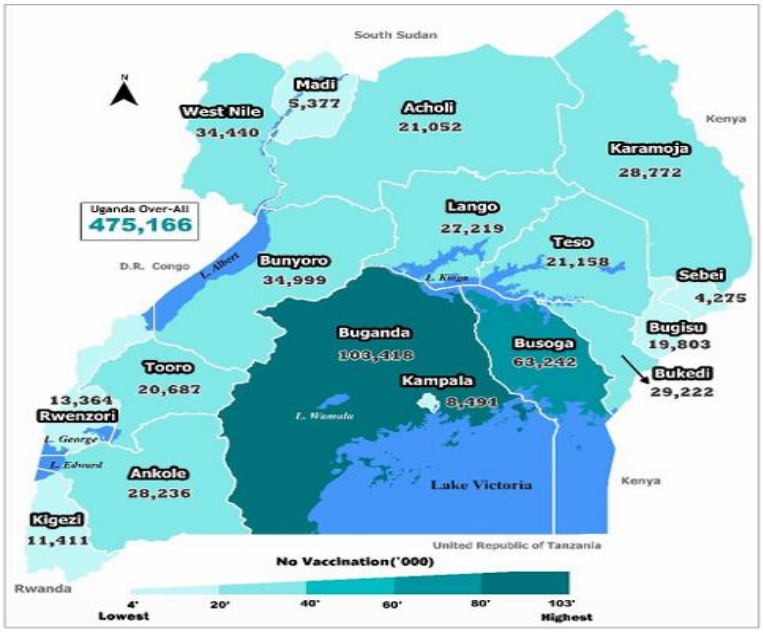
Figure 3: Number of ZD and UI Children, 2016-2024



Source: DHIS2

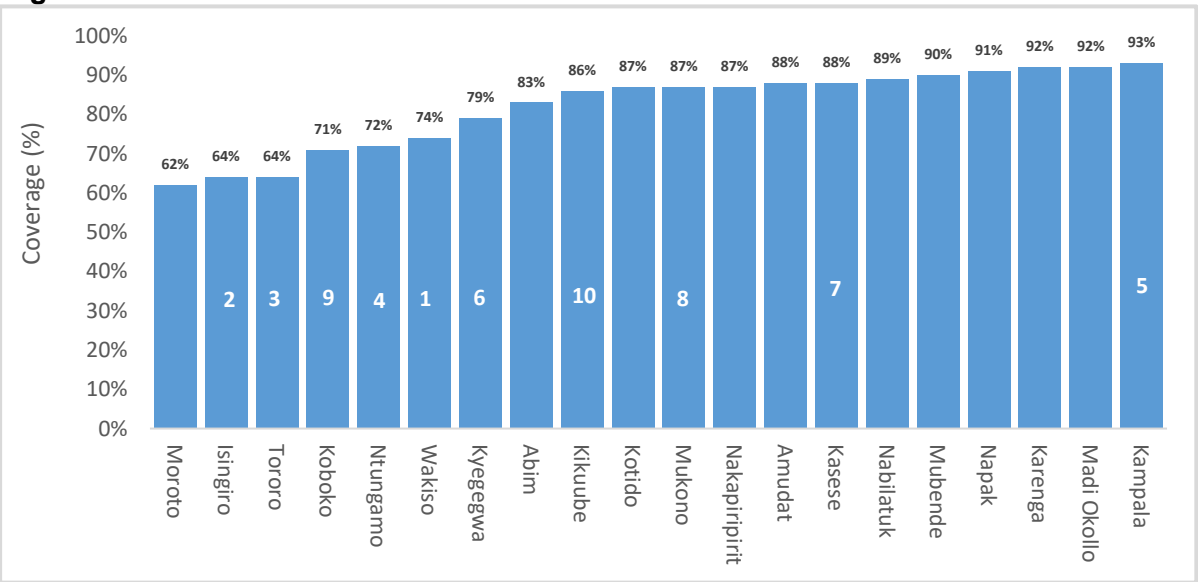
Further analysis using data from the National Population and Housing Census (NPHC), 2024, on routine basic childhood vaccination, showed that 475,166 children (12.2%) had not received any vaccine (ZD), with the highest number (103,418) reported in the Buganda sub-region and the lowest (4,275) in the Sebei sub-region. This analysis however, captures all children since birth as opposed to the traditional ZD calculation at 6 weeks for DPT1. Buganda region comprises of the biggest urban and peri-urban populations. In addition, it is home to the largest population size (close to 25% of the national population), and tends to also host the highest political opposition to government (garnered 62% of the vote in 2021). The opposition strongholds tend to harbor populations skeptical of existing government programs.

Figure 4: Map showing number of ZDC (0-2 years old) by Sub-Region, 2024



Source: NPHC, 2024

Figure 5: DTP1 Coverage in the 20 Lowest-Performing Districts, ranking the Top 10 Highest Zero-Dose districts



Sub-national analysis reviewing the contribution of individual districts to the ZD burden reveals that out of the 20 lowest performing districts with DPT1 coverage below 90%; 10 of these districts also have the highest zero dose burden as shown in Figure 5. All 10 districts also host Equity Reference Groups (ERGs) which indicates a strong correlation between poor EPI performance, high zero-dose burden and equity-related barriers.

The 2017 Uganda Immunization Equity Assessment Report identified distinct equity-related barriers in various communities hindering the access to and utilization of immunization services:

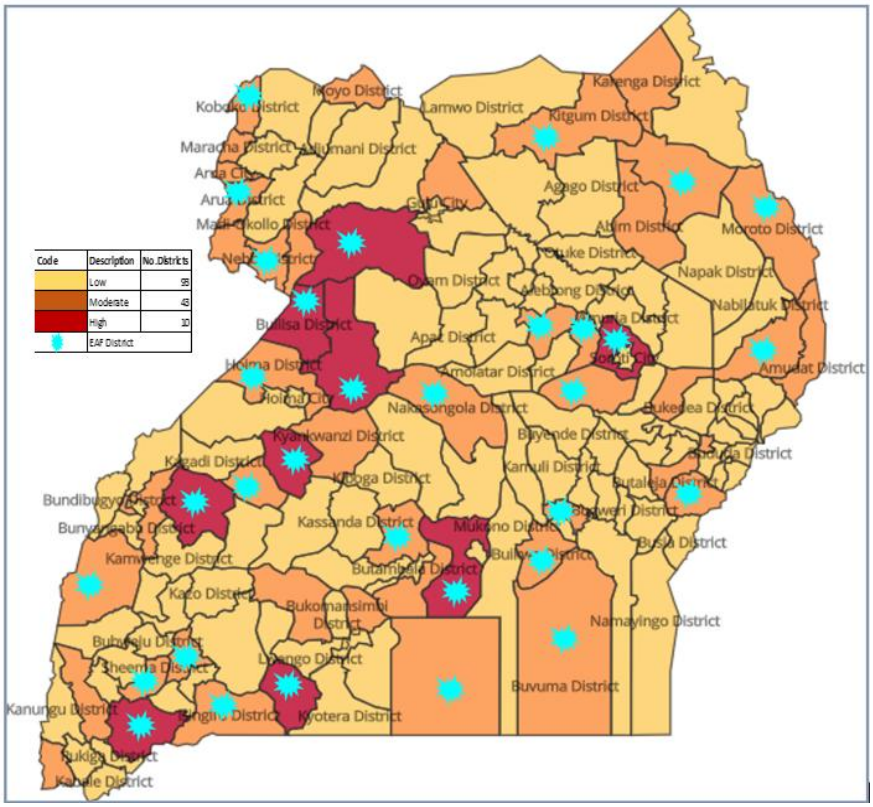
- **Urban communities**: Health workers face difficulty accessing informal settlements and gated communities, high mobility of residents, hidden costs, poor timing of services, and a lack of accurate, disaggregated data for tracking populations. Low-income, working-class caregivers often lack information, and partnerships with the private sector are

insufficient. Additionally, urban districts face challenges due to congested roads, leading to vaccine stock-outs at health facilities due to poor transport.

- **Fishing communities**: There is high population mobility, competing economic priorities, long distances to health facilities, limited service providers, and poorly timed vaccination sessions.
- **Island communities**: These communities have inadequate service delivery points. Geographical isolation limits access to immunization services, and poor living conditions and safety concerns hinder the attraction and retention of health workers. High operational costs—traveling by boat is three times more expensive than by road—and inadequate transport, safety equipment, and communication networks further complicate service delivery.
- **Pastoral communities**: Immunization service delivery is a challenge due to the high mobility of pastoralists as they move in search of water and pasture.
- **Refugee communities**: Marginalization of refugees by health workers leads to low demand for immunization services, fear of vaccine safety and side effects (especially for new vaccines), high population movement, and a lack of cross-border policies for sharing vaccination data and records. In addition, there are challenges in recruiting and retaining experienced health workers within refugee settlements.
- **Religious sects**: De-mobilization and resistance from religious sects reduces utilization of available immunization services.
- **Mountainous communities**: Health workers cannot easily access communities due to the difficult terrain, there are long distances that vehicles and motorcycles cannot navigate, and poor retention of health workers leads to understaffing. Furthermore, there is poor telecommunication network coverage (cell phone, radio, and internet), high operational costs because of the volume of fuel required to reach these areas, fear among health workers due to inadequate safety equipment (helmets, ropes, hooks), and limited engagement of community leaders in planning.
- **Conflict-prone communities**: There is difficulty in on-boarding and retention of health workers, mistrust between communities and authorities, and uncertain target populations due to displacement and migration. These factors make planning for immunization sessions more complex and accurate forecasting of vaccine needs challenging. Additionally, temperature control during transportation and outreach is subject to excursions, and at times, there is damage or destruction of infrastructure and the supply chain.

Through the Equity Accelerator Fund (EAF), these districts have been prioritized for tailored, equity-focused interventions that directly address identified root causes through targeted service delivery adaptations, intensified community engagement, and system-strengthening actions.

Figure 6: Map of districts burden of highest ZD burden highlighting EAF districts



All 10 districts with the highest zero dose burden are also districts hosting Equity Reference Groups (ERGs) with specific

The dropout rate (DPT1–DPT3) reduced by 20% over the period 2019-2024, as shown in Fig.1 due to the same interventions described above, showing overall improved utilization of the immunization services. However, the number of under-immunized children increased as shown by the rise in dropout rates by 25% (DPT1–MR1), signaling gaps in continuity of immunization after the initial enthusiasm in the first 3 months after birth. This highlights the urgent need to strengthen defaulter tracking mechanisms to ensure children complete their immunization schedules. Addressing this gap is essential for advancing the life-course vaccination approach, including the Malaria vaccine, MR2, HPV, and TD.

The country through the 2024 Big Catch Up campaign, significantly reduced the high number of zero dose and under immunized children as shown in the table below:

Table 3: Results from the Big Catch Up

Antigen	Big catch-up Target	BCU Results	BCU Coverage
(Zero-Dose	329,359	292,907	89%
Under Immunized (DPT3)	413,350	288,960	70%
Under immunized (MR1)	591,210	570,189	96%
Under immunized (MR2)	3,081,426	1,557,831	50%

Source: DHIS2

Efforts in strengthening routine immunization and the second year of life platform have been instituted as explained further in the country comments below.

Country comments (please consider the set of cross-cutting questions to structure comments):

Uganda has advanced immunization as a central pillar of national health development. UNEPI's vision of a population free of vaccine-preventable diseases is operationalized through measurable objectives: achieving 95% coverage across all antigens, reducing ZD prevalence to 0.5% by 2028, and eliminating stock-outs. These targets are aligned with Uganda's National Development Plan III, National Health Policy (2021), Ministry of Health Strategic Plan (2020/21–2024/25), National Immunization Strategy (2022–2026), and global frameworks such as IA2030, creating an enabling environment for sustainable, equitable progress.

In 2024, Uganda completed a Full Portfolio Planning (FPP) process with GAVI support, prioritizing health systems strengthening, reaching ZD/UI children, and optimizing the cold chain. The current GAVI Full Portfolio Plan (FPP), encompassing the Health Systems Strengthening (HSS) grant, the Equity Accelerator Fund (EAF), and the Cold Chain Equipment Optimisation Platform (CCEOP), presented a new opportunity to build on past gains. Anchored in GAVI's 5.0 strategy and the global Immunization Agenda 2030 (IA2030), Uganda is advancing data-driven, equity-focused approaches aimed at reducing the number of ZD children by 50% by 2028.

Key Enablers of Progress

To reach the zero-dose children, the following have been the enablers:

Strong political will: Immunization has remained a national health priority, consistently reflected in the Ministry of Health's strategic plans and anchored in the National Development Plan III. Political leaders such as the President of the Republic of Uganda, Parliamentarians, and local leaders at the subnational level have played an important role as advocates for Immunization. The government's endorsement of ambitious immunization targets, such as achieving 95% DPT3 coverage and reducing ZD prevalence to 0.5% by 2028, signals clear ownership and accountability for results. This political will has also been demonstrated through the integration of immunization into broader primary health care and universal health coverage agendas, ensuring that vaccines are not treated as a stand-alone intervention but as part of a comprehensive strategy to improve child survival and health equity. Importantly, government leadership in resource mobilisation and partner coordination has created a unified platform where GAVI, development partners, and civil society can align behind national priorities. This strong stewardship has provided stability, continuity, and confidence in programme implementation, even amidst competing health demands.

Strengthened partner coordination: The programme has consistently demonstrated strong stewardship in convening a wide range of stakeholders, including development partners, implementing agencies, NGOs, CSOs, academia, cultural institutions, and the private sector, to align behind a common immunization agenda. This inclusive approach has enabled timely mobilisation of technical and financial resources, reduced fragmentation, and ensured that interventions are complementary and synergistic. Notable examples of strengthened partner engagement include:

- Increased number of partners engaged, notably, the Inter-Religious Council of Uganda and the Buganda Kingdom, which represents the largest single population group across 26 districts in the Kampala Metropolitan Area and surrounding regions.
- Expanded private sector engagement, in particular, collaboration with the Rotary family, which mobilised resources and organised health camps where immunization was a key component.
- CSO and community engagement and mobilisation of religious leaders to strengthen community outreach and demand for immunization.
- Partner-supported initiatives such as the expansion of eCHIS for child registration, joint data quality improvement exercises, improved microplanning, support supervision, and nationwide advocacy campaigns.

- Contributions to vaccine delivery systems, expansion of cold chain capacity, enhanced data collection and use, and social mobilisation campaigns.
- Regular quarterly EPI partner meetings, partner mapping, and development of integrated work plans to align activities and minimize duplication of efforts.

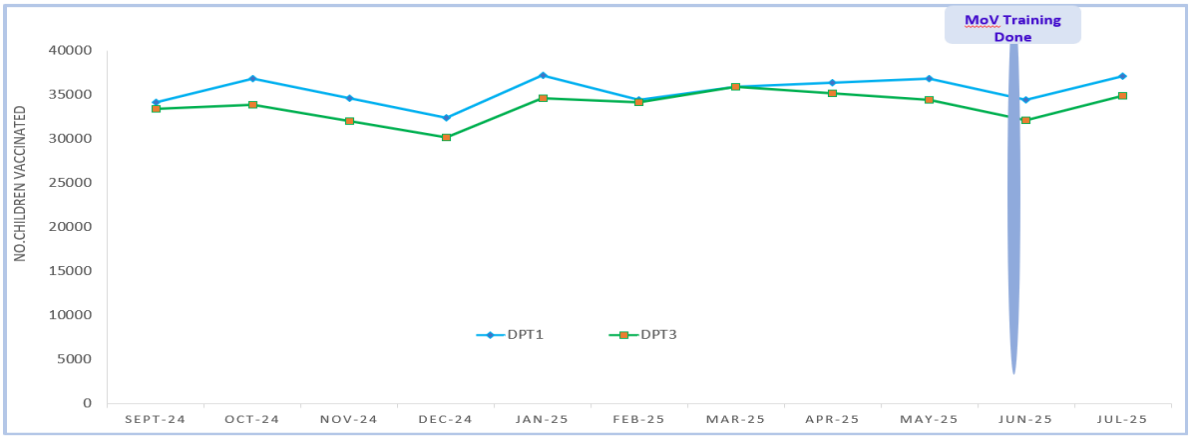
Through these coordinated efforts, Uganda has built a more resilient and responsive immunization program, better equipped to adapt to emerging challenges while sustaining gains in equity and coverage.

Availability of targeted funding for ZD and UI children: Dedicated funding, including EAF and CDS grant have provided critical resources to identify, reach, and sustain services for zero-dose children.

Integration of immunization with other health services: The MOH has instituted an integration strategy following the changes in the global shrinking fiscal space. Subsequently, immunization is being delivered in the broader context of MNCH services as elaborated below:

- Routine immunization is increasingly being offered alongside maternal and child health (MCH) interventions, nutrition screening, malaria prevention and treatment, Vitamin A supplementation, and outpatient (OPD) services. For example, during antenatal visits, mothers are sensitized about the importance of timely childhood immunization, while postnatal and child health clinics provide opportunities to vaccinate children who may have missed scheduled doses. This integration has allowed families to benefit from a broader package of services in a single encounter, reducing both the financial and time burdens associated with accessing healthcare.
- The programme collaborates with the National Malaria Elimination Program to leverage its bi-annual seasonal malaria chemoprevention (SMC) activities, which target certain regions, particularly in high-transmission areas like Karamoja. During these exercises, VHTs, supported by UNICEF, identify ZD and UI children at the household level and link them to immunization services. This integration has significantly improved the identification and referral of ZD and UI children.
- The programme is leveraging the malaria VHT integrated community case management (iCCM) platform, which provides household-based care for children under five. VHTs have been sensitised to integrate immunization into their service package, enabling the identification of ZD and UI children and linking them to appropriate immunization services.
- The program also trained different departments within regional referral and general hospitals, including HIV clinics, dental units, and outpatient departments, on how to identify unvaccinated children during service delivery and refer them to immunization services, ensuring no child is missed. The figure below shows the increase in the number of children reached following Missed Opportunities for Vaccination (MOV) training, which strengthened the integration of EPI services with other health services.

Figure 7: Contribution of DPT1 and DPT3 after MOV Training



Source: DHIS2

This integrated approach has not only increased service uptake but also reduced MOVs, particularly among children and mothers who might otherwise have limited contact with health facilities.

Cold chain expansion and reliability: Uganda has made progress in strengthening its cold chain system, a critical enabler of equitable vaccine access. Through GAVI's Cold Chain Equipment Optimization Platform (CCEOP) and complementary government initiatives, the country has distributed 776 solar/electric refrigerators, substantially expanding vaccine storage capacity at lower-level health facilities, especially in remote and underserved areas. This expansion has improved the availability of potent vaccines closer to communities, reducing both stock outs and wastage.

Additional gains were achieved through the Health Facility Solar Electrification (HFSE) Project, which solarized
250 health facilities. By providing a reliable and sustainable energy source, this project not only safeguarded vaccine potency but also enhanced the overall functionality of health facilities, enabling them to extend service hours and deliver immunization more consistently. Together, these investments have not only contributed to a more resilient cold chain system that can withstand shocks such as power outages and increased demand during mass vaccination campaigns, but also enhanced Uganda's capacity to integrate new vaccines and sustain routine services. These improvements have contributed to the reduction of geographic inequities in immunization access, ensuring that ZD and UI children in hard-to-reach areas are within reach of reliable vaccination services.

Targeted outreach approaches: The country has also advanced in reaching ZD and UI children through targeted outreach strategies supported by GAVI's Equity Accelerator Fund (EAF) and COVID-19 Delivery Support (CDS) grants. These resources enabled the Ministry of Health and partners to deploy mobile teams and strengthen school-based delivery in equity-challenged districts, particularly those with a high burden of ZD, UI children and hard-to-reach populations. For instance, in Karamoja, mobile outreach teams extended immunization services to remote pastoralist communities, reducing geographic and logistical barriers that had historically limited access. School-based delivery initiatives complemented these efforts by reaching older children who had missed earlier vaccinations and reinforcing health education to encourage sustained uptake. These efforts ensured that immunization services were not only available but also accessible to those most likely to be left behind.

By directly addressing equity gaps, these targeted outreach interventions have complemented routine facility-based delivery and contributed to a measurable reduction in ZD prevalence in several districts. They also demonstrate the importance of flexible, locally tailored approaches, backed by catalytic funding, in ensuring that immunization progress is inclusive and aligned with Uganda's national and global commitments to immunization equity.

Big Catch-Up (BCU): To further close immunity gaps, Uganda conducted a nationwide Big Catch-Up (BCU) in November–December 2024, targeting to vaccinate at least 90% children who had missed their due vaccinations during the COVID period. The exercise reached 89% (292,907) of the targeted 329,359 ZD children and 70% (288,960) of the targeted 413,350 UI children <5 years nationwide[2], as shown in the table below.

Community mobilisation: The on-boarding of CSOs provided an increased opportunity in community engagements, particularly in districts with high ZD children. Many of these CSOs were already existing in the same communities and were trusted partners. The country actively engaged trusted community actors, including local leaders, religious figures, civil society organisations

(CSOs), and Village Health Teams (VHTs), alongside mass media and digital platforms. These efforts built trust, addressed misinformation, and generated demand for vaccines. For example, during the April Integrated Child Health Days (ICHDs), radio campaigns on 34 national and district stations reached over 8.4 million people. In urban districts like Kampala, Wakiso, and Mukono, VHTs conducted house-to-house registration using digital tools (eCHIS) to identify ZD and UI children, enabling targeted outreach. Community mobilisation also included leveraging political leaders, influencers, and cultural institutions to encourage vaccine acceptance, demonstrating that combining grassroots engagement with mass media and digital tools effectively improves coverage, counters hesitancy, and ensures equity in immunization services.

Advocacy, communication and social mobilisation: In addition to traditional communication channels, the programme expanded outreach over the past year to include town hall engagements, conducting regional meetings to directly engage communities.

Data strengthening and improvements: To enhance the quality, accessibility, and use of immunization data, the EPI programme has implemented several initiatives to strengthen data systems, improve data accuracy, and support evidence-based decision-making:

- With support from HISP Uganda, an EPI Dashboard on DHIS2 was developed to visualize large volumes of raw data in a user-friendly format, enabling policymakers to make real-time, data-driven decisions. All DHOs, Biostatisticians, and ADHOs were trained on navigating analytical tools such as maps, charts, and tables within DHIS2.
- Conducted data triangulation using multiple data sources, including DHIS2 aggregate data, eIDSR, eCHIS, UBOS, and house-to-house (HTH) registration, to enhance the credibility and validity of findings. This process helped to validate the inaccuracies and discrepancies and overcome limitations associated with relying on a single data source.
- House-to-house registration supported by VHTs used digital tools such as eCHIS to register children at the household level. Data from HTH registration facilitated the identification of ZD and UI children for effective microplanning during the BCU through targeted outreaches.
- Conducted data cleaning with support from Biostatisticians, where data was internalized to detect and correct errors, inconsistencies, and inaccuracies, ensuring the validity of analyses and results.
- Conducted integrated performance review meetings to provide a comprehensive, transparent, and strategic assessment of programme performance, ultimately informing improvements in EPI service delivery.
- Printing and distribution of EPI data tools to support accurate documentation and recording of EPI services at the facility level.
- Data Quality Assessment (DQA) was conducted to identify data quality gaps in EPI data management processes, including reviewing collection, verification, aggregation, analysis, compilation, and reporting of EPI data. Attributes assessed included accuracy, completeness, timeliness, validity, and consistency. This has translated into fewer outliers within data.
- A 5-year EPI Data Quality Improvement Plan (DQIP) was developed detailing the processes, tools, and techniques employed to ensure data is accurate, consistent and complete[3].
- The national M&E personnel has been trained in data triangulation across multiple sources, improving the accuracy and completeness of programme data. Over time, this has resulted in administrative data closely aligning with WUENIC estimates.

Key Challenges in Reaching Zero-Dose and Under-Immunized Children

While Uganda has made progress in reaching ZD and UI children, sustaining gains remains a challenge. The following are the key challenges identified:

- Human resource constraints: Health worker (HW) shortage has affected both service delivery and accurate data reporting, limiting the program's ability to sustain quality routine immunization and targeted interventions. According to the Annual Health Sector Performance Report 2023/24[4], staffing levels in the public health facilities were 34% based on the new human resource structure. This implies that 66% of the approved HW positions are vacant/ unfilled. The increased HW workload amidst the growing immunization schedule, multiple concurrent campaigns, and other public health emergencies may have stalled momentum, even in districts with strong past performance.
- Manual data management system: Reliance on multiple registers, tally sheets, and stock books limited visibility of client-level data at the national level, hindering effective defaulter tracking.
- Persistent equity gaps: ZD and UI children remain concentrated in hard-to-reach areas, border districts, urban settings, religious sects, mountainous areas, and refugee settlements, where insecurity, high mobility, and socioeconomic barriers limit access to services.
- Access challenges: Although Uganda has achieved 86% population coverage within a 5 km radius of a health facility, some communities remain geographically distant, limiting their access to essential immunization services[5].
- Vaccine hesitancy: Misinformation and disinformation, exacerbated by the COVID-19 pandemic and amplified through the rapid growth of social media, have contributed to sections of the population becoming hesitant to vaccinate.
- Vaccine stock out at health facility level: Though vaccines are largely available both at the national and DVS levels, some HFs stock out due to delayed replenishment from the DVS. During this time, there are MOVs.

Promising Practices and Innovations

Recent implementation has highlighted several promising practices and innovative approaches that are strengthening immunization coverage and equity:

- House-to-House Registration Campaigns: Conducted in high-burden districts, these campaigns improved visibility of ZD and UI children. They generated comprehensive lists that informed targeted interventions, enabled follow-up, and increased accountability at the community level. For example, VHTs used this data to prioritize households during ICHDs, reaching previously missed children.
- Use of eCHIS by VHTs: Digital registration of children at the household level via eCHIS strengthened continuity of care. VHTs in urban districts conducted systematic household visits, ensuring that ZD and UI children were tracked, linked to services, and included in follow-up outreach, improving the efficiency of immunization delivery.
- Solar Electrification of Health Facilities: Through the HFSE Project, 250 facilities, particularly in remote and underserved regions, have been targeted for solarisation. This improved cold chain reliability, minimized vaccine spoilage, and reduced missed opportunities due to stock-outs or storage failures, supporting consistent service delivery.
- Social Listening System: UNICEF engaged IPSOS (a market research company) to monitor misinformation across social media platforms. This system has tracked trends around vaccines such as HPV and COVID-19, allowing the Ministry of Health and partners to respond promptly with targeted, evidence-based messages to counter myths and rumors.

- Deployment of TA staff at the regional level: These supported districts in the region to identify sections in their districts where ZD are prevalent and support microplanning, vaccine management and interventions.
- Integration of Services: Linking immunization with nutrition, maternal and child health (MNCH), deworming, and vitamin A supplementation, leveraging the malaria iCCM platform, demonstrated effectiveness in reducing missed opportunities for vaccination. These integrated service delivery models ensured that children accessing other health services were systematically assessed for immunization, enhancing coverage and efficiency.
- CSOs onboarding: These increased community engagement and interpersonal communication with communities, thereby leading to more identification of ZD and UI children, including the barriers to immunization.
- IRMMA (Identify, Reach, Monitor, Measure, Advocate) Approach supported by UNICEF: Piloted in Kampala, Wakiso, and Mukono, this enabled systematic identification, registration, and monitoring of ZD children. By strengthening technical capacity in these urban districts, the approach improved targeting of underserved populations and supported data-driven planning for outreach and catch-up activities.
- Continuous learning: Facilitated by The Learning Hub, the program identifies gaps in immunization service delivery, generates evidence, and collaborates with the program to design and implement responsive strategies, ensuring ongoing improvement in equity and coverage.
- Immunization mobile vans: These facilitated outreaches within urban settings, improving access and enabling the program to reach ZD and UI children.
- DHIS2 EPI Dashboard: The RI dashboard in DHIS2 was customised to enhance data visualisation, presenting key health information and indicators in a clear and user-friendly format. It enables districts, partners, and EPI stakeholders to effectively monitor performance, analyse trends, and make data-driven decisions to strengthen routine immunization.
- Data triangulation. This enabled the identification of areas with higher concentrations of ZD and UI children, enabling more targeted and efficient interventions.
- Revision of the EPI register to capture data by cohort has strengthened defaulter tracking and follow-up, ensuring timely completion of vaccination schedules.

Partner Contributions

GAVI and Alliance partners have provided critical financial and technical support to accelerate progress:

- UNICEF supported the identification of ZD and UI children, social mobilisation in urban centers, microplanning in 11 cities, solarization of 250 health facilities, especially in remote and underserved regions, and MoH call center strengthening.
- WHO, UNICEF, PATH, CHAI, AFENET, JSI, USAID, DFID, CDC provided technical support, data quality strengthening, capacity building of health workers, supportive supervision, cold chain maintenance, and service integration (IPV2, MR2, malaria rollout).
- CSOs and VHTs: Led household registration, community mobilisation, engagement with missed communities, and implemented tailored demand-generation approaches in equity-focused districts.
- NITAG provided evidence-based guidance on immunization activities such as the introduction of new vaccines, the MR FollowUp campaign due in 2026.

Key Risks to Sustained Progress

Although the program is advancing toward its goal of reducing ZD prevalence to 0.5% by 2028, potential risks could challenge system capacity and slow progress.

- Vaccine hesitancy and misinformation, especially around HPV and COVID-19, threaten uptake of both new and routine vaccines.
- Diminishing global fiscal space threatens the sustainability of efforts to reach ZD children.

- Reliance on a manual data management system limits data visibility of the clients at the national level, which affects defaulter tracking.
- Equity gaps remain entrenched, particularly in border districts, informal settlements, and fluid cross-border population movements, where conventional outreach models are insufficient, threatening progress towards national and IA2030 targets.
- Regional instability continues to drive up refugee numbers, while corresponding support funding has fallen significantly. This mismatch has placed substantial pressure on local governments, limiting their ability to ensure adequate healthcare for refugee populations.
- Persistent human resource gaps at subnational levels continue to affect service delivery quality. Nationally, the immunization division is still highly donor-dependent, with donor funding covering approximately 70% of staff positions.
- Maintaining the newly expanded cold chain requires consistent financing for maintenance and energy supply, particularly in remote solarised facilities and anticipated replacement costs.

2. Learning Question: How well are vaccine stocks being managed?

Indicator(s):

- **Number of health facilities that reported no stock-outs of DTP-containing vaccine**

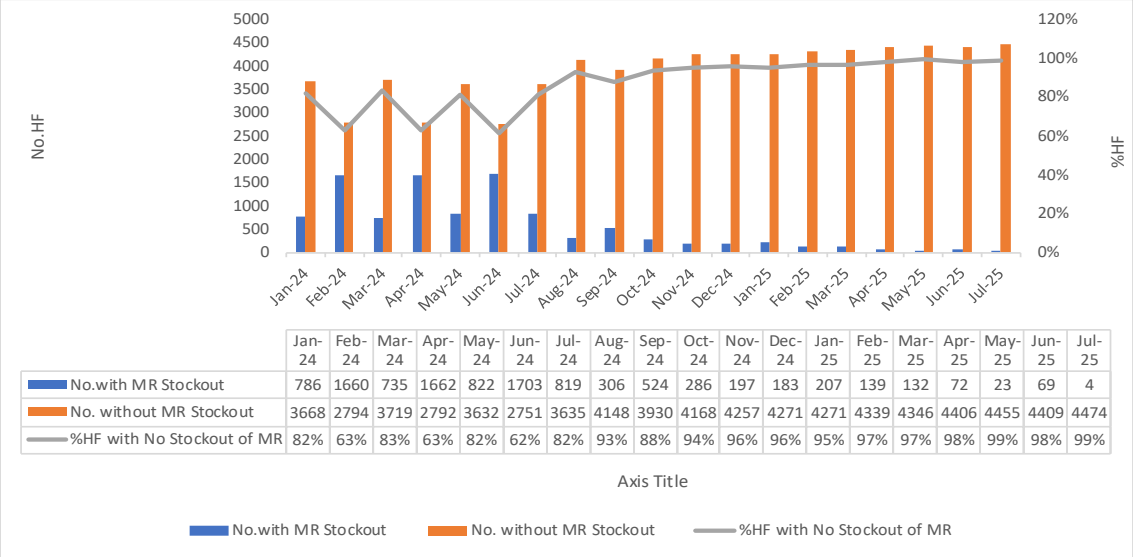
The programme currently has limited visibility into vaccine stock levels at the health facility, with MR being the only antigen tracked in DHIS2. This is because the existing HMIS reporting tools (HMIS Form 105, Pg 24) that feed into DHIS2 capture a narrow set of ≤50 items from the national essential medicines list to minimise health worker reporting fatigue[6]. To address this gap, the program is exploring the development of a vaccine-specific electronic logistics management information system (eLMIS) that can capture and report all key immunization supply chain indicators in a single, integrated platform.

However, based on available district stock reports, no district reported DPT stockout. This performance reflects the contribution of key supply chain measures, including informed forecasting, the streamlined ordering process through the NMS CSSP, efficient distribution mechanisms from the Central Vaccine Store (CVS) to the District Vaccine Stores (DVS) and the investments in a robust cold chain system. The full rollout of the vaccine last mile delivery (vLMD) mechanism, currently implemented (partially) in the Busoga region, together with the planned eLMIS investment, is expected to close current gaps in stock visibility and reporting, further strengthening supply chain performance.

- **Number of health facilities that reported no stock-outs of measles-containing vaccine**

  From January 2024 to July 2025, the number of health facilities that did not stock out of MR generally increased from 3668 (82%) to 4474 (99%). This improvement was supported by regular supervision, effective vaccine management (EVM) training, supportive mentorship, and ongoing engagement of facility in-charges, indicating a clear overall increase in MR vaccine availability.

Figure 8: Number of health facilities without MR stockouts, Jan 2024-July 2025



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
No.with MR Stockout	786	1660	735	1662	822	1703	819	306	524	286	197	183	207	139	132	72	23	69	4
No. without MR Stockout	3668	2794	3719	2792	3632	2751	3635	4148	3930	4168	4257	4271	4271	4339	4346	4406	4455	4409	4474
%HF with No Stockout of MR	82%	63%	83%	63%	82%	62%	82%	93%	88%	94%	96%	96%	95%	97%	97%	98%	99%	98%	99%

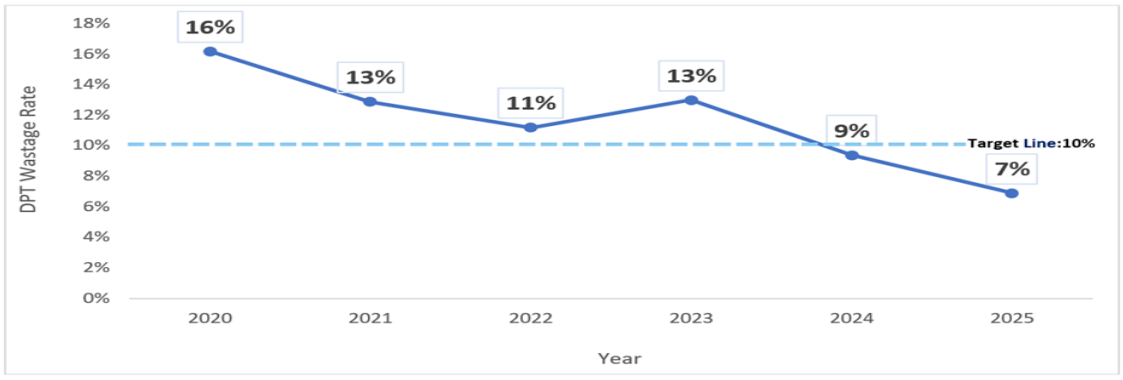
Source: DHIS2

- **Closed vial wastage rate of DTP-containing vaccine**

The national closed vial wastage rate for DPT improved from 16% in 2020 to 7% in 2025. Although a temporary increase was observed in 2023, largely associated with post-COVID-19 recovery challenges and disruptions in the District Cold Chain Technician (DCCT) supervision following an industrial strike, the program met and exceeded the ≤10% wastage target from 2024 onwards (Figure 8).

The elevated wastage during this period was influenced by reduced demand following the COVID-19 pandemic, persistent community misconceptions, and weakened supervisory support. In response, the program strengthened demand-generation and communication interventions, capacitated DCCTs following their reinstatement (although phased), and implemented corrective actions, including EVM training, refresher training for district health teams, and routine feedback on wastage trends. These measures contributed to sustained improvements in wastage management from 2024.

Figure 9: Closed Vial Wastage Rate of DTP-containing vaccine, 2020-2025



Source: DHIS2

- **Number of CCE received/installed/ leased through third-party providers.**

Over the last decade (2015- 2025), Uganda has made significant strides in strengthening its cold chain capacity. The country has acquired a total of 5,722 CCE units with support from various grants and partnerships, including HSS, UNICEF/ UNHCR/ MTN, CCEOP, COVAX, WFP, KOICA-WHO, and Africa CDC, as shown in the table below. Each initiative has since

contributed to the expansion and upgrading of the cold chain infrastructure in the country to align with new vaccine introductions and the broader immunization goals.

Table 4: Number of CCE Received/ Installed, 2015 - 2025

SN	GRANT	YEAR	# CCE	# CCE
1	HSS1	2015	1074	1446
2	HSS2	2018	90	
3	HSS2	2021	282	
4	UNICEF/UNHCR/MTN	2017	19	19
5	CCEOP1 Yr1	2017	608	3039
6	CCEOP1 Yr2	2018	906	
7	CCEOP 2	2021	749	
8	CCEOP 3	2025	776	
9	Coverage & Equity	2021	310	310
10	COVAX	2021	132	132
11	WFP (Ebola Vaccination Support)	2022	2	2
12	Japan Grant (UNICEF)	2022	115	115
13	Echo Grant (UNICEF)	2022	91	91
14	KOICA-WHO	2023	30	30
15	Africa CDC-1st Microplan	2023	38	538
16	Africa CDC-2nd Microplan	2025	500	
	TOTAL		**5,722**	**5,722**

Source: ODK-X

The major investment made in 2015, which saw the acquisition of 1,074 cold chain units, laid a strong foundation for subsequent years. However, according to the Cold Chain Rehabilitation Plan for 2020-2025, these initial units have reached the 10-year useful life and are due for replacement to maintain reliable and efficient vaccine storage and distribution across the country. By replacing ageing units and securing new funding, the cold chain system will be well-prepared to support ongoing and future immunization efforts across the country.

- **Equipment maintenance and/or onsite readiness.**

Uganda has strengthened vaccine stock management through the rollout of the Cold Chain Information System (CCIS) based on ODK-X, a mobile digital platform that tracks CCE functionality and maintenance in real time. Introduced nationally in 2022, ODK-X replaced the outdated manual inventory systems, enabling DCCTs to log preventive and corrective maintenance, capture equipment status, and monitor spare parts use. The system integrates with DHIS2 and eLMIS, providing dashboards that support procurement planning, warranty tracking, and timely response to faults. This has significantly improved oversight of CCE performance and informed readiness for vaccine storage and distribution.

i) CCE functionality status

The country has consistently maintained CCE functionality above the 98% threshold, as shown in the table below. This demonstrates that nearly all CCE is operational at any given time, ensuring vaccines remain potent while stored at the correct temperatures, and minimising vaccine wastage.

Table 5: CCE Functionality Status, Jan 2024 – June 2025

Year	Period	% Functionality	Total CCE Inventory
2024	Jan - March	98.4%	5325
	April - June	99.04%	5325
	July - Sept	99.1%	5325
	Oct - Dec	98.8%	5371
2025	Jan - March	98.7%	5371

	April - June	99.5%	5516

Source: ODK-X – Cold Chain Maintenance Application

i) Preventive Maintenance

In 2024, preventive maintenance coverage for CCE declined substantially, with the lowest coverage (0.7%) recorded in the second quarter (Table 4). This was largely due to the DCCT industrial strike, which extended into the first quarter of 2025. As DCCTs are responsible for routine preventive maintenance of CCE in their respective districts, the disruption adversely affected adherence to the annual maintenance schedule and increased the risk of equipment breakdowns. Following the resolution of their grievances, coverage increased to 42% in the second quarter of 2025, as shown in the table below.

Table 6: CCE Preventive Maintenance Status, Jan 2024 – Jun 2025

Year	Period	% Coverage	No. of Fridges
2024	Jan - March	4%	213
	April - June	0.7%	33
	July - Sept	16.2%	823
	Oct - Dec	8.2%	422
2025	Jan - March	15.9%	854
	April - June	42%	2,317

Source: ODK-X – Cold Chain Maintenance Application

ii) Corrective Maintenance

Given that NMS conducts corrective maintenance, the 441 repairs registered in 2024/25 demonstrate strong responsiveness to equipment breakdowns (Table 6). This reflects a significant strengthening of in-house capacity, with teams handling the majority of repairs as reliance on warranties declined. The high number of repairs also coincides with a period when DCCTs were less engaged in preventive maintenance due to an industrial strike, thus escalating the need for repairs.

Table 7: CCE Corrective Maintenance Status, Jan 2024-Jun 2025

Category	Jan-June2024	July24-June25	July-Aug25
In house / DCCT	60	357	64
Warranty	83	84	0
Total	143	441	64

Source: ODK-X – Cold Chain Maintenance Application

Together, these trends demonstrate a stable maintenance system, with Uganda shifting from warranty reliance and corrective focus to systematic preventive maintenance, improving equipment readiness and sustainability.

- **Cumulative volume of C19 doses expired to date (and volume specific to COVAX-supported doses, if the data is available)**

The country received a total of 55,043,440 doses of COVID-19 vaccines between March 2021 and March 2023 through the National Medical Stores (NMS)[7] as shown in the table below. Of these, a total of 3,447,825 were reported as expiries.

Table 8: Overall COVID-19 Vaccine Reconciliation, Mar 2021 – Mar 2023

Total C19 Vaccines Received (Mar-21 to Mar-23) (a)	Total distributed (Mar-21 to Sep-23) (b)	Total Returns (Mar-21 to Sep-23) (c)	Stock on hand as at 02-Oct-23 (d)	Reported Expiries (e)	Variance (f)=a-b+c-d+e
55,043,440	45,745,348	1,742,022	7,315,200	3,447,825	277,089

Source: NMS

Country comments (please consider the set of cross-cutting questions to structure comments):

Uganda has made steady progress in strengthening vaccine stock management, supported by improvements in infrastructure, capacity-building, and regular supervision. Key investments in the cold chain system, last-mile delivery and distribution trucks, and passive CCE have expanded national storage capacity. Preventive maintenance and daily monitoring have ensured functionality and reduced risks of breakdowns, while training of DCCTs and Assistant District Health Officers (MCH) has enhanced local-level competencies in cold chain management.

However, challenges such as the 30% (44 of 146) DCCT vacant positions[8], DCCT industrial strike in 2023 that spilt over to 2024 disrupted reporting and ordering processes, highlighting vulnerabilities in human resource stability. Vaccine wastage rates also remain a concern in some districts, though these are being addressed through support supervision and mentorship.

Promising Practices and Innovations

The following innovations have demonstrated a shift from reactive to proactive vaccine stock and cold chain management:

- Last-mile delivery innovation has enhanced strategies to ensure timely vaccine availability at the community level, particularly in hard-to-reach areas.
- Adoption of ODK-X has improved data capture, inventory tracking, and real-time monitoring of immunization activities.
- Deployment of technical officers at the regional level to mentor district teams and strengthen effective vaccine management (EVM) and service delivery arrangements.
- Cold chain optimisation through operationalisation of the Remote Temperature Monitoring Devices (RTMD) initiative has improved oversight and responsiveness in vaccine cold chain management.
- Institutionalisation of preventive maintenance schedules at daily, monthly, and quarterly intervals has improved cold chain reliability and reduced emergency breakdowns.

Partner Contributions to Driving Performance

Partner support, detailed below, has been instrumental in sustaining and improving vaccine stock management. These coordinated efforts have created a supportive environment for sustaining stock reliability and ensuring last-mile delivery.

- GAVI, UNICEF, WHO, and CDC supported infrastructure expansion and technical training.
- Africa CDC and World Bank provided funding for the procurement of CCE and vaccine last-mile delivery equipment.
- UNICEF has provided mentorship to frontline health workers, improving data quality and reducing wastage.
- NMS and UNEPI continue to provide oversight.
- PATH, CHAI, and USAID contribute to supervision, technical assistance, and system strengthening.

Key Risks that Need Mitigation

Despite progress, several risks require urgent mitigation.

- The 44 unfilled DCCT positions in some DLGs and cities threaten continuity of maintenance and local stock management; recruitment and retention of qualified technicians should be prioritized.
- Cold chain sustainability, as significant investments have been made in the cold chain system over the past period, which creates a substantial funding gap when rehabilitation and replacement needs arise.
- Continued reliance on manual data capture and reporting poses risks to data visibility, reliability, and timely transmission for decision-making.
- Efforts to address equity and access have contributed to an increase in the number of facilities providing immunization services. This expansion introduces operational and logistical risks that need to be mitigated.

3. Learning Question: Are vaccines being consumed in alignment with approved forecasts? What are the key drivers of consumption compared to expectation (e.g., stockouts, increased coverage, wastage)?

Indicator(s):

- Percentage of forecasted Annual Vaccine Requirement (AVR) consumed in prior period (by antigen)

Table 9: Vaccine Forecasting Accuracy (2023–2025)

Year	2023			2024			2025			Baseline Comparison	
Vaccine	Doses Issued	Doses Forecasted	AVR Consumption (%)	Doses Issued	Doses Forecasted	AVR Consumption (%)	Doses Issued	Doses Forecasted	AVR Consumption (%)	2023-2024 Change	2023-2025 Change
BCG	5,849,800	6,678,100	88	9,131,958	6,880,400	133	7,839,000	7,243,948	108	45	20
bOPV	6,582,000	8,358,700	79	11,030,265	8,612,000	128	10,197,000	9,018,050	113	49	34
DTP-HepB-Hib	4,393,680	6,302,700	70	7,036,817	6,493,700	108	5,268,240	6,701,939	79	38	9
HepB	663,290	1,652,300	40	1,045,011	1,702,400	61	1,500,000	1,653,510	91	21	51
HPV	1,500,230	1,119,200	134	1,693,506	1,153,100	147	1,497,924	787,980	190	13	56
IPV	2,551,925	3,819,900	67	4,357,771	4,261,200	102	3,666,600	4,008,553	91	35	24
MR	1,956,000	6,124,900	32	11,902,100	6,310,500	189	3,699,804	6,457,598	57	157	25
PCV10	4,086,360	5,729,800	71	6,415,817	6,635,900	97	4,746,000	6,485,748	73	26	2
Rota_liq	2,697,926	3,618,300	75	1,625,330	4,306,100	38	4,065,900	6,147,949	66	-37	-9
Td	3,291,900	3,023,900	109	6,334,950	3,391,600	187	4,744,500	740,741	641	78	532
YF	6,548,100	4,440,600	147	18,214,271	4,575,100	398	2,821,800	2,792,475	101	251	-46

Note: AVR consumption (%) $= \frac{\text{Actual vaccine doses consumed in the year}}{\text{Forecasted annual vaccine requirement}} \times 100$

The proportion of forecasted AVR consumed improved for most antigens over the past two years, indicating improved forecasting accuracy. While consumption exceeded forecasts for most antigens in 2024, with a significant surge in doses issued across 8 of 11 antigens exceeding 100%, consumption stabilised in 2025, with half of the vaccines within the

acceptable range (90-110%), indicating better alignment between forecast and actual consumption.

Key challenges influencing performance

- Vaccine stock challenges: HPV vaccine experienced low stock levels due to the ongoing vaccine switch, with some districts still administering two doses. Also, YF utilisation was initially low, prompting a scaled-down rollout for phases 1 and 2 to prevent expiries.
- Overstocking of other vaccines: MR, IPV2, and Rota vaccines were overstocked in certain areas because supply outpaced actual utilisation, despite good coverage for these newer vaccines.
- The Big catch-up: Intensive Big Catch-Up in November 2024 led to temporary surges in consumption, sometimes exceeding forecasted quantities.
- Data quality issues: Inaccurate and in some cases, delayed reporting, affected visibility of actual consumption, complicating forecasting and distribution.
- MR outbreak response: Emergency vaccine allocation for the Measles outbreak response occasionally disrupted routine supply, affecting consumption patterns.

Continued monitoring and refinement of forecast parameters will sustain supply chain efficiency and minimise wastage.

Country comments (please consider the set of cross-cutting questions to structure comments):

Enablers for good vaccine stock management

- Regular maintenance schedules for refrigerators, freezers, and other cold chain equipment.
- Conducting regular quality control checks on cold chain equipment to ensure it is functioning properly.
- Maintaining buffer stocks of vaccines in case of unexpected demand or supply chain disruptions.
- Continuous training and capacity building of cold chain staff on maintenance, handling, and storage of vaccines

Continued monitoring and refinement of forecast parameters will sustain supply chain efficiency and minimise wastage.

Promising practices and innovations

- The online-based forecasting tool supported by UNICEF provides an interactive platform which enables real-time feedback during the vaccine forecasting process, thus improving accuracy and responsiveness.
- Continuous tracking of both current and pipeline vaccine stocks to ensure timely decision-making and reduce stock-outs or overstocking.
- Regular multi-stakeholder Vaccine and Logistics Committee meetings provide technical guidance, oversight, and support for effective vaccine management and supply chain decisions[9].

Partner contributions to driving performance

- UNICEF supported procurement, expedited shipments into the country, and provided information on global supply markets.
- CHAI conducted supply chain data analysis to inform evidence-based decision-making.
- WHO provided policy guidance and best practices for effective supply chain management.
- PATH offered technical support on innovations in the immunization supply chain and promoted best practices.

- NMS served as the operational and logistics entity managing the immunization supply chain.

Risks That Need Mitigation

- Diminishing fiscal space could compromise supply chain financing, potentially undermining operations and affecting vaccine availability.
- A large proportion of supply chain personnel, particularly at the national level, rely heavily on partner and parastatal support, posing sustainability risks.
- Sustaining the current immunization programme portfolio requires ongoing government commitments, which could be strained.
- The "reaching every child at every opportunity" policy, while critical for equity, increases the risk of open vial wastage, especially for reconstituted vaccines.

4. Learning Question: Is the country complying with co-financing requirements in a timely manner?

Indicator(s):

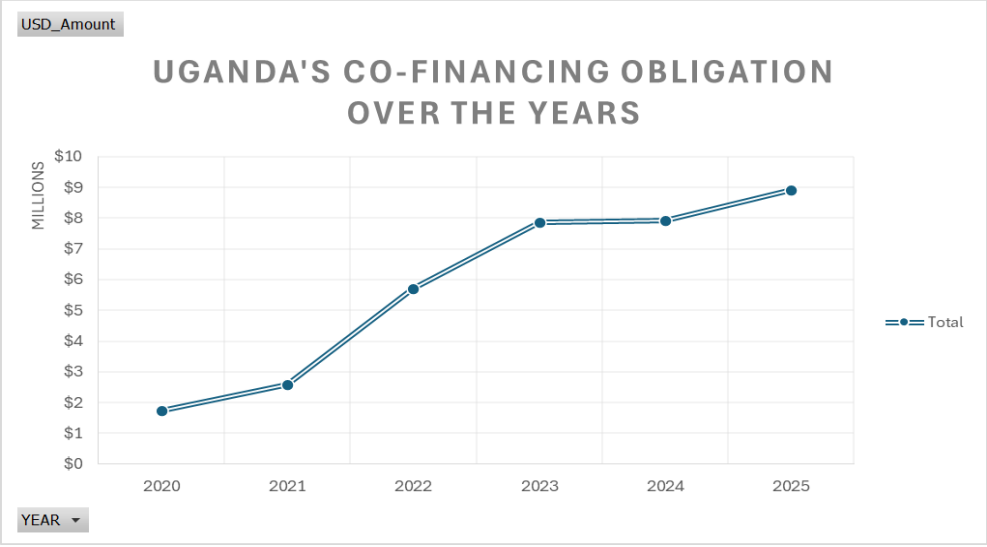
- **Country co-financing obligation met in a timely manner**

The country has fulfilled all its co-financing obligations promptly and on time, with the 2025 co-financing obligation fully cleared.

Country co-financing obligation in USD for 2024

Uganda has consistently met its co-financing obligations for both the current and previous years, reflecting a strong government commitment to sustaining immunization financing. However, the rapid expansion of the immunization schedule, with an increase in both the number of antigens and their required volumes, has placed additional financial pressure on the program. Currently, the co-financing requirement stands at approximately USD 8.9 million across eight antigens, which represents a significant rise compared to previous years.

Figure 10: Uganda's Co-financing Obligations, 2020-2025



Source: DHIS2

Country comments:

To bridge recent financing gaps due to overlaps in varying financial periods between GoU and GAVI or the need for additional vaccine doses during the year, the country has adopted the pragmatic approach of leveraging front-loaded GoU funds at UNICEF to cover vaccine co-

financing obligations. This innovation allows the country to pay timely and be flexible in case there is a need for additional financing to cover additional vaccines during the year.

Progressive, evidence-driven advocacy efforts, including high-level engagements between the GAVI CEO and H.E. the President of Uganda, as well as continued dialogue between MoH leadership and the Parliament, have contributed to increased government budget allocations for vaccination, rising from USD 2.6 million in FY 2021/22 to USD 3.7 million in FY 2022/23 and USD 8.1 million in 2024. These investments have enabled the country to fully (100%) finance all traditional vaccines while sustaining DPT3 coverage above 90%.

The program, through WHO support, is undertaking an investment case analysis to inform advocacy for resource mobilisation[10].

Partner Contributions

- UNICEF, being the funds recipient agent, ensured the timely procurement and shipment of co-funded vaccines.
- WHO is supporting the program to undertake an investment case study to inform advocacy for resource mobilisation.
- PATH supported the program in organising high-level advocacy engagements effectively.
- GAVI and other partners continue to engage with the Ministry of Health and the Ministry of Finance to highlight the importance of increasing domestic allocations for immunization.
- GAVI facilitated the GAVI CEO engagement with the President of Uganda for high-level advocacy.

This coordinated partner support has been instrumental in ensuring the country meets its co-financing obligation.

Risks that Need Mitigation

- Uganda delivers a big vaccine portfolio, and this has translated into increasing co-financing obligations. This will require progressive increments in budgetary allocations per year to cover the variances in the co-financing obligations.
- Rising costs linked to new vaccine introductions, increased birth cohorts, and higher vaccine costs and depreciation of the shilling all contribute to this risk.
- Uganda is likely to transition into the lower-middle-income status soon. This will initiate transitioning in the GAVI financing support, which translates into higher financial obligations.

Proactive advocacy is therefore required to ensure that immunization financing is prioritised in national budgets, with stronger commitments from government and partners to secure the long-term sustainability of the program.

5. Learning Question: If applicable, have new vaccines been introduced as planned and if not, why? Is coverage of recently introduced vaccines being scaled-up as expected?

Indicator(s):

- **Number of routine introductions completed over number of targets set for the calendar year**

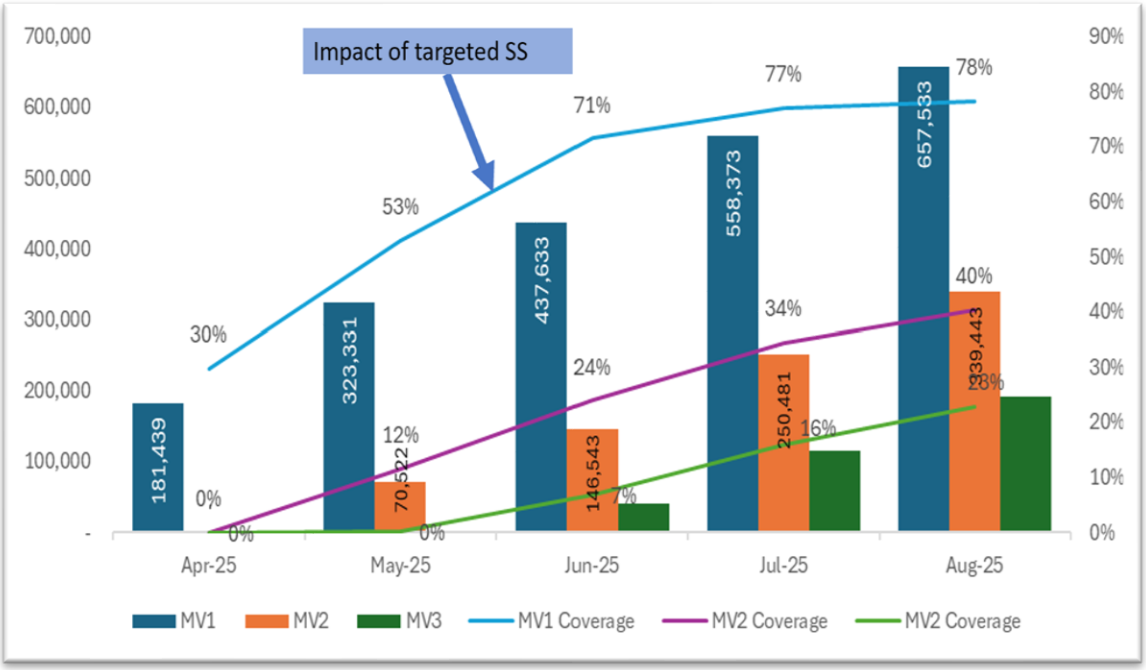
Uganda has successfully kept pace with its vaccine introduction agenda, rolling out new vaccines and additional doses as planned. The country targeted to introduce the malaria vaccine in 2025, and in April of the same year, the Malaria vaccine (MV) was introduced across 105 districts, marking a historic milestone as the first malaria vaccine rollout in the country. This

milestone demonstrates Uganda's commitment to advancing its immunization agenda in line with IA2030.

- **Coverage of recently introduced vaccines**

The country has completed the MV rollout with 78% coverage for the first dose as of August 31, 2025, reflecting strong initial uptake for a new vaccine. However, the trend across the three-dose schedule shows steep attrition, with coverage dropping from 78% for dose 1 to 40% for dose 2 and 23% for dose 3, an overall decline of about 80% between the first and third doses as illustrated in the figure below. This indicates that while awareness and demand for the initial dose are high, follow-through to complete the schedule remains a significant challenge that threatens the overall effectiveness of the intervention. Additionally, the MV follows new schedules that communities are not yet familiar with, making it harder for them to remember and adhere to the required appointments.

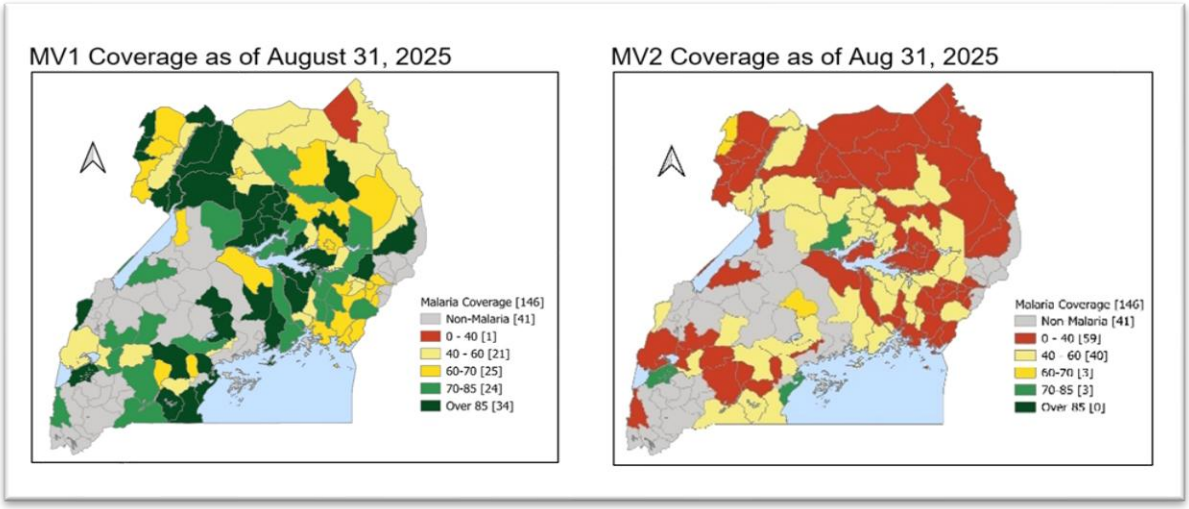
Figure 11: Coverage of Malaria Vaccine Introduction, Apr - Aug 31, 2025



Source: DHIS2

Based on geographical variation, coverage for the first and second doses of the malaria vaccine (MV1 and MV2) shows marked geographic variation across the country. While most districts achieved high coverage for MV1, their performance for MV2 remains considerably lower. As illustrated in the maps below, 34 districts attained MV1 coverage above 85%; however, none of these districts met the target for MV2, as no district recorded coverage above 85%. Instead, 59 districts reported MV2 coverage below 40%, including several that had achieved strong performance for MV1. This disparity highlights challenges in completing the malaria vaccination series, linked to follow-up mechanisms, caregiver awareness, and continuity of service delivery between doses.

Figure 12: Geographical Variation for MV1 and MV2 Coverage, Aug 2025



Source: DHIS2

Country comments (please consider the set of cross-cutting questions to structure comments):

Following the April 2025 malaria vaccine rollout, coverage and reporting were below target, with only 5 districts registering coverage above 80% and only 54% of the target districts reporting. To address these gaps, 50 districts, including 45 poorly performing and the 5 districts that had achieved >80% coverage, were selected for targeted support supervision to improve uptake of the new vaccine and ensure its integration into routine immunization, identify barriers and enablers to effective malaria vaccine introduction, build capacity of district health teams and health workers through mentorship, and document good practices and develop actionable district/facility plans.

Key gaps identified included health worker knowledge and poor data management. In response, on-site mentorship and on-the-job training were conducted to address gaps, and joint debriefs with DHTs, HF Incharges and EPI FPs were conducted to agree on action points and accountability follow-up. As a result (outcomes), the program witnessed;

- Improved health worker knowledge on malaria vaccination, particularly MV schedule and eligibility.
- Enhanced data quality and reporting rates.
- Better visibility of malaria vaccine stock.

To further identify best practices and lessons learned, a post-introduction evaluation (PIE) was conducted in September 2025. Findings will enable course correction and improvements to the programme during the critical early period of introduction (Annexe Table A1.1).

Going forward, the program has prioritised the following next steps and recommendations to address prevailing gaps, strengthen ongoing interventions, and sustain best practices across programmatic areas:

- Engagement with the Ministry of Education to update the routine immunization (RI) schedule in the school curriculum.
- Implementation of malaria vaccine research agenda.
- Community mobilisation and engagement for tracking defaulters and missed opportunities through existing structures (iCCM, CSOs & CHEWs).
- Updating of IEC materials to emphasize new visits at 7 and 8 months and uptake of doses 2 and 3.
- Provision of ITNs at 18 months as an incentive for mothers to return for dose 4.
- Continued integration of malaria vaccine mobilisation and implementation in all RI and malaria elimination activities.
- Support the subnational level to routinely update and utilize microplans.
- Routinely monitor malaria vaccine efficacy through molecular surveillance.

Partner Contributions to Driving Performance

- NITAG - provided timely, evidence-based recommendations that informed Uganda's vaccine introduction decisions, ensuring alignment with both global best practices and national priorities. This strengthened government ownership and supported the smooth rollout of new vaccines, including malaria.
- WHO supported the implementation of the PIE.
- WHO & UNICEF - Provided technical guidance, capacity building for health workers, and led demand-generation initiatives to increase immunization coverage.
- CSOs - Actively engaged communities, driving awareness and mobilisation, particularly in districts facing equity challenges.
- National Malaria Control Division (NMCD): Collaborated with UNEPI to integrate malaria vaccination with routine immunization services, enhancing program efficiency and coverage.

6. Learning Question: If relevant, how effective have recent GAVI-supported vaccination campaigns been?[11] Please highlight lessons learned which are applicable for routine immunization and upcoming campaigns (e.g., timeliness of outbreak response, quality, campaign reach and link back to strengthening routine immunization).

Indicator(s):

- **Number of vaccination campaigns conducted (stratified by type of campaigns, including preventive, reactive, catch-up, follow-up, sub-national and national)**

Since the last Joint Appraisal in 2019, Uganda has conducted 5 campaigns, including measles, YF and COVID-19 at the national level, nOPV2 at the regional level and mPOX for special groups, as shown in the table below. Of these, only 1 was preventive, reflecting a stronger emphasis on proactive routine immunization, and 4 were reactive, indicating widespread/ targeted outbreak responses. The 2022 measles follow-up campaign aimed to support completion of MR2.

Table 10: Number of Vaccination Campaigns Conducted, 2022-2025

Campaign	Period	Coverage	Nature	Implementation Level
Measles	2022	98%	Follow-up	National
nOPV2	2022	Phase 1: 111.2% Phase 2: 123%	Reactive	National
nOPV2	2024	Round 1: 118% Round 2: 127%	Reactive	Subnational
Yellow Fever	2024 & 2025	Phase 1: 71% Phase 2: 75% (54% PCCS) Phase 3a: 92%	Preventive	National
COVID-19	2021–2023	44% (dose 1) 29% (dose 2)	Reactive	National
Mpox	2025	86%	Reactive	Special groups

- **Coverage of recent GAVI-supported campaigns, compared to the target (coverage rate disaggregated by sex if collected)**

i) Covid 19 Vaccination

WHO declared the COVID-19 pandemic in Uganda on 26th March 2020. In response to the growing number of cases, the country launched the COVID-19 vaccination on 10th March 2021, targeting 21,464,704 persons above the age of 18 years and 6,520,114 children aged 12-17 years. Between 2021 and 2023, 29% of the target population were fully vaccinated with 2 doses, 44% reached with at least one dose, leaving 56% unvaccinated (Table 10).

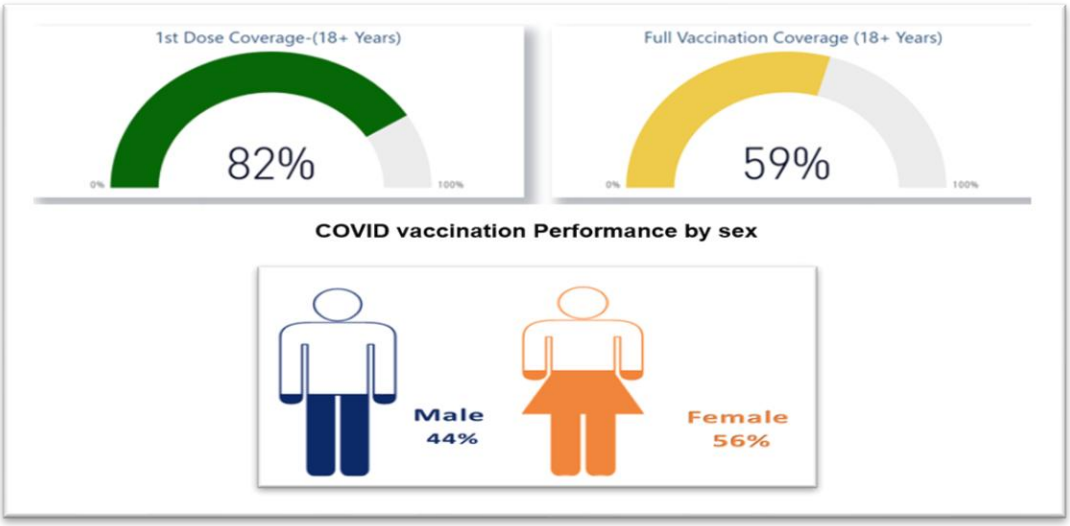
Table 11: National COVID -19 Vaccination Coverage by Age, 2023.

	18+ Years		12-17 Years		Overall	
	No.	%	No.	%	No.	%
Target	**21,464,704**		**6,520,114**		**44,354,511**	
1st Dose	17,622,401		1,583,894	0	19,206,295	
2nd Dose	6,306,936		388,479	0	6,695,415	15%
Booster Doses	459,761		14,725	0	474,486	1%
Total Doses Administered	24,389,098		1,987,098	0	26,376,196	
Received At least One Dose	17,622,401	**82%**	1,583,894	**24%**	19,206,295	**44%**
1st Dose -Vaccinated with J&J	6,104,363		388,479		6,492,842	
Received 1st Dose as J&J or 2 Doses of 2 Dose Vaccine	12,609,717	**59%**	388,479	**6%**	12,998,196	**29%**
Partially (Not Received 2nd Dose)	5,215,257	**24%**	1,195,415	**18%**	6,410,672	**14%**
Not Vaccinated	3,639,730	**17%**	4,936,220	**76%**	24,945,643	**56%**

Source: Uganda COVID-19 Vaccination Update, 2023

Of those vaccinated, more females (56%) were reached than males (44%), as shown in the figure below.

Figure 13: National Covid-19 Vaccination Coverage by Age and Sex, 2021 - 2023



Source: DHIS2

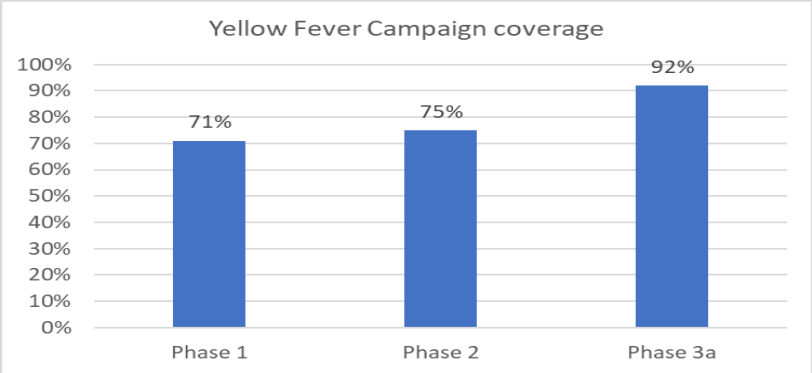
The country conducted several COVID-19 vaccination performance reviews, and the consistently low coverage over the vaccination period was largely attributed to individual data entry backlog despite the deployment of smart paper technology (SPT). Other challenges reported as contributing to low vaccination coverage included inadequate preparations for the vaccination campaigns, poor mobilisation of target populations, poor coordination by local governments, negative risk perception of the vaccines, and lack of strategies for utilising vaccine balances at the district level. A key lesson learned from this campaign was that adult vaccination requires different mobilisation models while acknowledging the importance of demand generation.

ii) Yellow Fever Campaign

Uganda is a Yellow Fever (YF) endemic high-risk country. Thus, the country planned to conduct a phased implementation of the YFPMVC covering 123 of 146 districts. Phase 1 was conducted in May 2023, phase 2 in Apr 2024, and phase 3a in Apr 2025, achieving coverage of 71%, 75%, and 92% respectively (Figure 13). As a result, 25,862,737 Ugandans were protected against YF by the end of Phase 3a.

While phase 3b was conducted in late September 2025 (report not yet complete), the progressive improvement across the 3 phases reflects effective programmatic adjustments and learning from earlier implementation experiences. The substantial increase in phase 3a indicates that strategies refined from the initial phases were successfully applied to reach previously unvaccinated populations. By nearly attaining the 95% target, the phased approach effectively closed coverage gaps and maximised overall campaign impact.

Figure 14: National Coverage of YF Campaign, 2023-2025

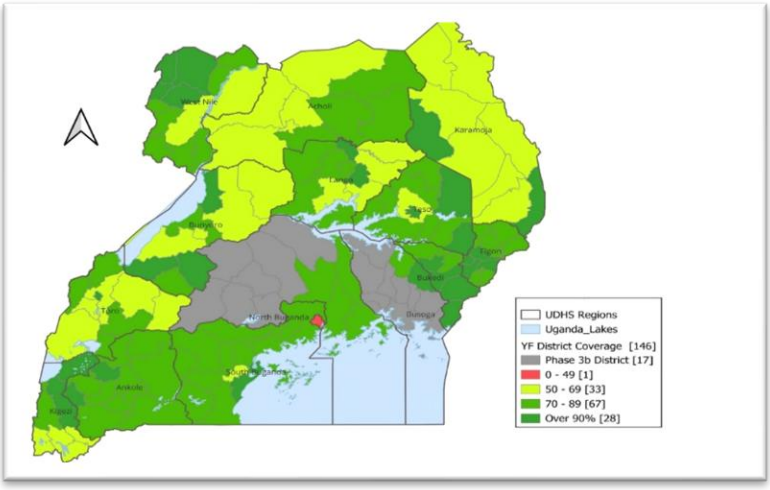


Source: DHIS2

A Post-Campaign Coverage Survey (PCCS) conducted for phases 2 and 3a, which recorded survey coverages of 54% and 78% respectively, revealed several operational, logistical, and communication gaps across key thematic areas of campaign implementation.

Notably, Kampala City was the only district that performed below 50% as shown in the map below. This result was largely attributed to typical urban vaccination challenges, including busy and transient populations, host to high numbers of residents already vaccinated, and many of these already vaccinated travelling out of the city. In addition, prior YF vaccination activities conducted in earlier years were not fully documented, making it difficult to reconcile data and establish an accurate target population. These factors, combined with the identified operational and communication gaps, contributed to the low coverage observed.

Figure 15: Subnational Coverage of YF Campaign, 2024-2025



Source: DHIS2

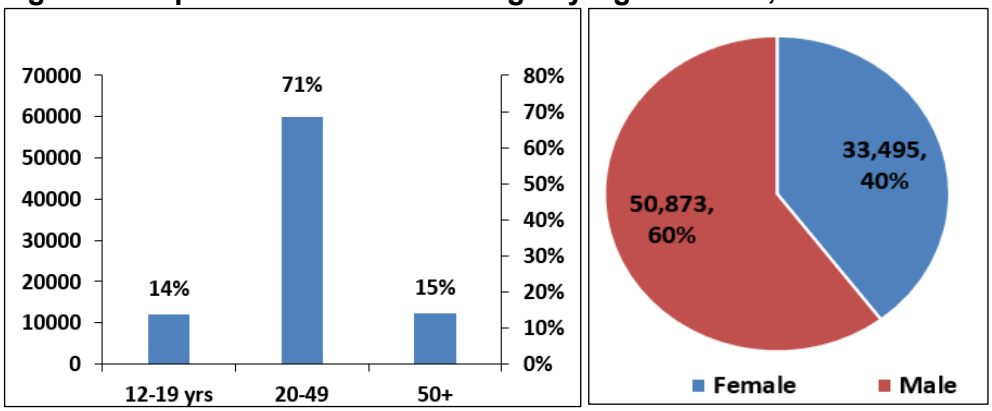
To address these gaps and strengthen future immunization activities, a comprehensive mitigation plan was developed (Annexe A2.2). The program has identified key lessons learned from previous YF vaccination campaigns to inform planning and implementation of future immunization activities:

- Early engagement of stakeholders improves acceptability.
- Early deployment of national supervisors to support both readiness and implementation improves performance.
- Deployment of a dedicated ACSM person from the national level to focus on and coordinate demand generation activities improves uptake of YF vaccination.
- Involvement of Ministry of Education structures in planning and implementation expands reach to school-going children.
- Effective communication and social mobilisation improve demand.

iii) Mpox Vaccination Campaign, 2025

Uganda has been experiencing an Mpox outbreak since the first cases were confirmed in July 2024. In February 2025, the country rolled out the Mpox vaccine targeting a cumulative total of 105,000 high-risk individuals, including sex workers and long-distance drivers along highway routes and major cities. As of August 2025, 98% of the 89,000 doses received had been utilised, reaching 82% of the target population. The majority (60%) were females and 40% males, as illustrated in the figure below.

Figure 16: Mpox Vaccination Coverage by Age and Sex, 2025



Source: DHIS2

Performance reviews have highlighted key challenges, including managing resource and logistics gaps, while responses have improved through better coordination, surveillance, and cross-border collaboration.

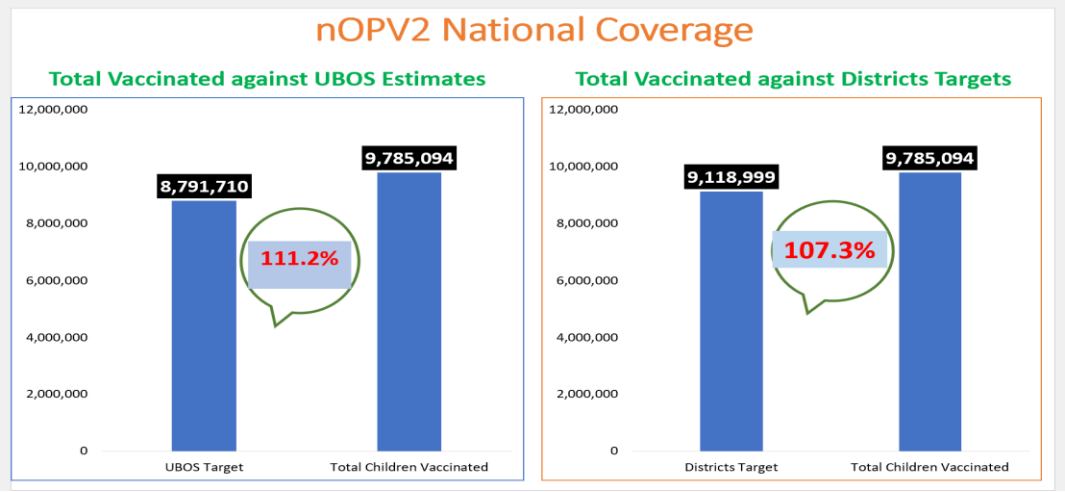
iv) nOPV Campaign, 2022

Following the cVDPV2 outbreak in Uganda in 2021, the country launched a nationwide introduction of nOPV2 through two rounds of supplementary immunization campaigns in a total of 140 districts for Round 1 (R1) and 150 districts, including 10 new cities, for Round 2 (R2). Note that R1 planning in 2020 was based on the country's 136 districts, together with the four divisions of Kampala Capital City. Following the national revision of administrative units in June 2021, which created an additional 10 cities, these new administrative units were incorporated in R2 planning. As a result, R2 covered a total of 146 districts and cities, in addition to the four divisions of Kampala Capital City.

R1 was implemented in January 2022, targeting 8,791,710 children under five (20.5% of the total population) in a house-to-house vaccination. A total of 9,785,094 (111.2%) children were vaccinated (Figure 16). Nearly all districts registered coverage of over 100% save for one that

achieved 70% coverage due to being assigned a target higher than its actual eligible population, as estimated from the UBOS national census figures.
At the sub-national level, most districts adjusted their target populations to reflect the actual number of children residing in their areas. Consequently, districts collectively achieved a vaccination coverage of 107.3% against a total target population of 9,118,999 children.

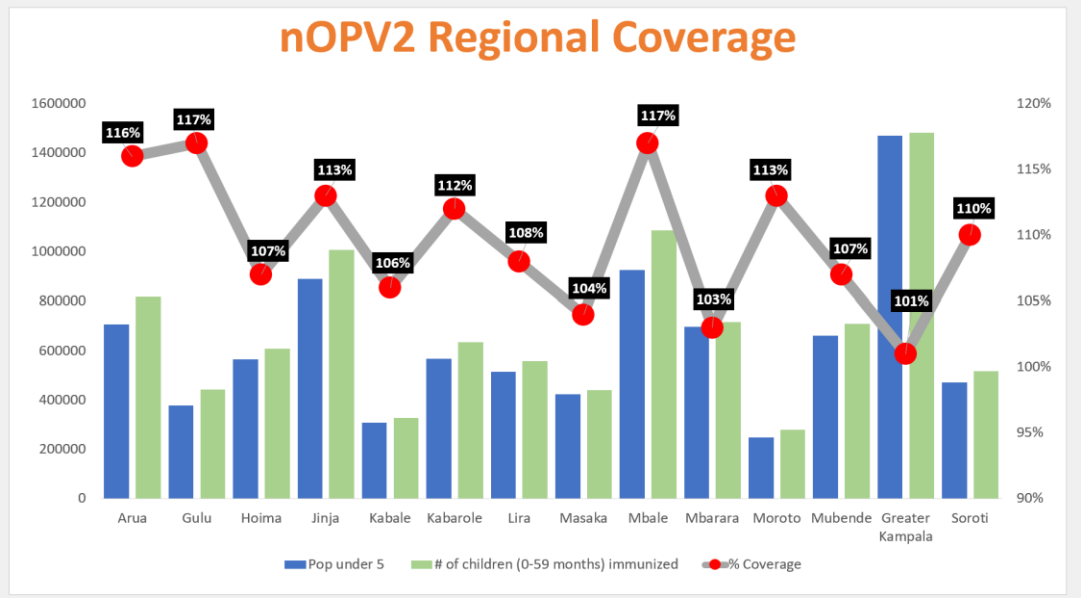
Figure 17: National nOPV2 R1 Vaccination Coverage, 2022



Source: Uganda Round 1 nOPV2 Campaign Report

While all regions exceeded 100% coverage, a performance attributed to effective microplanning, supervision, and community engagement during the campaign, Greater Kampala recorded the lowest coverage at 101% (Figure 17). Although this still exceeded the target, the comparatively lower performance was attributable to the high population mobility and underestimation of the target population denominator.

Figure 18: Regional nOPV2 R1 Vaccination Coverage, 2022



Source: DHIS2

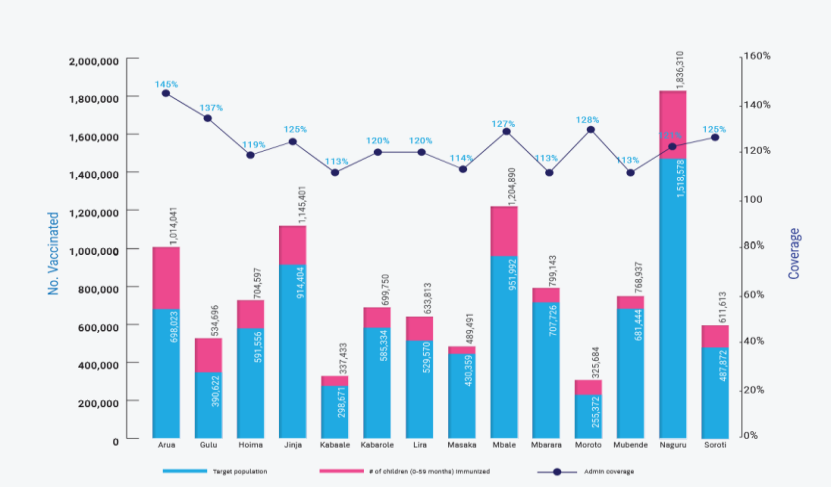
After R1, an after-action review meeting was conducted, and feedback obtained from all the regions was used to develop a quality improvement plan (QIP) to address the gaps identified ahead of the R2 implementation.

The nationwide R2 nOPV2 campaign was implemented in three phases following the confirmation of an Ebola Virus Disease (EVD) outbreak, which necessitated the postponement of activities in five affected districts, i.e., Mubende, Kassanda, Mukono, Wakiso, and Kampala.

Phase 1 was completed in November 2022. Implementation in the affected districts resumed after Uganda was declared EVD-free, with Phase 2 conducted in January 2023 across four districts and Phase 3 implemented in Kampala in February 2023.

Overall, the campaign achieved an administrative coverage of 123%, with 11,105,799 children vaccinated, compared to 111% (9,785,094 children) in R1 (Figure 18). This increase indicates improved reach of the target population and enhanced protection against poliovirus transmission. Independent monitoring across all districts reported coverage of 95.3%, compared to 93.19% in R1. Furthermore, Lot Quality Assurance Sampling (LQAS) results showed that 46% of sampled districts passed, an improvement from 33% in R1. These gains were largely attributed to the implementation of the QIP, which strengthened microplanning, supervision, and community engagement.

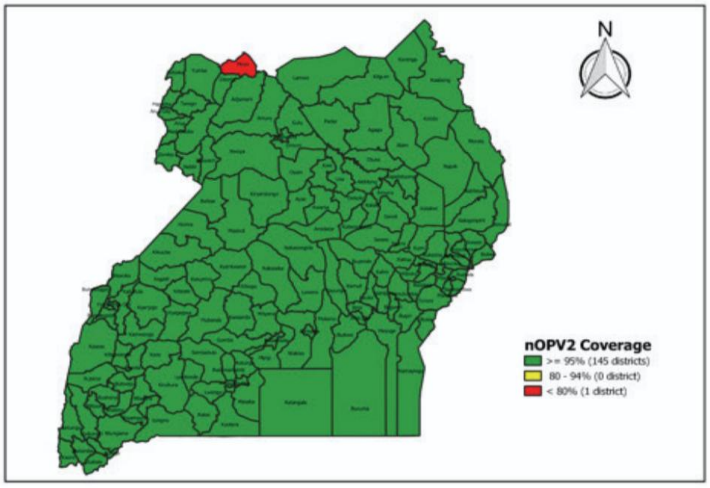
Figure 19: nOPV2 R2 Vaccination Campaign Coverage by Region, 2024



Source: Uganda Polio Campaign R2 Report, July 2023

Coverage of at least 95% was achieved in the majority of districts, as shown in the figure below. Of the 145 districts assessed, 144 (99.3%) met or exceeded the 95% coverage target, demonstrating a strong commitment to reaching and protecting children within their communities. Of special interest is Moyo, the only district that did not meet the target, recording a coverage of 68.9%. This was primarily associated with an underestimation of the target population, as the number of children under five years was higher than projected, resulting in a lower calculated coverage.

Figure 20: nOPV2 R2 Coverage by District, 2023



Source: Uganda Polio Campaign R2 Report, July 2023

Overall, the increase in coverage between rounds indicated improved implementation and reach. However, this round of the campaign highlighted both implementation challenges and key lessons. Delays in fund release, competing priorities, vaccine shortages, coinciding EVD outbreaks in some districts, operational gaps such as vaccine hesitancy, insufficient practical training, inadequate supervisory tools, transportation constraints, and suboptimal use of ODK by team supervisors affected smooth implementation and data reporting, while LQAS results indicated areas of suboptimal coverage despite high administrative figures.

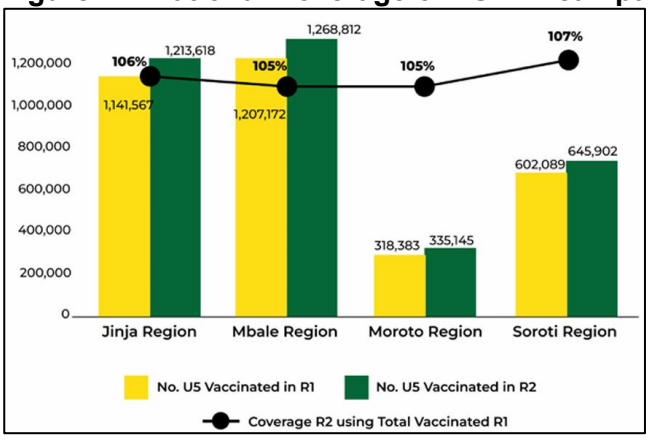
Nonetheless, strong planning and coordination, including systematic review of previous QIP and use of pre-campaign readiness dashboards, strengthened preparedness and accountability. Extensive advocacy, communication, and social mobilisation facilitated access to children and addressed hesitancy, while timely cold chain assessments and early vaccine distribution enabled a staggered and smooth rollout. Effective supervision and monitoring, supported by skilled personnel from government, partners, and the private sector, coupled with daily review meetings and rapid feedback through digital platforms such as ODK and WhatsApp, enhanced real-time problem-solving and overall campaign performance.

v) nOPV2 Campaign, 2024

Following the new cVDPV2 outbreak detected in June 2024, the country conducted a two-phased polio outbreak response campaign in October and November 2024, targeting 2.7 million children under five years of age across 49 districts in the Jinja, Karamoja, Mbale, and Soroti regions. The response campaign prioritised rural communities with limited healthcare access with the aim of containing the outbreak, interrupting virus transmission, and closing immunity gaps.

The aggregated data shows significant progress in vaccination coverage across all regions (Figure 20). Round 1 successfully achieved a coverage rate of 118%, vaccinating 3.269 million children across all districts, reflecting the campaign's extensive reach and community acceptance. Round 2 further enhanced the campaign's success, with a coverage rate of 127%, vaccinating 3.5 million children. This round focused on addressing missed children from Round 1 and ensuring comprehensive coverage in high-risk and hard-to-reach areas. Collectively, both rounds of the campaign ensured that more than 100% of the target population was vaccinated, significantly contributing to the interruption of the outbreak and safeguarding the health of vulnerable children.

Figure 21: National Coverage of nOPV2 campaign, 2024



Source: DHIS2

The polio vaccination campaign achieved strong results, with high coverage across all regions, including hard-to-reach and high-risk areas, thanks to strategies like house-to-house vaccination and intensified social mobilisation. While health workers, supervisors, and mobilizers played a central role in ensuring the campaign reached millions of children, effectively reducing the risk of polio transmission, and the campaign also strengthened systems through improved cold chain capacity, expanded training, and better data management.

Despite these gains, the campaign faced challenges such as logistical delays, cold chain gaps, team shortages, and community resistance driven by misinformation and hesitancy, underscoring the importance of robust advocacy and communication strategies. Training gaps and data inconsistencies further highlighted the need for continued capacity building. Even so, collaboration with community leaders and support from partners such as WHO and UNICEF were critical in overcoming hesitancy and ensuring effective planning, logistics, and supervision.

Overall, the nOPV2 campaigns reaffirmed commitment to polio eradication and underscored the need for sustained system strengthening and community engagement. By addressing the identified gaps and building on lessons learned, future efforts can achieve greater impact. The dedication of health teams and partners remains key to ensuring that no child is left behind and to advancing the goal of a polio-free world.

vi) Measles Vaccination Campaign, 2022

The Ministry of Health, in collaboration with partners, instituted a 3-year cycle of Measles supplementary immunization activities (SIAs) as a strategic approach to close the immunity gap. Following the 2019 campaign, a subsequent campaign was conducted in 2022 (summarised in the table below), with the next campaign scheduled for 2026.

Table 12: Summary of the Measles Campaign, 2022

Target age range	9-59 months
Target population	7,015,156
Geographic extent	National
Number vaccinated	6,728,710
Wastage rate (%)	6.8%
Administrative coverage (%)	95.9%
Coverage by coverage survey (%)	PCCS not done
Under 5 prev. unvaccinated & reached (%)	1.2%
Additional comments	14-19th October 2022

While almost all districts achieved over 80% coverage, four districts fell below this threshold: Nwoya and Kalaki at 73%, and Arua City and Mubende at 37% and 5.5%, respectively. The performance in these districts was largely associated with funding and operational challenges. At the onset, local governments (LGs) lacked funds, which hindered coordination, distribution of supplies, and campaign supervision. When funds were later released, accountability issues at LGs arose, as resources were channelled through RRHs that lacked the capacity to adequately support activities such as frontline health worker training, campaign supervision, and financial oversight.

Note: The 2022 Measles PCCS was not conducted due to the protracted procurement processes, which extended beyond 6 months post-campaign, rendering the PCCS unfeasible. However, this campaign highlighted the need to strengthen RRH capacity for decentralised implementation.

- **Number of reported outbreaks of vaccine-preventable diseases (for which GAVI supports with reactive campaigns)**

Polio Outbreaks

Since 2019, the country has registered 2 circulating vaccine-derived polio virus (cVDPV) type 2 outbreaks. On 23 July 2021, cVDPV2 was isolated from the environmental surveillance site located in Lubigi in Kampala. This was a major public health challenge that threatened to

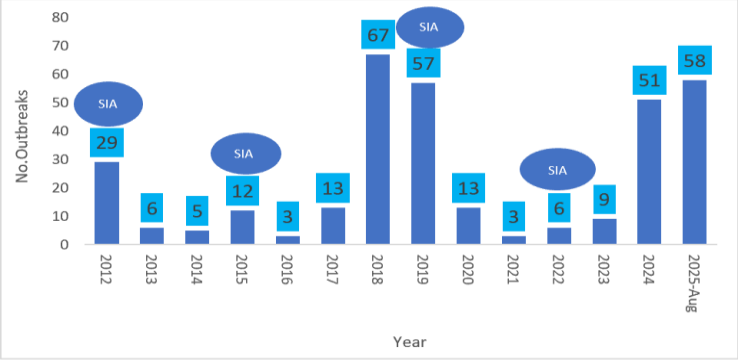
reverse Uganda's Polio certification status. This pointed to significant gaps in Uganda's routine immunization coverage, warranting a major public intervention.

On 07 May 2024, cVDPV2 was isolated from the environmental surveillance site located in Doko in Mbale city. This was a major public health challenge that threatened to reverse Uganda's Polio certification status. This pointed to significant gaps in Uganda's routine immunization coverage, warranting a major public intervention. Following notification by the Lab on 27 May 2024 and an IHR notification on 30 May 2024, MOH declared the outbreak on 01 June 2024. Laboratory testing and environmental surveillance revealed the presence of a cVDPV2, confirming its transmission within the region. The test also revealed that the virus was imported from Kenya, neighbouring Uganda, in the East Garrisa with 98.78% similarity, underscoring the persistent risk posed by cross-border movements.

Measles outbreaks

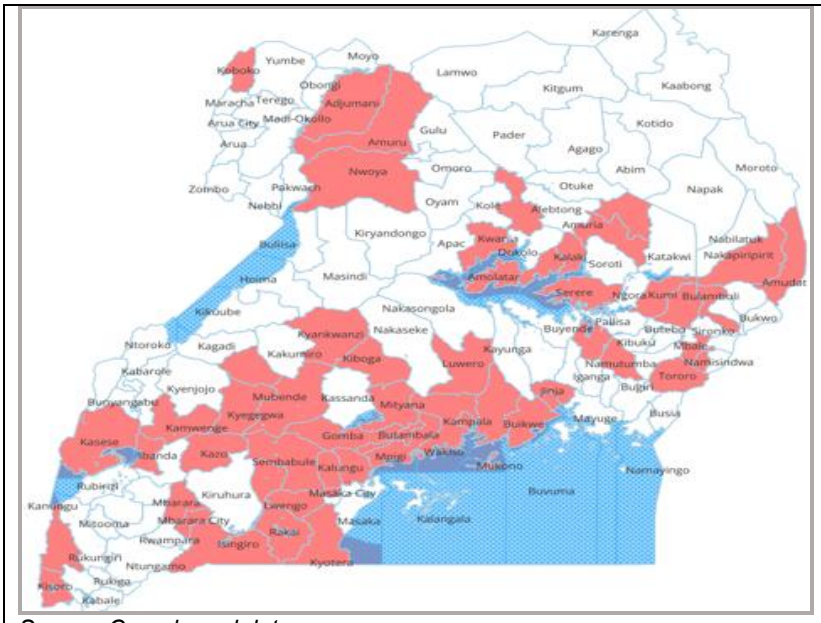
Uganda has over the past 2 years seen a resurgence of Measles outbreaks. By December 2024, 51 districts had reported measles outbreaks, with initial outbreak hotspots concentrated in border districts, largely due to an influx of refugees, before spreading to other regions across the country. As of August 2025, 58/146 (40%) districts had recorded at least 3 measles laboratory-confirmed cases. The last significant outbreak had been registered in 2018, whereupon a campaign was conducted in 2019 giving reprieve until 2024. During the introduction of MR2 in 2022, a campaign was conducted, but the lack of resources during the campaign period, made the efforts ineffective, and outbreaks were registered as early as January 2024. The campaign was done by districts using local resources without central level supervision, and this protracted over a 6 month period.

Figure 22: No. of Measles Outbreaks, 2021 – Aug 2025



Source: Case-based data

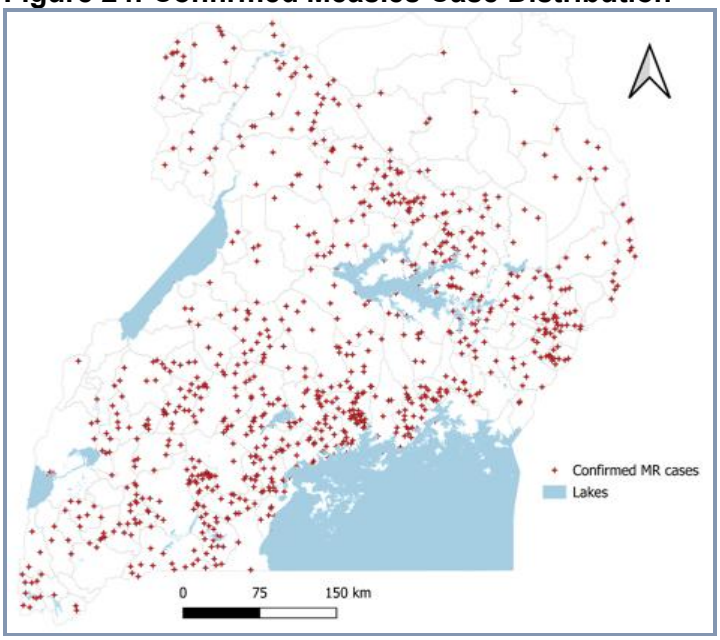
Figure 23: Distribution of Measles Outbreaks by District, Aug 2025



Source: Case-based data

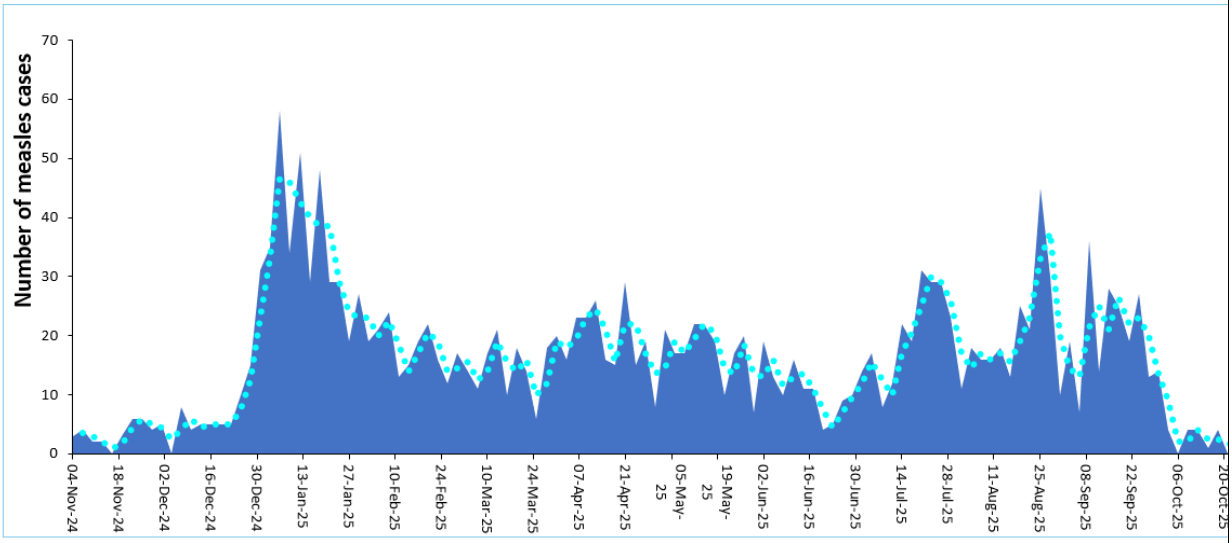
Inspite of the progressive improvement of the MR2 coverage since 2022(Fig.1), it still remains below the target of 95%. Thus, over the years, the accumulated numbers of vulnerable populations coupled with the high mobility in the region, many of whom come from fragile states with persistent measles outbreaks, has made fertile ground for outbreaks.
Outbreaks that started with border districts hosting mobile populations have gradually spread across the country (Fig.24)

Figure 24: Confirmed Measles Case Distribution



The country has put in place mitigation measures including targeted response in the districts, where to date over 50% have already responded using local resources. This has led to a significant decline in the cases, even as the country has started preparations for the comprehensive MR campaign in October 2026.

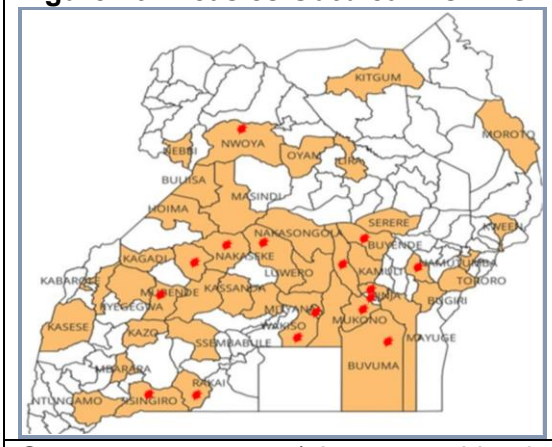
Figure 25: Measles Epicurve



To better understand the underlying drivers of the ongoing measles outbreaks, the country conducted outbreak investigations throughout 2024 and in 2025. Epidemiological investigations found that children <5 years were the most affected age group, with over 60% found unvaccinated. The following key findings highlight critical gaps and trends that continue to fuel measles transmission across affected districts.

i) Low population immunity due to suboptimal MR coverage, creating a fertile ground for the spread of measles outbreaks.
ii) A significant proportion of suspected measles cases (mostly unvaccinated) were imported from neighbouring high-burden countries, i.e., the DRC and South Sudan, entering Uganda through numerous porous border points.
iii) Continued influx of refugees from conflict-affected regions, who integrate into host communities with already weak herd immunity.
iv) Delays in the detection of measles outbreaks at health facilities due to a low index of suspicion and limited data use;
v) Socio-economic and cultural factors: Resistant communities, low community measles risk perception, immunization fatigue, community deliveries, and long distances to vaccination service points.
vi) Human resource challenges, including low staffing levels, technical and capacity gaps in leadership and management, and absenteeism amongst health workers.
vii) System challenges, such as underserved areas, inadequate follow-up mechanisms for MR2, inefficient use of primary healthcare funds for EPI, limited supervision, inadequate demand generation, poor data capture and reporting practices (mixing data), and limited data use for decision-making among health workers, suboptimal implementation of the urban immunization strategy.
viii) Logistics issues, such as limited last-mile distribution of vaccines, and inadequate EPI data collection tools.
ix) By August 2025, 16/58 districts with measles outbreaks are equity-challenged districts

Figure 26: Measles Outbreak vs ERG Districts



Country comments (please consider the set of cross-cutting questions to structure comments):

Overall, recent GAVI-supported vaccination campaigns in Uganda have been effective in rapidly responding to outbreaks, achieving high coverage in most settings, and protecting large populations, particularly for polio and YF. Where performance improved over time, this was strongly linked to learning-driven adaptations, strengthened microplanning, supervision, and partner-supported coordination mechanisms. However, persistent challenges, especially data quality, population denominators, financing flows, human resource constraints, and demand-related barriers, limited effectiveness in some campaigns, highlighting systemic vulnerabilities that also affect routine immunization.

Key lessons for routine immunization and future campaigns

- Leverage trusted local actors (VHTs, religious leaders, community leaders) for ongoing routine immunization promotion.
- Early engagement ensures comprehensive population coverage.
- Standardized training and messaging should be maintained across all levels to improve communication quality.
- Micro-planning and stakeholder involvement are critical for targeting hard-to-reach areas and optimizing resources.
- Adaptive, phased approaches allow programs to learn and correct course, which can strengthen both campaign and routine immunization strategies.
- Integration and leveraging related EPI activities have demonstrated synergy in ensuring response efforts are supported.
- Special strategies targeting cities and institutions.

Key risks that need mitigation

- Persistent low coverage among non-nationals and hard-to-reach communities may sustain immunity gaps and increase the risk of recurrent outbreaks.
- Misinformation, if messaging is not standardised or adequately disseminated, may potentially undermine community trust and reduce vaccine uptake.
- Delayed or insufficient stakeholder engagement (e.g., schools, workplaces, private providers) could limit access to eligible populations and reduce campaign reach.
- Cross-border transmission of VPDs, driven by porous borders and population movement, poses a continued threat to outbreak containment and elimination efforts.
- High population mobility in urban and peri-urban settings complicates microplanning, follow-up of missed children and accurate estimation of target populations.
- Persistent data quality and denominator inaccuracies may affect coverage estimates and misinform decision-making.
- Lessons from campaigns may not translate into routine immunization without deliberate integration strategies, risking short-term gains.

7. Learning Question: How have CDS funds been used to strengthen broader RI efforts?

Indicator(s):

- **Describe how CDS funds have supported routine immunization & other primary health care services.**

CDS funding was initially designated to support the COVID-19 response. However, with the evolving pandemic landscape, Uganda sought and obtained approval to reprogram these funds toward HSS activities being implemented since 2024 to date. The grant has played a pivotal role in strengthening RI and primary health care services by supporting service delivery, vaccine management, and social and behaviour change, while also leveraging strong partner collaboration.

1. Strengthening immunization service delivery

- Reaching ZD and UI children: In collaboration with partners, CDS funds supported targeted interventions, including microplanning in 107 underperforming districts, updating 71 district microplans; mentoring 415 health facilities and training 1,566 health workers, training 303 district health team members, 185 community leaders, and 642 VHTs. Townhall meetings, advocacy sessions, and CSO engagement further addressed ZD, UI, and HPV challenges.
- Urban immunization: Addressed gaps in urban districts (Kampala and Wakiso) through microplanning, training of 462 new health workers, development of improved 218 health facility microplans, and procurement of immunization mobile vans.
- Private sector engagement: CDS funds also supported technical assistance to private sector facilities to expand access.
- Child registration and outreach: Approximately 13,000 children <5 years were registered in 20 worst-performing districts, reducing ZD children. In addition, supported outreaches and the April 2024 ICHDs.
- Human resource surge support: UNEPI recruited surge support staff to bolster program TA.
- Capacity building for coordination: Training was extended to DCCTs and vLMD focal persons, continued support, supervision and integrated regional review meetings led by WHO.

2. Improving Effective Vaccine Management (EVM)

- Cold chain and logistics strengthening: CDS funds facilitated the procurement and commissioning of CCE, including refrigerated trucks, cold rooms, vaccine vial racks, RTMD equipment, and colour-coded waste bins (UNICEF). Obsolete and non-functional CCE were retrieved and destroyed, while COVID-19 waste was safely managed.
- Capacity building and technical support: 14 Vaccine Management Officers (VMOs) were deployed across 71 districts, mentoring 2,166 health workers and 540 district staff. Additional training on microplanning tools and EPI dashboards enhanced data-driven targeting of ZD and UI children.
- Data systems and quality assurance: CDS supported Data Quality Assessments (DQAs), the printing of data tools.
- Maintenance and supervision: Supported integrated supervision, retrieval and destruction of obsolete CCE, healthcare waste management assessments, and standardisation of vaccine management processes.

3. Advancing Social and Behaviour Change Communication (SBCC)

- Mass communication and community engagement: Through PATH, UNICEF, and WHO, CDS supported multi-media campaigns and printing of IEC materials, reaching over 7.7 million people. The funds also supported town hall meetings and advocacy with CSOs and community leaders to strengthen vaccine demand.

- Social listening and feedback mechanisms: Misinformation and rumours were actively monitored and addressed through social media, call centres, and community dialogues to build vaccine confidence.

Overall, RI performance improved across all antigens, particularly between 2024 and 2025, when 70% of scheduled vaccinations achieved coverage above 90% (Table 1). This progress is partly attributable to the support provided through the CDS grant.

B. Programme Management

Financial implementation of GAVI cash grants

Cash[12] Support Summary*

			Status as of September 2025						Compliance**	
Grant	Recipient	Period	Grant Value	Appr.	Disb.	Expenditure	Utilisatio	Cash Bal	Fin. Rep	Audit
HSS 2 NCE	MOH		3,334,043	3,334,043	3,334,043	3,318,527	100%	15,516	Yes	Yes
CDS-NBF	MOH	2021-2025	3,000,003	3,000,003	3,000,003	2,997,811	100%	2,192	Yes	Yes
ROTA SWITCH	MOH	2023-2024	552,317	552,317	552,317	545,311	99%	7,006	Yes	Yes
YF CAMPAIGN	MOH	2022-2025	12,768,376	12,768,376	12,768,376	11,457,159	90%	1,311,217	Yes	Yes
CDS 3-Third Window	MOH	2023-2025	6,708,624	6,708,624	6,708,624	5,668,700	84%	1,039,924	Yes	Yes
FPP(Health System Stren	MOH	2024-2028	19,050,862	19,050,862	4,220,838	3,228,815	76%	992,023	Yes	Yes
FPP(Equity Accelarator F	MOH	2024-2027	5,273,272	5,273,272	640,691	180,975	28%	459,716	Yes	Yes
HSS Performance Based	MOH	2019-2025	2,912,000	2,912,000	2,912,000	2,850,419	98%	61,581	Yes	Yes
Malaria Vaccine introduc	MOH	2025	981,133	981,133	981,133	570,003	58%	411,130	Yes	Yes
MPOX	MOH	2025	935,724	935,724	413,104	6,130	1%	406,974	Yes	Yes
Human Papillomavirus C	MOH	2025	592,092	592,092	592,092	-	0%	592,092	Yes	Yes
Hepapitis B	MOH	2025	1,874,174	1,874,174	1,874,174	-	0%	1,874,174	Yes	Yes
CDS 3-Third Window	UNICEF	2023-2025	4,765,952	4,765,952	4,412,919	2,088,212	47%	2,324,706	Yes	Yes
FPP(Health System Stren	UNICEF	2024-2028	15,495,085	15,495,085	13,660,419	132,672	1%	13,527,747	Yes	Yes
FPP(Equity Accelarator F	UNICEF	2024-2027	2,372,064	2,372,064	3,065,199	1,179,067	38%	1,886,132	Yes	Yes
Cold Chain Equipment O	UNICEF	2023-2025	5,818,776	5,818,776	5,818,776	5,818,776	100%	-	Yes	Yes
FPP-TCA	UNICEF	2024-2025	1,676,884	1,676,884	1,676,884	1,488,428	89%	188,456	Yes	Yes
YF CAMPAIGN	PATH	2022-2025	406,991	406,991	406,991	-	0%	406,991	Yes	Yes
CDS 3-Third Window	PATH	2023-2025	3,487,613	3,487,613	3,487,613	3,379,537	97%	108,076	Yes	Yes
FPP(Health System Stren	PATH	2024-2028	1,165,819	1,165,819	417,952	21,258	5%	396,694	Yes	Yes
FPP(Equity Accelarator F	PATH	2024-2027	3,760,286	3,760,286	992,197	527,621	53%	464,576	Yes	Yes
CDS 3-Third Window	WHO	2023-2025	1,327,274	1,327,274	1,240,443	981,343	79%	259,100	Yes	Yes
FPP(Health System Stren	WHO	2024-2028	248,641	248,641	739,381	483,388	65%	255,993	Yes	Yes
FPP(Equity Accelarator F	WHO	2024-2027			41,561	34,284	82%	7,277	Yes	Yes
Malaria Vaccine introduc	WHO	2025	80,441	80,441	80,441	-	0%	80,441	Yes	Yes
FPP-TCA	WHO	2024-2025	828,678	828,678	828,678	495,575	60%	333,103	Yes	Yes
CDS 3-Third Window	CHAI	2023-2025	457,052	457,052	347,272	347,272	100%	-	Yes	Yes
FPP(Health System Stren	CHAI	2024-2028	73,422	73,422	6,033	6,033	100%	-	Yes	Yes
FPP-TCA	CHAI	2024-2025	75,475	75,475	75,475	75,475	100%	-	Yes	Yes
				100,023,073	**75,295,629**	**47,882,791**	**64%**	**27,412,838**		

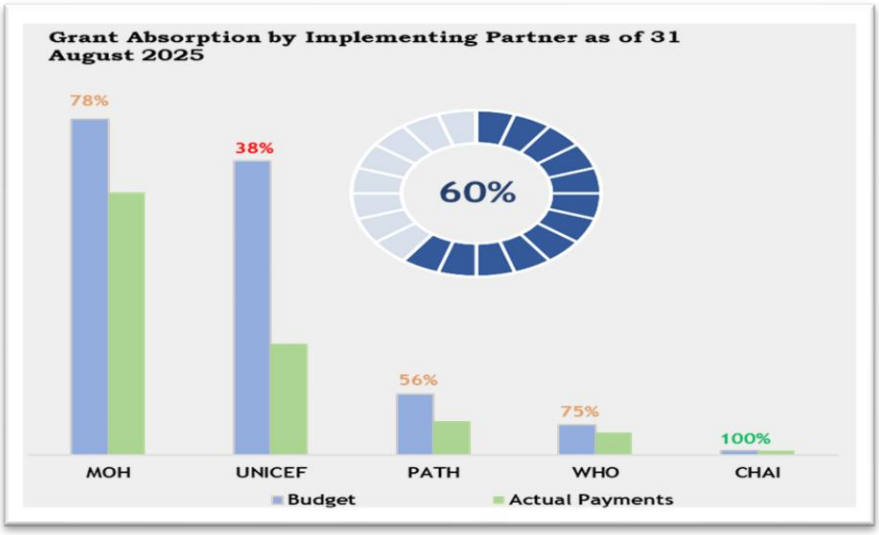
*All amounts are in USD
**Comment below in case of non-compliance

9. Learning Question: How well is the country able to absorb GAVI funding and what are the drivers? (This should cover all funding including funds channelled through partners.)

- **Comment on the financial implementation progress of grants, including but not limited to the utilisation rates. What are the key issues?**

Indicator(s):

- **Percentage of grant funds utilised**



- **Amount of cash balance in-country**

As of August 31, 2025, the country had a total balance of **US$27,443,453,** reflecting available resources to support ongoing immunization activities and related health system strengthening interventions.

Country comments:

Uganda has continued to demonstrate a strong capacity to absorb GAVI funding while adhering to the financial management requirements. As of 31 August 2025, the overall absorption rate across all active grants stood at 60% as shown in the table below. The relatively lower performance was largely attributable to timing and operational disruptions rather than systemic financial management weaknesses. Specifically, Year 1 Q1 implementation for FY 2024/25 was delayed because initial GAVI disbursements were only received in September 2024, pushing back planned program activities and reducing the time available for execution within the reporting period. In addition, activity implementation in January-March 2025 was significantly affected by concurrent Ebola, mpox, measles outbreaks, and the Malaria vaccine introduction. These events required immediate reallocation of attention and resources, temporarily slowing routine implementation and, consequently, absorption.

Table 13: GAVI Grants – Budget Vs Actual Analysis, August 2025

GAVI GRANTS TO MINISTRY OF HEALTH OVERALL BUDGET VS ACTUAL ANALYSIS Status as of 31st August 2025				
Grant	**Budget**	**Disbursed**	**Actual payment**	**Absorption**
YF Campaign	14,046,515	13,175,367	11,457,159	87%
CDS 3	17,596,415	16,303,775	12,932,231	79%
PBF	2,912,000	2,912,000	2,850,419	98%
HSS 3	36,033,829	19,052,209	3,892,107	20%
EAF	11,405,621	4,739,647	1,746,486	37%
Malaria VIG	1,061,575	1,061,575	570,003	54%
HPV	592,092	592,092	-	0%
HepB	1,874,174	1,874,174	-	0%
Mpox	935,724	935,724	41,617	4%
FPP-TCA	2,210,620	2,076,574	1,789,663	86%
CCEOP	5,818,776	5,818,776	5,818,776	100%
TOTAL OVERALL	**94,487,340**	**68,541,913**	**41,098,460**	60%

Despite these challenges, the programme continues to demonstrate strong stewardship and reliability in managing GAVI resources. Several key factors continue to drive its ability to sustain and scale up absorption as operational conditions stabilise.

- Structured planning and monitoring: The development of a costed, integrated work plan with clear timelines facilitated better planning, budgeting, and implementation of grant activities. Monthly monitoring and reporting to technical working groups (TWGs) supported timely follow-up actions.
- Effective fund utilisation: Funds are effectively absorbed where planning is clear, disbursements are timely, and supervision is structured. Activities such as ICHDs, campaigns, and targeted outreaches were implemented within budgeted timelines, demonstrating high absorption when funds reach District Local Governments (DLGs) and implementing partners with adequate support.
- Delegated procurement and supply chain management: Selected procurements (tools and supplies) and supply chain services, including decommissioning obsolete equipment, waste management, and last-mile delivery, were successfully delegated to the National Medical Stores (NMS). Total funds channelled through NMS in 2024/25 amounted to US$3,157,846.
- Capacity building and technical support: Surge staffing, data quality audits, and other capacity-building efforts strengthened the use of funds for broader routine immunization initiatives. Funds worth USD 28,634,197 channelled through UNICEF also demonstrated strong absorption in 2024/25.

However, several challenges continue to influence absorption performance and overall programme execution.

- Capacity gaps at the sub-national level: Understaffing and limited technical and managerial capacity at the district level affected efficiency in planning, budgeting, and execution of grant activities. Inadequate knowledge of evolving Public Financial Management (PFM) systems and poor record-keeping further constrained the utilization of funds.
- Low uptake of certain vaccines (e.g., MR2) highlights gaps in community-level engagement that require ongoing social and behavioral change interventions and consistent service delivery.
- Operational bottlenecks: Closure of financial management systems in July and August for the fiscal year limited timely disbursements, while delays in accountability from DLG delayed subsequent releases.
- Fund commingling complicated tracking, reporting, and accountability.

The program identified the following strategies for strengthening and accelerating grant absorption:

- Digitizing the Integrated EPI Workplan to enhance monitoring of fund utilization.
- Exploring innovative fund disbursement mechanisms to improve access for local governments.
- Engaging regional EPI partners to support non-compliant DLGs.
- Enhancing local-level technical and financial management capacity.
- Strengthening financial management capacities, e.g., better ICT infrastructure, targeted PFM/e-cash training, and robust records management.

Partner contributions

- UNICEF and National Medical Stores (NMS): Managed significant funding allocations, ensuring the timely implementation of RI activities.
- GAVI Secretariat: Provided overarching guidance and timely disbursement of grant funds.
- Technical and Civil Society Partners: Supported capacity building, social mobilisation, and accountability mechanisms at sub-national levels.

Overall, Uganda's capacity to absorb GAVI funding is closely tied to proactive planning, continuous monitoring, and addressing operational bottlenecks. By strengthening district-level capacity, improving accountability mechanisms, and leveraging digital tools, fund absorption and compliance are expected to improve further in the coming years.

10. Learning Question: How well is the country resolving issues arising from assurance activities? What issues are left to solve and what is the path forward?

➢ **What is the progress of Grant Management Requirements implementation?**

a) MoH/UNEPI has fully implemented the following GMRs:
- Program Oversight 1.1, 1.2, and 1.3
- Funding Mechanism 2.1 and 2.2
- Strengthening the capacity of UNEPI 3.4 and 3.5
- Budgeting and planning 4.2
- Management of cash advances 6.2 and 6.4
- Banking arrangements 7.1 and 7.2
- Non-vaccine procurement 8.1
- Internal Audit 10.3
- External Audit 11.1, 11.2 and 11.3

b) Status of ongoing GMR implementation:
- GMR 3.1 UNEPI in collaboration with World Health Organisation (WHO) contracted a consultant to conduct the HR assessment. MoH/UNEPI and Partners including FMTA and AP attended a validation meeting and shared feedback on the Draft Report. Finalisation of the HR assessment is anticipated by 30 September 2025.
- GMR 4.3: MoFPED representatives to assess and advise whether loading of the GAVI Budget had progressed on the IFMS system.
- GMR 5.1: MoFPED confirmed that IFMS will be able to generate all reports if the workplan is well mapped in the system. The 2025/2026 workplan was shared by MoH/UNEPI with the Commissioner Planning department MoH for review and onward submission to MoFPED for mapping into IFMS.
- GMR 5.2: MoFPED to finalise training of the MoH/UNEPI finance team on the Advances Module and assigning rights to users.
- GMR 6.3: All cash transfers to be made directly through IFMS at national level and Financial Management guidelines for every disbursement made available to

sub national level specifically directing the districts to use Ecash for payments to final beneficiaries.

- GMR 6.5: Presentation of the International Induction Programme (IIP) for medical professionals to the top management is to follow for approval.
- GMR 8.2: Bi-annual approval of the procurement plan mainly due to the numerous budget reprogramming.
- GMR 9.3: MoH/UNEPI to submit the asset register in the required format to the MoFPED contact person for upload. A physical asset verification was conducted in 2023. MoH/UNEPI continues to update the fixed asset register with GAVI assets/disposals.
- GMR 10.1: The Grants Coordinator to request the Internal Audit team to submit their Audit plan.

➢ How has the country addressed recommendations arising from past audit recommendations (annual external audits + GAVI Programme Audit)?

- The program has been able to address most of the recommendations from the previous year audits. For the Office of the Auditor General (OAG) external audit for FY 2023/24, of the 7 issues and recommendations provided, the program addressed 6 fully and one is partially implemented. This is the issue on inventory management that we are working to streamline with the DLGs and the rollout of the electronic logistics information management system.
- For the previous GAVI program audit, the report highlighted 69 issues; 34 have been fully implemented, 35 are partially implemented or not applicable.

➢ Comment on the improvements that have been made to financial management and risk assurance activities with the support of assurance providers (e.g., Fiscal Agents, Monitoring Agents, Financial Management Technical Assistance)?

a) Budget Review: There has been an improvement in quality of the budgets and applications submitted by the Ministry of Health/Uganda National Expanded Program on Immunization (MoH/UNEPI) in ensuring compliance with budgeting and implementation frameworks.
b) Financial Oversight & Risk Mitigation. The program continues to work with the Financial Management T.A and the AP to ensure financial and risk mitigation measures are implemented. Enhanced accuracy, reliability and compliance of financial reports has been progressively registered following these interventions.
c) MoH/UNEPI in 2024 and 2025 conducted Consolidated Finance Supervision Visits with the FMTA and AP at the sub-national level to DLGs to fast-track accountability of advances and to obtain expenditure support documents from DLGs for Central Payment Processing following the directive from the Immunization Coordination Committee (ICC) that payments should be processed centrally for DLGs with outstanding advances, effective April 2025 DLGs.
d) Based on the quarterly reviews and sample expenditure verification conducted by the AP team, the MoH/UNEPI financial internal controls and compliance with the Standard Operating Procedures has been enhanced.
e) MoH/UNEPI with support of the FMTA prepares activity-specific Financial Management guidelines and inducts representatives from the DLGs regarding grant utilisation to enhance implementation and the quality of accountabilities.
f) MoH/UNEPI has built capacity of the DLGs through Financial Management Guidelines and templates that are shared prior to implementation of the respective immunization activities and training of DLGs on their use, thus improving the quality of accountabilities received from the DLGs.

Audit Support and follow up

a) MoH/UNEPI, FM-TA and AP hold engagements with the Office of Auditor General (OAG) to enhance preparedness of the external audit and compliance with the GAVI Audit Requirements.
b) MoH/UNEPI has enhanced the preparedness of Audits by addressing gaps noted in previous audit reports.

Capacity building & skills transfer

a) The FM TA and AP team have held engagements with the MoH/UNEPI Finance Team in budgeting, financial reporting, audit readiness and GAVI guidelines for Budgeting, Financial Management, Reporting and Audit. This contributed to improved quality and timeliness of GAVI Budget submissions and increased compliance with GAVI financial guidelines.
b) During the 2024 and 2025 Consolidated Finance Supervision Visits at the sub-national level to DLGs to fast-track accountability of advances and to obtain expenditure support documents, feedback was shared by the review teams with the respective DLGs, which has enhanced the quality of expenditure support documentation and strengthened adherence to financial management and reporting guidelines at the sub-national level.

Country comments:

Uganda has made progress in strengthening assurance processes, with notable improvements in compliance, accountability, and audit preparedness. The system is increasingly demonstrating transparency, reliability, and alignment with GAVI's financial management requirements. However, sustaining these gains requires addressing persistent gaps at the sub-national level, reducing dependence on centralised processing, and institutionalising skills to ensure long-term capacity beyond partner support.

11. Learning Question: Please comment on any other financial management-related bottlenecks for implementation and compliance.

Country comments:

Uganda's financial management for immunization programs faces several challenges that can impede timely implementation and compliance with GAVI funding requirements. Key bottlenecks include:

1) Delayed approval of supplementary budgets for off-budget items, particularly during emergency responses, which slows down timely intervention. To address this, the Program prepares and shares in a timely manner Indicative Planning Figures (IPFs) with LGs to enable them to include GAVI funding within their annual budgets during the budgeting cycle. The Program is also working with MoFPED to get visibility on the inclusion of GAVI activities in the LG budgets.
2) Inadequate financial resources to support the collection of transaction documents from health facilities, data entry, photocopying and transfer of documents to the Ministry of Health. This will be addressed by encouraging accountability using soft copies rather than hard copies. The Program is procuring scanners for Local Government and data storage devices for MoH.
3) Unstable IFMS network, poor [GMM1] internet connectivity, and unreliable power supply, all of which hinder the timely processing and disbursement of funds. The Program will continue advocating for the strengthening of internet connectivity and power supply. [RM2] The Program will also work with the LGs to put in place contingency measures, such as the use of Generators. The Health Facility Solarisation Project, funded by the Africa CDC, is also addressing the problem of unreliable power.
4) Communication gaps regarding health interventions for which funds are disbursed. District Local Governments (DLGs) often report limited access to official emails, and in some cases, officers are too engaged with other priorities to delegate appropriately.[ES3] [RM4] The HSS has provision for publishing of disbursements the local press.The

Program is also using other mechanisms, such as support supervision to communicate information disbursements.

5) Incomplete and late submission of field reports by district implementers, which delays accountability and subsequent disbursements. This is being addressed through regular financial supervision visits to Local Governments.
6) Delays in accountability review and compilation by internal DLG teams.
7) Low staffing levels for finance staff and staff attrition at DLGs, which constrain both the implementation of health interventions and timely financial reporting. The Program will continue to provide capacity building through regular financial supervision.
8) Inadequate knowledge and skills among personnel due to the evolving Public Financial Management (PFM) landscape, with limited training opportunities for e-cash system users.
9) Delayed responses to accountability review comments issued by the Ministry, which prolong the closure of financial reports.
10) Poor filing and record management of accountability documents, complicating retrieval during audits and assurance processes. Commingling of funds and accountabilities between different supporting partners creates challenges in financial tracking, reconciliation, and reporting. The Program prepares financial management guidelines and orients Local Government staff through training and financial supervision.

12. Learning Question: Is the country effectively addressing immunization related barriers (e.g. faced by caregivers or adolescents in accessing immunization services and barriers faced by health workers in delivering immunization services)?

Indicator(s):

- **Did (when) the country conduct analysis on identified barriers faced by health workers, caregivers and adolescents (yes/no)**

Yes

(See attached summary of the learnings from the Uganda Learning Hub).

- **Has the country implemented initiatives to remove or reduce immunization-related barriers?**

Several initiatives have been implemented, either piloted by the Learning Hub or adopted by the Ministry of Health and partners:

i) House-to-house (HTH) registration and community-led tracking of ZD and UI children by VHTs, which was scaled into the 2024 Big Catch-Up.
ii) Outreach and campaign-based delivery to reach the underserved and hard-to-reach communities.
iii) Integration of ZD identification with service delivery, e.g., linking HTH findings to outreach microplans and aligning efforts with ICHDs.
iv) Community engagement and education through targeted communication, gender-sensitive approaches, and the involvement of trusted community actors (e.g., traditional birth attendants - TBAs, local leaders) to address myths, misconceptions/ cultural barriers.
v) District-led innovations to extend services to underserved areas despite limited funding.
vi) Adoption of geospatial mapping and targeted surveys to identify missed communities.
vii) Collaboration platforms between health facilities, VHTs, and local councils to reconcile outreach sites and strengthen accountability.

- **What new programming or reprogramming is required to improve impact?**

To improve sustainability and equity, Uganda will need to reprogram efforts from short-term campaigns toward long-term system strengthening, focusing on:

i) Institutionalising ZD identification and follow-up within routine systems by embedding HTH registration into district health plans, supported by community health extension workers (CHEWs), adequate supervision, and operational resources.
ii) Strengthening and standardising outreach services through dedicated community-based immunization teams, better logistics (transport, digital scheduling), and verified outreach site records integrated into DHIS2/eCHIS.
iii) Addressing caregiver and socio-cultural barriers via locally tailored communication, elimination of informal payments, structured male engagement, and gender-sensitive health worker training.
iv) Investing in health worker capacity (training on microplanning, provision of computers/software, supportive supervision, and reducing workload through adequate staffing).
v) Targeting missed populations (immigrant, transient, and remote communities) using mobile/pop-up clinics, multilingual education materials, and flexible budgeting that accounts for district-specific challenges.
vi) Embedding equity approaches in broader PHC and immunization strategies by integrating ZD interventions into ANC, postnatal care, and other health campaigns.
vii) Improving governance and accountability mechanisms with joint community–facility task forces, participatory microplanning, and routine feedback loops.

Country comments:

Overall, Uganda is actively addressing immunization-related barriers through initiatives such as HTH registration of ZD and UI children, outreach campaigns, community engagement, integration of ZD efforts into routine services, health worker capacity building, and targeted interventions for high-risk populations. However, structural, sociocultural, and health system barriers persist, and some interventions remain short-term rather than fully embedded. Sustained, integrated, and system-strengthening approaches are needed to fully overcome these barriers, particularly for hard-to-reach, transient and vulnerable populations.

13. Learning Question: How well is the country implementing its health information systems and data strengthening, monitoring and learning activities?

- What is the progress of planning and implementing health information system and data strengthening, monitoring and learning activities? Do these collectively constitute at least 10% of your HSIS/EAF grant budget?

Uganda has made substantial progress in planning and implementing a health information system (HIS) and data strengthening, monitoring, and learning activities. The country has established a functional and increasingly digitised HIS with the following key features:

1. **Data collection, quality, and use:**
   - Standardised tools such as Child Health Registers, Tally Sheets, and Child Health Cards are used nationwide.
   - Standard operating procedures (SOPs), job aids, and indicator definitions that support proper data collection, processing, storage, retrieval, and dissemination.
   - Weekly and monthly reports are systematically submitted, validated, and entered into DHIS2 for use in program planning.
2. **Digitisation and digital health technologies:**
   - Digital solutions (DHIS2 dashboards, e-CHIS, e-Tracker, eMR, ODK, and soon eLMIS) support visualisation, analysis, and decision-making.
   - Well-designed digital health technologies enhance the timely availability of high-quality information, client identification, and continuity of services while protecting sensitive data.
   - User-centred designs aim to ensure responsive, resilient, and inclusive health systems.
3. **Monitoring, learning, and capacity-building activities:**

- Quarterly reflection meetings, annual program reviews, After-Action Reviews, and participatory workshops facilitate structured learning and adaptive management.
- Health workers and records personnel are trained on data reporting, storage, and utilisation, reinforcing evidence-based decision-making.

To ensure accurate, timely, and actionable immunization data, Uganda has established a structured system for capturing, reporting, and validating immunization information across all health system levels.

Process: Immunization data is captured through Child Health Registers and reported on a weekly and monthly basis through the weekly surveillance report (HMIS 033B) and the monthly HMIS report (HMIS 105), respectively. A Child Health Card is issued to every child vaccinated, and doses are tallied using the Child Tally Sheet. Standard Operating Procedures (SOPs) have been developed and shared with all districts and health facilities to guide proper documentation, data collection, reporting, and dissemination.
Reporting timelines: Weekly reports, which include vaccine-preventable diseases, are submitted by health workers through the mTrac system every Monday before midday. Monthly reports are submitted by health facilities for entry into DHIS2 by the 7th of the following month and should be captured in the DHIS system by the 15th of the same month.
Data quality and validation: Following data entry, five days of data cleaning and validation ensures accuracy and completeness. Additionally, case-based surveillance is reported through the eIDSR system to support timely investigation.

EPI validation rules and dashboards were developed by the Ministry of Health – Division of Health Information in consultation with UNEPI and integrated into the DHIS2 in order to ensure data consistency, accuracy and data utilisation at all levels to aid efficient decision making.

Structured learning mechanisms such as quarterly reflection meetings, annual program reviews of performance data, After-Action Reviews (AARs) following major UNEPI activities, and participatory mechanisms like ongoing knowledge-sharing sessions, dialogues and stakeholder workshops after research and evaluation activities ensure continuous monitoring, adaptive management, and the use of data to guide program improvement.

The country has facilitated data management processes through several coordinated actions:

- Printing and distribution of registers and report forms systematically to ensure accurate and consistent data collection.
- Comprehensive training for relevant staff on performance indicators, including their definitions and significance, to strengthen understanding and correct application.
- Targeted training for healthcare workers and health facility records personnel on effective data reporting, storage, and management practices.
- Development of clear and concise instructions for data collectors outlining the steps and responsibilities involved in the data management process.
- Generation of comprehensive written guidelines, job aids, and standard operating procedures (SOPs) for health facility staff that define indicator specifications, reporting requirements, deadlines, and data flow plans.
- Establishment of a robust monitoring system to track the inventory of data collection tools, registers, and monthly reports at supported sites, ensuring continuity in data collection and preventing stockouts.
- Development of DHIS2 dashboards presenting maps, charts, reports, and tables to support data visualisation and promote effective data use for decision-making.

Collectively, these activities, covering data collection, digitisation, quality assurance, capacity building, and structured learning, represent a significant investment under the HSIS/EAF grant and constitute 12% the FPP budget, reflecting the country's commitment to strengthening HIS and using data to improve immunization program performance.

- How will the country address remaining data-related gaps or barriers to immunization programme performance?

To address persistent data-related challenges that affect planning and decision-making for immunization service delivery, the program is prioritising innovative and complementary approaches to strengthen data quality, accuracy, and use. These approaches focus on improving population estimates, enhancing real-time reporting, and integrating digital and NIRA Birth Registration systems to close information gaps and better track ZD and UI children.

1. **Strengthening population estimates and coverage data:**
    - Implement house-to-house (HTH) registration at the community level to identify ZD and UI children.
    - Use geospatial mapping and geo-enabled digital technologies to better estimate target populations and identify missed communities.
    - Apply mathematical modelling, such as BCG-delivered WUENIC estimates, to improve denominator accuracy and coverage planning.
    - Conduct data triangulation across multiple sources (facility data, survey findings, birth registration, and digital platforms) to validate estimates and improve reliability for decision-making.
2. **Integration with national registration systems:**
    - Collaborate with NIRA mobile vital registration systems (VRS) to capture real-time birth data, ensuring timely tracking of newborns for immunization.
3. **Digital solutions and interoperability**:
    - Expand and integrate DHIS2 - eHMIS, DHIS2 e-Tracker, eIDSR, e-CHIS, eMR (eAfya & Clinic Master), ODK, and the soon-to-be-deployed eLMIS to streamline data capture, reduce duplication, and provide timely, actionable information.
    - Ensure digital platforms are user-centred, resilient, and responsive to the needs of health workers and communities.
4. **Data quality assurance and capacity building:**
    - Continue training health workers and records personnel on data reporting, documentation, storage, and use.
    - Maintain structured data cleaning, validation, and triangulation processes to improve accuracy and completeness.
    - Monitor the inventory of registers, reporting forms, and other data collection tools to prevent stockouts and gaps in reporting.
5. **Enhanced data utilisation for decision-making:**
    - Strengthen dashboards, feedback mechanisms, and regular review meetings to ensure data informs planning, outreach microplans, resource allocation, and course correction.
    - Promote evidence-based decision-making at facility, district, and national levels to improve immunization program performance and reach underserved populations.

- Comment on key results or findings for identified learning priorities based on the country's application. Specifically, what actions have been taken to improve immunization programme performance based on these data? e.g. better understand specific barriers to immunization, successfully guide implementation, inform course correction for grant activities

Key results and findings from the identified learning priorities have directly informed actions to strengthen immunization program performance in Uganda[13]. Data-driven approaches have helped the country to understand barriers to immunization, guide implementation better, and enable timely course correction:

1. **Understanding barriers to immunization**
   - Data from DHIS2 dashboards, surveys, and surveillance systems have highlighted gaps such as inequities in access, low uptake in urban settings, and reporting challenges.
   - Participatory mechanisms, including quarterly reflection meetings, after-action reviews (AARs), and annual program reviews, have provided platforms for stakeholders to analyse these barriers and co-create solutions.
2. **Guiding implementation and improving coverage**
   - Data validation and triangulation have been used to refine microplans and strengthen targeting of ZD and UI children.
   - Real-time reporting through mTrac and eIDSR has improved detection and response to vaccine-preventable diseases, ensuring service continuity.
   - Evidence has informed demand-generation strategies, including social mobilisation and community dialogues, tailored to address knowledge and awareness gaps.
3. **Informing course correction for grant activities**
   - Analysis of performance data has led to adjustments in training content for health workers, emphasising data use, reporting accuracy, and documentation.
   - Systematic monitoring of data collection tools and registers has reduced stockouts, ensuring uninterrupted data flow.
   - Digital innovations such as DHIS2 e-Tracker, e-CHIS, and electronic medical records have been scaled up to strengthen data quality, availability, and use.

Through these actions, Uganda has demonstrated progress in translating learning into tangible improvements in immunization program performance, with continuous feedback loops ensuring that grant-supported activities remain responsive and adaptive.

Please share any documentation of learning results if available (e.g. reports, evaluations, assessments, etc).

Country comments:

Uganda has made progress in implementing its health information systems and data strengthening, monitoring, and learning activities. The program benefits from a well-established system for routine data collection, reporting, and validation through tools such as DHIS2, mTrac, and eIDSR, supported by clear SOPs and comprehensive training of health workers. Investments in dashboards, reflection meetings, after-action reviews, and program performance reviews have enhanced the use of data for decision-making and adaptive programming.

At the same time, challenges remain, including incomplete real-time reporting, occasional tool stockouts, and limited data utilisation at subnational levels. To address these, the program is scaling up digital health solutions (e.g., DHIS2 e-Tracker, e-CHIS, eLMIS), strengthening data triangulation and population estimates, and integrating NIRA birth registration systems to improve the accuracy and timeliness of immunization data. Overall, the country is implementing HIS and related data strengthening activities effectively, with learning and course corrections actively guiding improvements in immunization program performance.

C. Implementation of Technical Country Assistance (PEF-TCA)

14. Learning Question: Is the country implementing PEF TCA and CDS TA as expected? Please explain how the TCA has helped to support the achievement of the country's objectives.

Indicator(s):

- Country analysis on partner performance as per work plans

PEF TCA

Organisation	Complete	Minor Delays	On Track	Reprogrammed	Grand Total	Achievement

CHAI	3				3	100%
PATH	2		2	3	7	29%
UNICEF		1	1		2	0%
WHO			1	1	2	0%
Grand Total	**5**	**1**	**4**	**4**	**14**	**36%**

CDS

Organisation	Complete	Major Delays	Minor Delays	On Track	Reprogrammed	Unreported	Grand Total	Achievement
CHAI	3				1		4	75%
PATH	3			4			7	43%
UNEPI	2		1	1			4	50%
UNICEF	7	1	4	2	1		15	47%
WHO	2					3	5	40%
Grand Total	**17**	**1**	**5**	**7**	**2**	**3**	**35**	**49%**

Source: UNEPI Joint Workplan, 2024/25

From the table above, partner progress in Year 1 was generally limited, with an overall CDS TA completion rate of around 49% (17 completed activities out of 35). All partners had had significant numbers of activities in progress, highlighting strong engagement but slower execution relative to planned targets. Several contextual factors, including short implementation windows, delays in concluding grant agreements, and protracted procurement processes, constrained timely execution. Competing program priorities, including Polio, Ebola, Mpox, measles reactive campaigns, Yellow Fever PMVC, and the malaria vaccine introduction, further stretched limited human resources, affecting partner capacity to deliver planned activities and contributing to MOVs. Specifically;

- PATH - had a short interval between grant signing (May–June 2025) and reporting deadlines, as most CDS activities under CSOs were scheduled for full rollout in October 2025, alongside ICHDs. Despite this, catch-up plans were established to mitigate anticipated delays.
- WHO - CDS3 implementation, which commenced in May 2025, was slowed primarily by competing priorities, particularly the malaria vaccine introduction, which demanded the same technical and human resource bandwidth required for CDS activities.

Overall, while partners demonstrated strong momentum and commitment, external constraints and operational bottlenecks significantly limited Year 1 execution, with the majority of activities still in progress rather than completed.

Country comments:

Overall, PEF-TCA and CDS TA contributed to the achievement of Uganda's EPI objectives by strengthening the core system enablers required to reduce ZD and UI children, improve and sustain routine immunization coverage towards the ≥95% national target, and address persistent inequities in urban, high-mobility, and refugee-hosting settings. Through targeted support across partners, health system levels and geographies[14]. The TA improved identification and reach of missed children, strengthened service delivery, and improved vaccine demand generation. These

efforts contributed to measurable improvements in high-burden settings, including reductions in the proportion of ZD children in worst-performing districts, improved tracer antigen coverage and low dropout rates in supported districts, and strengthened immunization service delivery in complex urban and refugee-hosting contexts such as Kampala, Wakiso, Lamwo, Kamwenge, and Ntungamo.

In addition, TCA enabled progress towards national EPI objectives by strengthening governance, accountability, and data-driven decision-making across the Program. Support to coordination platforms (ICC, TCC, technical working groups), effective vaccine management and last-mile delivery systems, social and behaviour change communication, and evidence-informed policy and advisory mechanisms (including NITAG, surveillance and AEFI committees) improved programme responsiveness, reduced operational bottlenecks, and enhanced the quality and equity of immunization services. Collectively, these gains underpin Uganda's capacity to sustain coverage improvements, reduce inequities, and protect immunization gains in an increasingly constrained fiscal environment, in line with Immunization Agenda 2030 and GAVI 5.0 priorities.

Section 2: Looking forward: Summary of key discussion points and follow-up actions

A high-level technical dialogue between the Ministry of Health, GAVI, and Alliance partners focused on reviewing the implementation progress of the HSS3, EAF, and CDS3 grants, assessing the performance of routine immunization and new vaccine introductions (NVIs), and reprioritising activities to optimise the use of available resources. The discussions were anchored within the context of a constrained global funding landscape and aimed at positioning Uganda strategically for the upcoming GAVI 6.0 phase (2026–2030) as summarised below.

1. Strategic Context and Transition to GAVI 6.0

The 2021–2025 JA period aligns with the GAVI 5.0 strategy, during which Uganda implemented multiple grants, including HSS3, EAF, and CDS3, with additional funding envelopes under the FPP and the upcoming Measles-Rubella Follow-Up Campaign (MRFUC) planned for October 2026. In September 2024, the country started HSS3 and EAF implementation, with EAF targeting 59 districts for ZD and UI, and 10% fund allocation to CSOs.

The next strategic period (2026–2030), aligning with the GAVI 6.0 strategy, will commence on 1st January 2026. This will introduce major shifts in programming and funding modalities due to a shortfall in the GAVI replenishment of approximately USD 3 billion that saw GAVI reduce the scope and ambition of its 6.0 strategy. Implications of changes in the 6.0 strategy include:

- Significant reductions in available resources, estimated at 40–50% against GAVI cuts.
- Future funding to be managed through a single, consolidated application to GAVI and a consolidated ceiling, encompassing all forms of cash support.
- Requirements for the transition/ replenishment will include;
  - ✓ Achieving a minimum of 70% absorption rate for all partners and timely financial reporting.
  - ✓ A "use it or lose it" funding policy, which will no longer permit no-cost extensions (NCEs) for unutilized funds.
- The GAVI 6.0 strategy thresholds will guide fund allocations.
- 10% of the funds will be allocated to CSOs, with a minimum amount to CCE, preventive and follow-up campaigns.
- Active grants (HSS3, EAF, CDS3 NCE up to June 2026) and ongoing NVIs will transition into this 6.0 framework. In other words, from January 2026, all expenditures will count against the 6.0 ceiling, underscoring the urgency for Uganda to accelerate current implementation and spending.

Uganda is still in the initial self-financing phase, contributing USD 0.20 per vaccine dose. With an expanding immunization portfolio currently at 14 antigens, including the malaria vaccine introduced in April 2025 and the Hepatitis B birth dose introduction, the country's co-financing obligations have grown significantly (rising to USD 8.9 million between 2020 and 2025). This increasing financial burden highlights the need for sustainable domestic funding to ensure programme continuity and stability.

In this regard, the MoH has engaged WHO to conduct a Vaccine Impact Assessment to demonstrate the impact of the immunization programme in Uganda and inform a sustainable financing investment case in the context of the transition agenda.

Key Priority Areas

- Expedite the Vaccine Impact Assessment to guide evidence-based advocacy for sustainable immunization financing.
- Sustain engagements with the Ministry of Finance, Planning and Economic Development (MoFPED) and the Parliament of Uganda to strengthen domestic resource mobilisation for the immunization program.

2. Performance of Routine Immunization and Vaccine Introductions

Uganda's immunization programme currently delivers 14 antigens in the routine schedule. The introduction of the malaria vaccine (RTS, S) in April 2025 marked a significant milestone, with coverage reaching 78%, 40%, and 23% for doses 1–3, respectively, by 31 August 2025. However, completion rates for multi-dose vaccines remain suboptimal, particularly in high-mobility urban settings.

Persistent measles outbreaks remain a major concern for the country, despite substantial investments in prevention and response. Between 2022 and 2025, approximately USD 11.5 million was allocated to MR activities. However, outbreaks have continued to occur in 2025, underscoring both the scale of the challenge and the burden placed on the programme and affected communities. A review of MR data revealed inconsistencies with reported coverage in the JRF exceeding 100%, while Plan of Action (POA) performance data showed lower figures, highlighting significant data quality issues.

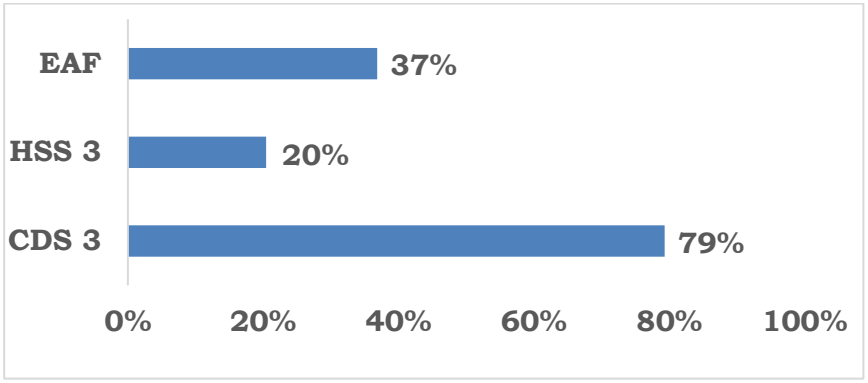
Key Priority Areas

- Intensify defaulter tracking and community-based mobilisation to improve completion of the malaria vaccine schedule.
- Strengthen the second year of life (2YL) platform to improve coverage of multiple-dose antigens.
- Ensure data accuracy for realistic microplanning and more precise targeting of high-risk districts for the 2026 MR Follow-Up Campaign (MRFUC).

3. Grant Performance Analysis (HSS3, EAF, CDS)

The Ministry of Health, through UNEPI, created a unified Annual Work Plan (AWP) for July 2025 to June 2026. This plan consolidates activities focused on enhancing health system capacity for more effective and sustainable immunization services (HSS3), identifying and reaching ZD and UI children (EAF), and promoting the integration and strengthening of routine immunization for lasting impact (CDS3). The MoH/UNEPI, in partnership with WHO, UNICEF, PATH, and CHAI, is responsible for implementation. However, Y1 progress varied across the three grants, as shown in the figure below.

Figure 27: Summary of Combined Absorption by Grant, Y1



Source: UNEPI Joint Workplan, 2024/25

While the program demonstrated strong momentum, particularly under CDS3, overall Year 1 execution was affected by operational and contextual constraints, including a short implementation window due to delayed grant agreements, protracted procurement processes, competing public health priorities (Polio, Ebola, Mpox, measles reactive campaigns, Yellow Fever PMVC, malaria vaccine introduction), and limited human resources. These factors contributed to missed opportunities for vaccination (MOVs) as routine immunization sessions and outreach activities were sometimes postponed, vaccine supply occasionally disrupted, and HWs stretched across multiple priorities.

It was also noted that some resource-intensive activities, by their nature, require long timelines and therefore cannot be completed within the stipulated reporting periods. For instance;

- Over 90% of the HSS3 allocation to UNICEF was dedicated to infrastructure investments, including the design and rollout of the eLMIS. While progress had been initiated, full implementation was expected to span several months, given the scale, complexity, and contracting requirements for system development.
- Procurement of vaccine cold boxes under the WHO's HSS3 allocation had been committed and expected to be completed by December 2025.
- Plans for evidence-generation activities such as the equity assessment (UNICEF) were in their final stages, with implementation anticipated shortly.
- The Lot Quality Assurance (LQA) survey by WHO, designed to follow EAF implementation, was rescheduled for 2026 to assess the quality and coverage of EAF activities.

These examples illustrate that, despite appearing slow in terms of completion, partners were actively advancing complex activities that require longer timelines.

Other challenges noted:

- Consistent use and updating of microplans: Although MoH, with support from WHO and PATH, conducted comprehensive microplanning sessions involving HWs and community actors to identify and reach ZD and UI children, the resulting microplans are not consistently used at facilities and districts and are not regularly updated.
- Incomplete integration of EPI with MNCH services: While EPI is delivered under MNCH platform at the health facility level, not all HWs within these units are adequately trained to provide EPI services, resulting in MOVs.
- Limited outcome-focused grant reporting: Grant reporting primarily focused on processes and outputs, with insufficient emphasis on outcomes and measurable results. This limited the program's ability to clearly demonstrate impact, monitor progress toward EPI objectives, and support timely, data-driven decision-making.

Across all grants, these challenges highlighted the need for enhanced technical leadership, better coordination, early communication, and standardised documentation and reporting across stakeholders.

Key Priority Areas

- Strengthen advocacy for the recruitment of more HWs to bridge the human resource gaps and workload challenges highlighted.
- Expedite available plans to train additional health workers in the Immunization in Practice (IIP) program to strengthen MNCH capacity and adequately leverage the integration platform to reduce MOVs.
- Strengthen the impact of RED/REC Microplanning to enhance coverage of ZD children and improve defaulter tracking by ensuring that the available microplans are:
  - Consistently used and regularly updated;
  - Incorporated into district sector plans to inform planning and resource allocation;
  - Linked to supervision and monitoring tools, such as HMIS 107 follow-up and accountability.
- The integrated child health days (ICHDs) platform continues to be an effective catch-up mechanism; thus, it should be leveraged for districts to catch up.
- Integration is an essential strategy for improving programme effectiveness. Therefore, MoH should create a unified "MoH Activity Plan" or "Health Calendar" that covers all MoH programmes, along with a tracking tool accessible to both DLGs and implementing partners. This will enhance visibility, accountability, and most importantly, promote programme integration.
- Implement a standardised results-based reporting framework aligned to national EPI objectives, with reporting tools that clearly capture the impact of supported activities, outcomes, and measurable results and learning to guide decision-making and strengthen accountability.

4. Supply Chain

i) Cold Chain Management

Substantial progress has been made in cold chain infrastructure, with new walk-in cold rooms and freezers installed and temperature mapping nearly complete. Key operational gaps, such as the absence of DCCTs in some (44) districts, the recent DCCT strike disrupting maintenance and reporting, and vaccine ordering accuracy, particularly in urban areas where high population mobility can create discrepancies between projections and actual needs, were highlighted.

ii) Effective Vaccine Management

Effective Vaccine Management (EVM) provides the global benchmark for immunization supply chains, offering tools to monitor and assess performance and guide continuous improvement. As part of global requirements, Uganda is expected to conduct an EVM assessment every five years and has so far completed six assessments (2001, 2004, 2007, 2011, 2014, and 2018).

The last full external assessment in 2018, followed by a self-assessment in 2020, identified persistent gaps in vaccine availability, stock management, and cold chain maintenance. Although the 2018 assessment showed overall improvement, meeting the minimum performance threshold of 80%, it highlighted a significant weakness in vaccine availability (48%), driven by challenges in ensuring timely and complete fulfilment of vaccine requests at all levels.

In September 2025, Uganda conducted its next EVM assessment across 72 sites, including one central vaccine store (PR), 23 district vaccine stores (LD), and 48 health facilities/service points (SP). Sites were selected using the EVM 2.0 tool criteria, with an 80% confidence level and ±10% precision, minimising selection bias. The assessment provided a comprehensive review of the supply chain, measured progress against previous recommendations, and identified areas requiring further strengthening. Performance was evaluated against iSC objectives, using availability, quality, and efficiency as indicators.

Preliminary findings, pending finalisation of the report, indicate that the national immunization supply chain demonstrates strong performance in quality and efficiency, with all indicators meeting or exceeding the 80% threshold. This reflects adherence to standards and good management practices, ensuring vaccines are stored and transported under appropriate cold chain conditions and delivered efficiently, with wastage rates within EVM limits. However, availability scores remained below the 80% benchmark across all levels: PR (41%), LD (52%), and SP (56%). This low performance is primarily due to the system's inability to ensure that all vaccine requests are fulfilled completely and on time at each supply level.

Figure 27: Summary of iSC Performance Indicators across the PR, LD and SP Levels

Overall, Uganda achieved an operational and managerial score of 87%, also the highest in the region, with PR at 95%, LD at 85%, and SP at 85% as shown in the table below. This performance demonstrates a well-managed and functionally effective immunization supply chain.

Table 14: National EVMA Result – All Levels

EVM		Infrastructure	Equipment	Information technology	Human resources	Policies & procedures	Financial resources			TOTAL
		C1	C2	C3	C4	C5	C6	OUTPUTS	ERFORMANC	
Vaccine arrivals	E1			92	100	59	100	100		88
Temperature management	E2			100	94	92		74	98	91
Storage and transportation	E3	98	91		99	100	100	91	100	94
Facility infrastructure and	E4	84	88	73			79	98		86
Maintenance and repair	E5			79	97	100	79	85	96	89
Stock management	E6			96	92	100		81	72	89
Distribution of vaccines and dry	E7		91	60	84	67	74	85	84	80
Vaccine management	E8				96	100		98		98
Waste management	E9		77		94	93	86	67	95	89
Annual needs forecasting	M1				97	100		99	27	88
Annual work planning	M2				95	100	80	93	17	90
Supportive supervision	M3	100	100	98	99	100	82	63		88
iSC performance monitoring	M4			100	90	97		55		74
TOTAL		85	89	92	94	92	78	80	87	87

Following this assessment, a continuous improvement plan (CIP) is being developed to address the identified gaps and sustain high performance across the vaccine supply chain. The resulting CIP will guide implementation of corrective actions and foster a cycle of continuous improvement, ensuring the supply chain remains responsive, adaptive, and aligned with evolving program needs and innovations.

Key Priority Areas
❖ Advocate for the urgent recruitment of vacant DCCT positions to ensure effective implementation of vaccine management activities. ❖ Institutionalise preventive maintenance within district work plans to ensure long-term equipment functionality. ❖ To address challenges in vaccine ordering accuracy, consider estimating vaccine requirements based on average monthly consumption as opposed to the current approach that combines population and consumption-based methods. It is believed that this process will be enhanced once the eLMIS system is fully operational. ❖ Prioritise critical activities from the EVM CIP activities in the reprioritised FPP guided by the 6.0 ceiling.

Data Systems and Quality

Data quality remains a cross-cutting concern with the transition from paper-based tools to digital platforms, creating temporary gaps and inconsistencies. There are concerns about partners withdrawing support for printing tools, yet digitisation is not yet complete, i.e., currently covering fewer than 100 of over 3,000 government-owned health facilities. The presence of multiple systems, including official and parallel digital platforms, further complicates data consolidation.

Key Priority Areas
❖ Expedite rollout of eLMIS to improve immunization data visibility and supply chain efficiency. ❖ Urgently harmonise reporting tools across programs by standardising reporting templates to improve consistency, comparability, and timeliness of programme data. ❖ Strengthen routine data use by enhancing capacity for data analysis and interpretation at the subnational level to support evidence-based decision-making and improve programme performance. ❖ Accelerate completion of the digitisation of immunization workflows to improve data accuracy, reporting timeliness, and overall programme efficiency.

Reprioritisation and Next Steps

In response to the strategic context and transition to the GAVI 6.0 strategy discussions, the country reviewed and reprioritised its activities across HSS3, EAF and CDS3 grants for the remaining implementation period (October 2025–December 2026)[15]. Key outcomes of this exercise are summarised in the table below. These adjustments aim to ensure that resources are directed toward high-impact, essential, and integrated interventions, particularly those addressing zero-dose, under-immunized, and equity gaps.

Thematic Pillar	Programme Mgt	Service Delivery	ACSM	MEL/Data	iSC
Total Number of Activities (HSS3/EAF/CDS3)	40	59	40	25	15
Number of High Priority Activities	18	22	15	12	5
Number of Activities for Integration	5	37	13	5	1

The program conducted further discussions and reflections on the major shifts in programming and funding modalities, new vaccine introductions into the EPI over the next 5 years (2025–2030). These deliberations took into account prevailing disease epidemiology, socio-economic conditions, and operational feasibility in the country.

Key programmatic priorities and planned activities for the next JAR period include:

Advocacy for increased domestic immunization financing: The program will use findings from the ongoing Vaccine Impact Assessment to develop a compelling evidence-based case for resource mobilisation and sustainable financing of Uganda's immunization program, taking into account the country's transitioning agenda.

In the meantime, the program has since shared its financing needs with the Office of the Auditor General to inform audit planning and parliamentary oversight, particularly around sustainability and transition risks affecting the country's immunization programme.

New Vaccine Introductions: Reflected on the two major vaccine shifts in the routine immunization schedule, i.e., introduction of the HepB BD and how to fully operationalise the HPV vaccine switch.

i) HepB BD: On 5 September 2025, the MoH officially introduced the Hepatitis B birth dose (HepB BD) into the routine immunization schedule. The initial rollout targeted the highest burden region - Northern Uganda, specifically Pader District, whose Hepatitis B prevalence is higher (approximately 9%) than the national prevalence (4.4%).
ii) HPV Vaccine Switch: Working towards fully operationalising the HPV vaccine switch from the two-dose to a single-dose schedule.

Considering the emerging strategic direction, the program prioritised an integrated national orientation for health workers across all health facilities on both the HPV vaccine switch and HepB BD introduction to promote efficiency of available resources and system readiness.

In addition, reflections on the NITAG recommendation and phased introduction sequencing (2025-2030) guided by the WHO Priority Vaccine List are ongoing[16]. The recommended scenarios will be reassessed following communication on the new GAVI ceilings.

Supplementary Immunization Activities: The Measles-Rubella Follow-Up Campaign (MRFUC) is scheduled for October 2026. The program hopes to complete the review of the plan of action (POA), identifying activities for integration within the approved reprioritisation guided by the GAVI 6.0 ceiling.

Capacity Building of District Health Leadership: The MoH, through the Department of Human Resources and Institutional Capacity Building, prioritised a Leadership and Governance training of DHOs and ADHOs to enhance their capacity in program oversight for immunization and other program activities.

Follow-up action	Timeline	Responsible person/partner
Conduct timely procurement and implement scheduled grant activities to ensure the 70% absorption threshold is met before the GAVI 6.0 transition.	Dec 2025	UNEPI, Partners
Monitor and follow up on CSO activity implementation to ensure timely completion of planned activities and the submission of reports for accountability.	Dec 2025	PATH
Finalise the 2025 EVM CIP to enable prioritisation of critical corrective actions in the larger FPP activity reprioritisation	Dec 2025	UNEPI, UNICEF

Identify activities in the 2026 MRFUC POA that can be integrated within the reprioritised HSS3, EAF and CDS activities to conduct preparatory planning.	Jan 2026	UNEPI, Partners
Finalise activity reprogramming and reprioritisation for the remaining implementation period upon receipt of GAVI ceilings.	Jan 2026	UNEPI, Partners
Fast-track completion of the Vaccine Impact Assessment and Vaccine Investment Case to be used as an advocacy tool for resource mobilisation.	Feb 2026	UNEPI, WHO, PATH
Finalise the BeSD study and develop tailored interventions as per recommendations.	Feb 2026	UNEPI, Partners
Expedite eLMIS design and rollout to strengthen immunization data visibility and supply chain efficiency.	Jun 2026	UNEPI, UNICEF
Conduct training of health workers in IIP to bridge the vaccinator gap at the community level.	Feb 2026	UNEPI
Conduct RED/REC microplanning trainings for the remaining 30 districts.	Mar 2026	UNEPI, WHO
Conduct Leadership and Governance training for all DHOs and ADHOs to strengthen district-level oversight for programme activities.	Ongoing	UNEPI, Partners
Conduct integrated orientation on the HPV vaccine switch and HepB BD introduction at all health facilities nationally.	Nov 2025	UNEPI, Partners
Incorporate immunization workflows in the existing MOH digital health systems (e-AFYA).	Feb 2026	DHI, UNEPI
Conduct focused support supervision to poorly performing districts to address identified gaps and improve coverage.	Q1, Q2, Q3, Q4 2026	UNEPI, Partners
Revise and standardise the reporting template, emphasising outcomes, measurable results and learnings to better capture the impact of supported activities.	Jan 2026	UNEPI, Partners
Finalise and disseminate the UNEPI workplan to be integrated into the larger MOH calendar for district planning.	Jan 2026	UNEPI

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18) EPI Reprioritised Activities by Pillar, 2025- Dec 2026
19) Measles Case Investigation Report 2025

ANNEXES

Table A1.1: Summary of Findings from the Malaria Vaccine Post-Introduction Evaluation (PIE)

THEMATIC AREA	BEST PRACTICES	CHALLENGES	RECOMMENDATIONS
PROGRAM MANAGEMENT	• Strong national-level coordination between UNEPI, NMED & partners • Use of data & global guidelines • Regular joint meetings • Multi-sectoral engagement at national & district levels	• Inadequate use of district microplans • Limited MoES/MGLSD involvement • Insufficient RRH engagement	• Institutionalise RED/REC microplans • Engage RRHs & private sector early
FINANCE	• Early gap analysis • Timely government co-financing • Strong partner mapping • Integration with RI • Centralized payments	• Inadequate facilitation for key stakeholders (e.g., parish leaders) • Delayed payments • Minimal accountability funding	• Fast-track UCREPP payments • Develop SOPs for finance feedback • Early engagement of districts with IPFs • Clear reallocation guidelines • Increase government PHC funding
SERVICE DELIVERY	• Adaptation of best practices from Kenya, Ghana, Malawi • Integrated technical support supervision • Integration of RI into malaria interventions (SMC, SBCC, iCCM, IRS) • Daily static sessions at high-volume sites • Outreaches in mobile & hesitant communities	• Provider knowledge gaps due to infrequent CMEs • Weak leadership in EPI clinics • Absence of AEFI kits • Inconsistent outreaches • Irregular static sessions in low-volume HFs • Long waiting times • Weak defaulter tracking • Misinterpretation of MVI activities as campaign	• Conduct refresher training (MV schedule, AEFI) • Strengthen supportive supervision • Reduce waiting times • Functionalize defaulter tracking • Integrate activities into PHC plans • Scale up outreaches in underserved areas
COLD CHAIN & LOGISTICS	• Adequate MV stock across all districts • No HF-level stockouts reported • DCCT mentorships during maintenance visits	• Absence of city vaccine stores • Inadequate cold chain storage in lower-level facilities	• On-job mentorship for HWs • Replace gas fridges with solar units in selected districts • Construct vaccine stores in new cities
ADVOCACY, COMMUNICATION & SOCIAL	• Use of RDC airtime • Early mobilization • Engagement of key stakeholders (religious,	• Few RCCE workplans • Poor male involvement	• Integrate MV ACSM into RCCE plans • Conduct regular community dialogues

MOBILIZATION (ACSM)	political, cultural leaders, paediatricians) • Rumor tracking & response	• Minimal school engagement • Myths & misinformation • Limited translated IEC materials	• Develop additional FAQs/leaflets • Targeted male-focused messaging • Refresher training for VHTs
MONITORING & EVALUATION	• Use of EPI dashboards • DQA conducted • Decentralized DHIS2 data entry	• Stock out of updated data tools • Data discrepancies • Limited data use at district/HF level • High MV1–MV3 dropout rates	•Supply additional data tools •Nationwide data validation •Monthly data quality audits •Improve computer literacy for HIAs.

Table A2.2: Mitigation Plan Following Results of PCCS

Service Delivery		
S/N	IDENTIFIED GAP	MITIGATION MEASURE
1	Low perceived risk for Yellow Fever	Early engagement of stakeholders to raise awareness about Yellow Fever disease and risks.
2	Vaccine fatigue	Conduct early community engagement on the benefits of vaccination and public health protection.
3	Unfavourable vaccination timing	Schedule campaign activities outside holy days and public holidays.
4	Training gaps – untrained staff; short training duration	Ensure presence of central supervisors in districts during training and implementation.
5	Human resource shortages	Mobilize health workers from private facilities and training institutions.
6	High target number per vaccination team	Reduce daily vaccination target per team from 320 to 240 in community settings.
Vaccines, Cold Chain and Logistics		
S/N	IDENTIFIED ISSUE	MITIGATION MEASURE
1	Lack of visibility of Yellow Fever vaccine balances	Institute vaccine accountability mechanisms to improve stock management.
2	Inadequate cotton supply	Procure adequate quantities of cotton wool.
3	Excess Yellow Fever vaccine vials in Phase II districts	Retrieve excess vaccines for redistribution and use in Phase III districts.
Data and Surveillance		
S/N	IDENTIFIED ISSUE	MITIGATION MEASURE
1	Demand for no-cost Yellow Fever vaccination booklets	Decentralize booklet distribution to regional level and standardize cost to UGX 10,000.
2	Data backlog (individual-level data)	Conduct early training and deployment of data entrants.
3	Underreporting of AEFIs	Strengthen utilisation of the eIDSR system for real-time reporting.
Finance and Management		
S/N	IDENTIFIED ISSUE	MITIGATION MEASURE
1	Delayed approval of campaign funds by the Accountant General	Engage the Accountant General's Office to expedite fund approvals.
2	Late release or missed e-cash payments in districts	Ensure early preparation and requisition of e-cash payments through the district local governments.
3	Unsubmitted accountabilities	Engage Phase III districts to clear all pending accountabilities.

4	Pending payments from previous campaigns	Clear all outstanding payments before the next campaign phase.
5	Under-budgeting for urban settings	Consider urban divisions as independent planning units in budgeting and microplanning.
Advocacy, Communication and Social Mobilisation (ACSM)		
S/N	IDENTIFIED ISSUE	MITIGATION MEASURE
1	Negative publicity from anti-vaccine groups/persons	Engage anti-vaccine influencers through evidence-based dialogue and community advocacy.
2	Resistance from anti-vaccination religious sects	Engage and orient religious leaders and cult representatives on vaccine safety and public health impact.
3	Inadequate community mobilisation	Conduct early and multi-channel community mobilisation activities.
4	Fear of side effects for Yellow Fever and other vaccines	Sensitise communities on vaccine safety, benefits, and potential side effects.
5	Vaccine fatigue	Reinforce communication on continued vaccination benefits and community protection.
6	Limited engagement of private schools	Involve MoES and teachers early in planning and mobilisation.
7	Misguided elites/youth	Use multiple media channels and engage MoH leadership for high-level advocacy targeting youth and elite groups.
8	Low awareness in urban settings	Engage urban leaders early and implement targeted awareness campaigns.
9	Late or poor-quality mobilisation	Initiate early, high-quality mobilisation using multiple communication platforms.