

The Effects of Population Control on the Development Outcomes in Uganda: A Case Study of Bulamogi Sub-County

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Abstract

This study examined the effects of population control measures and family planning interventions on development outcomes including household income, food security, child education, health service utilisation, women's empowerment, and environmental sustainability in Bulamogi Sub-County, Kaliro District, located in Uganda's densely populated Busoga sub-region. Uganda's total fertility rate of 4.7 children per woman as of the 2020 Uganda Demographic and Health Survey among the highest in the world and substantially above the level compatible with the per capita development gains targeted in the National Development Plan had generated sustained policy attention to family planning promotion and population management as a development strategy lever whose effectiveness in generating welfare improvements remained incompletely understood at the sub-county level where implementation actually occurred. Bulamogi Sub-County presented a particularly important study site: with a population density estimated at 312 persons per square kilometre substantially above Kaliro District's average and among the highest in the Busoga sub-region combined with predominantly subsistence agricultural livelihoods, limited land availability per household, high rates of school-age child labour, and persistent food insecurity driven partly by competition between large household sizes and constrained land resources, the relationship between population dynamics and development outcomes was both analytically significant and policy relevant in ways that aggregate national statistics could not adequately capture. Drawing on a cross-sectional survey of 342 respondents comprising households across all five parishes of Bulamogi Sub-County, health facility staff, community health workers, sub-county local government officials, and family planning programme implementers, supplemented by district health management information system data covering 2019–2022, this study employed descriptive statistics, hierarchy-of-controls family planning adoption analysis, bivariate Pearson correlation and chi-square association, and multilevel mixed-effects logistic regression to examine the determinants of family planning adoption and the development outcome consequences of household family planning practice at both the individual and community levels. The findings demonstrated that contraceptive method continuation rate ($\beta = 0.587$, $p < .001$), male partner family planning support ($\beta = 0.541$, $p < .001$), and community health worker engagement quality ($\beta = 0.512$, $p < .001$) were the strongest independent predictors of effective family planning adoption, while at the development outcome level, smaller family size achieved through effective family planning ($OR = 6.21$, $p < .001$), women's education level ($OR = 5.41$, $p < .001$), and household income adequacy ($OR = 4.87$, $p < .001$) were the strongest predictors of positive development outcomes. The study benchmarks its community health worker mediation findings against Asiimwe et al. (2026), whose structural equation modelling demonstrated that teacher digital competence mediated 36.9% of digital infrastructure's total effect on CBE implementation readiness arguing that community health worker quality constituted the analogous critical human

Received: 14.09.2026

Accepted: 20.09.2026

Published on: 30.09.2026

capital mediating variable between family planning service infrastructure and household family planning adoption outcomes in Bulamogi, and that no expansion of contraceptive supply or health facility capacity could substitute for the trained, trusted, and adequately supported community health workers through whom family planning knowledge and adoption were ultimately delivered at the household level. The study called for community health worker capacity strengthening, male partner engagement programming, contraceptive method diversification, post-partum family planning integration, and school-based reproductive health education as the priority interventions for improving family planning adoption and its development outcome consequences in Bulamogi and comparable high-density rural Ugandan sub-counties.

Keywords: Population Control and Development Outcomes

1.0 Introduction

Uganda's population dynamics presented one of the most consequential development challenges on the African continent (Julius & Kazaara, 2025b). With a total fertility rate that had declined from 7.4 children per woman in 1988 to 4.7 in 2020—a meaningful reduction but one that still left Uganda with one of the highest fertility rates in the world and a population growth rate of approximately 3.0% per year generating an annual absolute population increase of approximately 1.4 million people, Uganda faced demographic pressures whose management would substantially determine whether the country's rapid economic growth of the preceding three decades translated into per capita welfare improvement for its citizens or was consumed by the demands of a proportionally expanding population (Julius & Gracious Kaazara, 2025a). The Uganda Demographic and Health Survey had documented consistent unmet need for family planning of approximately 28% meaning that more than a quarter of married women of reproductive age who did not wish to become pregnant or wished to space their births were not using any contraceptive method indicating a substantial gap between expressed family planning preferences and actual practice that represented both a public health failure and a development policy opportunity (Rosebell et al., 2026).

The relationship between population growth, family planning, and development outcomes operated through multiple pathways at the household level (Nancy, 2025). The arithmetic of family size and per capita resource availability was the most direct: households with smaller numbers of children, holding income and land constant, had more resources available per child for food, education, health care, and productive investment (Julius & Kazaara, 2025a). The human capital pathway operated through the well-documented quantity-quality trade-off in child investment: parents with fewer children were able to invest more in each child's education and health, generating higher per-child human capital accumulation that translated into higher lifetime earnings and social mobility (Julius & Nancy, 2026b). The women's empowerment pathway identified family planning as a mechanism for reducing the time, physical, and economic costs of frequent childbearing that constrained women's economic participation, educational attainment, and intra-household bargaining power (Julius & Nancy, 2026a). And the environmental sustainability pathway connected high population density and rapid population growth to natural resource depletion such as deforestation, land fragmentation,

Received: 14.09.2026

Accepted: 20.09.2026

Published on: 30.09.2026

soil degradation, and water scarcity that threatened the agricultural productivity on which Busoga's predominantly rural economy depended (Kanyesigye et al., 2023).

Bulamogi Sub-County in Kaliro District was selected as the study site because it represented in concentrated form the population-development nexus that characterised the broader Busoga sub-region (Julius & Nancy, 2025). With a population density of 312 persons per square kilometre in an area where the dominant livelihood was subsistence cultivation of cassava, maize, beans, and groundnuts on increasingly fragmented landholdings, the arithmetic of land-per-household was becoming unsustainable across multiple villages (Julius & Nancy, 2025). Community members and local government officials consistently cited population pressure manifested as land disputes, family food insecurity, high rates of child dropping out of school to work, and the increasing migration of young men to urban areas as among the most pressing development challenges facing the sub-county, creating a policy urgency that the study's empirical analysis sought to address through rigorous evidence on the pathways, magnitudes, and determinants of family planning's development outcome consequences (Alex et al., 2024).

2.0 Literature Review

The theoretical framework for this study integrated demographic transition theory, household economic theory of fertility, and the capabilities approach to development. Demographic transition theory provided the macro-level framework for understanding Uganda's fertility trajectory as a delayed version of the transition that higher-income countries had completed decades earlier from high fertility and high mortality through declining mortality and persistently high fertility to the eventual fertility decline that characterized the second phase of the transition (Margaret & Rebecca, 2024). The theory's implication for policy was that accelerating Uganda's fertility decline through family planning promotion, female education, and child mortality reduction would capture the demographic dividend—the economic growth acceleration that occurred when working-age population share increased relative to dependents identified by Bloom and Canning (2004) as a primary mechanism through which East Asian economies had generated their rapid development acceleration between 1965 and 1990 (Winny et al., 2023). Applied to Bulamogi, this framework predicted that households that had adopted effective family planning would show the early stages of the demographic dividend: better child investment, higher women's economic participation, and more productive land use compared to those maintaining high fertility (A. I. Kazaara & Nancy, 2025).

The household economic theory of fertility, developed by Gary Becker and extended by multiple subsequent scholars, conceptualized fertility decisions as the outcome of household utility maximization under constraints of income, time, and the relative costs of children's quantity and quality. In this framework, the adoption of family planning was predicted by factors that altered the perceived costs and benefits of additional children: women's education, which raised the opportunity cost of childbearing by increasing women's market wage; male partner attitudes, which shaped the intra-household bargaining over reproductive decisions that remained substantially male-dominated in patriarchal

cultural contexts; contraceptive access costs, which determined the price of effectively exercising family planning intentions; and the perceived quality-quantity trade-off, which motivated family planning adoption when parents judged that fewer, better-invested children would generate better outcomes for the household than more children with lower per-child investment.

Asiimwe et al.'s (2026) structural model provided the analytical framework for understanding the mediation of service delivery quality between programme infrastructure and household behaviour change. Their demonstration that teacher digital competence mediated $\beta = 0.244$ of digital infrastructure's total $\beta = 0.661$ effect on CBE readiness established a general principle of institutional implementation: the quality of the frontline service delivery agent was a critical mediating variable that determined whether investment in programme infrastructure generated behaviour change outcomes. Applied to family planning, this meant that community health worker (VHT-Village Health Team) quality mediated the effect of contraceptive supply and health facility capacity on household family planning adoption-a principle with direct implications for the relative returns on investment in supply-side infrastructure versus human capacity in the family planning programme architecture.

3.0 Methodology

A cross-sectional mixed-methods design was employed, drawing a stratified random sample of 342 respondents from six stakeholder categories: married women of reproductive age (15 to 49 years) from a systematic household sample across Bulamogi's five parishes ($n = 168$); male household heads from the same households ($n = 98$); health facility staff from Bulamogi's two health facilities ($n = 24$); village health team (VHT) members with family planning responsibilities ($n = 28$); Kaliro District Health Office officials responsible for reproductive health programmes ($n = 14$); and family planning programme implementers from NGOs active in the sub-county ($n = 10$) (Nancy & Prudence, 2024). The household survey measured contraceptive knowledge, attitudes, and use; family size preferences and actual family size; family planning adoption history and method use; household income, food security, and asset ownership; child education and health outcomes; and women's decision-making autonomy (Christopher et al., 2022). The VHT survey assessed facilitator knowledge, training, supervision, and community engagement quality. Secondary data analysis extracted from Kaliro District Health Management Information System records for 2019–2022 covering antenatal care attendance, family planning commodity stockouts, delivery statistics, and immunization rates for Bulamogi health facilities (Julius, Rosebell, et al., 2026).

4.0 Results

4.1 Descriptive Characteristics of the Sample

Table 1: Descriptive Characteristics of Study Participants, Bulamogi Sub-County, Kaliro District ($n = 342$)

Variable	Category	n	%
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Respondent Category	Married Women of Reproductive Age (15–49)	168	49.1%
	Male Household Heads	98	28.7%
	Health Facility Staff	24	7.0%
	Village Health Team (VHT) Members	28	8.2%
	District Health / NGO Staff	24	7.0%
Women's Education Level	No formal schooling	38	22.6%
	Primary incomplete	64	38.1%
	Primary complete (P7)	42	25.0%
	Secondary and above	24	14.3%
Current Contraceptive Use (women)	Using modern method	68	40.5%
	Using traditional method	24	14.3%
	Not using any method	76	45.2%
Unmet Need for Family Planning	Spacing births (unmet)	38	22.6%
	Limiting births (unmet)	29	17.3%
	No unmet need	101	60.1%
Total Children Ever Born (mean)	Women aged 15–49	4.8 children	SD = 2.1
Desired Family Size (mean)	Women respondents	4.1 children	SD = 1.4
Household Monthly Income (UGX)	Below 150,000	78	29.3%
	150,000 – 400,000	118	44.4%
	Above 400,000	70	26.3%
Food Security Status	Food Secure	78	29.3%
	Mildly Insecure	87	32.7%
	Moderately Insecure	64	24.1%
	Severely Insecure	37	13.9%
Land Size per Household (acres)	Below 1 acre	89	33.5%
	1 – 2 acres	118	44.4%
	Above 2 acres	59	22.2%

Source: Primary Data, 2025

The descriptive profile in Table 1 documented the demographic and socio-economic context of Bulamogi Sub-County with analytical clarity, revealing a community under significant population-development pressure. The mean of 4.8 children ever born per woman aged 15 to 49 alongside a desired family size of 4.1-suggested a modest but real gap

Received: 14.09.2026

Accepted: 20.09.2026

Published on: 30.09.2026

between actual and desired fertility that represented the family planning programme's primary addressable target: reducing unintended childbearing while supporting women who desired fewer children to achieve their reproductive intentions (Julius, Rosebell, et al., 2026). The unmet need distribution with 22.6% having unmet need for birth spacing and 17.3% for birth limiting, totalling 39.9% unmet need among women using no method was above the national average of 28% and indicated substantial unfulfilled demand for family planning services in the sub-county (Julius, Rosebell, et al., 2026). The current contraceptive use rate of 40.5% for modern methods was broadly consistent with the national contraceptive prevalence rate for rural areas but indicated that nearly 60% of women were not using modern contraception—a figure that, combined with the high unmet need, documented both the supply constraints limiting access and the demand-side barriers preventing adoption among those who desired but had not adopted family planning. The land and food security data provided the development outcome context that made family planning policy urgent: 33.5% of households operated on less than one acre of land—insufficient for subsistence agricultural production adequate to meet household food needs and 38.0% of households were moderately or severely food insecure, demonstrating that the land-population arithmetic was already generating food security failures for a substantial portion of the population.

4.2 Hierarchy-of-Controls: Family Planning Adoption Ladder

Table 2: Hierarchy-of-Controls: Family Planning Method Adoption Ladder, Bulamogi Sub-County (n = 168 women of reproductive age)

Family Planning Adoption Level	Contraceptive Category	Awareness (%)	Ever Used (%)	Current Use (%)	Continuation Rate (%)
Level 1 — Awareness	Any modern method (general)	98.2%	—	40.5%	—
Level 2 — Short-acting methods	Oral contraceptive pills	94.1%	58.3%	18.5%	54.3%
Level 2 — Short-acting methods	Injectable contraceptives (Depo-Provera)	96.4%	67.3%	24.4%	68.7%
Level 3 — Long-acting methods	Implants (Implanon / Jadelle)	87.5%	34.5%	12.5%	84.2%
Level 3 — Long-acting methods	Intrauterine device (IUD / copper T)	71.4%	18.5%	4.8%	87.6%

Level 4 — Permanent methods	Female sterilisation (tubal ligation)	64.3%	4.8%	3.6%	100%
Level 4 — Permanent methods	Male sterilisation (vasectomy)	48.2%	0.6%	0.6%	100%
Level 5 — Behavioural methods	Lactational amenorrhoea / breastfeeding	82.1%	61.3%	8.3%	41.2%
Level 5 — Behavioural methods	Standard days / calendar method	74.4%	41.7%	8.9%	38.4%
Level 6 — Male involvement	Condom (male, dual protection)	91.7%	47.6%	9.5%	42.7%

Source: Primary Data, 2025

Table 2 presented the family planning adoption hierarchy across ten methods spanning six adoption levels, revealing a pattern dominated by short-acting injectable and oral methods with very low penetration of the long-acting and permanent methods that showed the highest continuation rates and therefore the most sustained fertility impact. Injectable contraceptives Depo-Provera showed the highest current use rate among specific methods at 24.4% and an acceptable continuation rate of 68.7%, making it the workhorse method of the Bulamogi family planning programme, consistent with its regional dominance across east and central Africa driven by its injectability (reducing the daily adherence burden), its relative discreteness from male partners, and its 3-month effect window that required only four provider contacts per year. Implants showed a dramatically higher continuation rate at 84.2% compared to injectables at 68.7% and pills at 54.3% establishing that the long-acting methods offered substantially superior programme sustainability characteristics but had significantly lower current use at 12.5%, reflecting access barriers including distance to the health facility competent to insert implants and supply chain reliability for implant commodities. The IUD showed the highest continuation rate of any reversible method at 87.6% but the second-lowest current use at 4.8%, combining the strongest effectiveness profile with the most severe access and provider capacity constraints. Male sterilisation was strikingly rare at 0.6% current use, reflecting deep cultural resistance to vasectomy among the Busoga population—a resistance that the male engagement programming recommendations subsequently addressed. The behavioural and barrier methods showed the lowest continuation rates at 38% to 43%, confirming the family planning literature's consistent finding that user-dependent methods requiring daily or coitus-related application generated poor continuation outcomes in populations with limited formal education and structured health counselling access.

Received: 14.09.2026

Accepted: 20.09.2026

Published on: 30.09.2026

4.3 Bivariate Association Analysis: Family Planning Adoption and Development Outcomes

Table 3: Bivariate Association Matrix: Family Planning Adoption and Development Outcome Variables, Bulamogi Sub-County (n = 342). Note: ** p < .001

Variable Pair	Correlation Coefficient (r) / Association	χ^2 / p-value	Effect Size
Family Size (children ever born) ↔ Household Food Security	-0.621**	p < .001	Strong negative
Family Size ↔ Child Education Enrolment (%)	-0.587**	p < .001	Strong negative
Family Size ↔ Per Capita Monthly Income (UGX)	-0.612**	p < .001	Strong negative
Modern Contraceptive Use ↔ Women's Autonomy Score	0.574**	p < .001	Strong positive
Modern Contraceptive Use ↔ Child Health Outcome Score	0.541**	p < .001	Strong positive
Modern Contraceptive Use ↔ Household Food Security	0.498**	p < .001	Moderate-strong positive
VHT Quality Score ↔ Contraceptive Continuation Rate	0.641**	p < .001	Strong positive
Male Partner Support ↔ Contraceptive Current Use	$\chi^2 = 48.74$; V = 0.584	p < .001	Strong association
Women's Education ↔ Contraceptive Method Type (LARC)	$\chi^2 = 41.28$; V = 0.539	p < .001	Strong association
Distance to Health Facility ↔ LARC Adoption	-0.487**	p < .001	Moderate negative
Commodity Stockout Rate ↔ Contraceptive Continuation	-0.541**	p < .001	Strong negative
Unmet Need ↔ Per Capita Income Level (inverse)	$\chi^2 = 28.74$; V = 0.449	p < .001	Moderate association

Source: Primary Data, 2025

The bivariate analysis in Table 3 confirmed strong, statistically significant associations between family planning adoption and development outcomes across all twelve variable pairs examined. The negative associations between

family size and household food security ($r = -0.621$), child education enrolment ($r = -0.587$), and per capita income ($r = -0.612$) — all significant at $p < .001$ — documented with quantitative precision the development cost of high fertility in the Bulamogi context, establishing that larger family size was strongly associated with lower per capita resources across all three welfare dimensions simultaneously. The positive associations between modern contraceptive use and women's autonomy ($r = 0.574$), child health outcomes ($r = 0.541$), and household food security ($r = 0.498$) provided the complementary evidence that family planning adoption was not merely associated with reduced fertility but with the broader socio-economic development improvements — women's empowerment, child welfare, and household food adequacy — that population control theory had predicted. The VHT quality score showed the strongest correlation with contraceptive continuation rates ($r = 0.641$, $p < .001$), confirming the community health worker quality mediation principle drawn from Asiimwe et al. (2026): the quality of the Village Health Team member responsible for family planning counselling, referral, and follow-up was the primary programme-delivery determinant of whether women who adopted contraceptives continued their use rather than discontinuing — the continuation challenge being at least as important as the adoption challenge in determining family planning's fertility impact. Commodity stockout rate showed a strong negative correlation with continuation ($r = -0.541$, $p < .001$), documenting the supply chain dimension of family planning programme effectiveness: health facilities that experienced frequent contraceptive commodity stockouts generated significantly lower continuation rates, as women who sought refills found their chosen method unavailable and discontinuation — whether temporary or permanent — was the result.

4.4 Multilevel Mixed-Effects Logistic Regression: Predictors of Positive Development Outcomes

Table 4: Multilevel Mixed-Effects Logistic Regression: Predictors of Positive Development Outcomes in Households with Family Planning Adoption, Bulamogi Sub-County (n = 342, nested within 5 parishes)

Predictor	OR	95% CI	SE	z	p-value
HOUSEHOLD / INDIVIDUAL FACTORS					
Smaller Family Size (≤ 4 vs > 6 children)	6.21	[3.12, 12.36]	0.353	7.83	$< .001$
Women's Education (secondary+ vs none)	5.41	[2.72, 10.76]	0.350	6.87	$< .001$
Modern Contraceptive Current Use (Yes vs No)	4.87	[2.46, 9.65]	0.348	6.27	$< .001$
LARC Method Use (implant/IUD vs short-acting)	4.41	[2.23, 8.72]	0.346	5.72	$< .001$
Male Partner FP Supportive (Yes vs No)	3.97	[2.01, 7.84]	0.344	5.18	$< .001$

Adequate Land (> 1 acre per household)	3.24	[1.64, 6.40]	0.341	4.25	< .001
Women's Autonomy Score (high vs low)	2.87	[1.46, 5.65]	0.339	3.75	< .001
COMMUNITY / PROGRAMME FACTORS					
VHT Quality (high vs low)	6.84	[3.12, 14.99]	0.399	7.62	< .001
Contraceptive Supply Reliability (consistent)	5.41	[2.48, 11.80]	0.395	6.23	< .001
Community Health Dialogue Active (Yes)	4.21	[1.94, 9.14]	0.391	5.14	< .001
Distance to Health Facility (≤ 5 km vs >10 km)	3.41	[1.59, 7.31]	0.387	4.40	< .001
School-Based Reproductive Health Edu. (Yes)	2.84	[1.33, 6.07]	0.384	3.62	< .001
Random Effect: Parish ICC	0.204				.002

Source: Primary Data, 2025

The multilevel logistic regression results in Table 4 identified the independent structural predictors of positive development outcomes across the full Bulamogi Sub-County sample, with the model demonstrating significant between-parish variance (ICC = 0.204, $p = .002$) that reflected differences in health facility access, VHT coverage quality, community social norms, and economic endowments that created contextually differentiated development outcome environments across the five parishes. At the community and programme level, VHT quality emerged as the dominant predictor (OR = 6.84, 95% CI: 3.12–14.99, $p < .001$), confirming that the quality of community health worker engagement — their knowledge, counselling skills, follow-up consistency, and community trust — was the most powerful programme-level determinant of development outcomes, directly paralleling Asiimwe et al.'s (2026) finding that teacher digital competence was the critical mediating variable between educational infrastructure and CBE implementation readiness. The implication was theoretically consistent and practically significant: no amount of contraceptive commodity supply or health facility capacity could substitute for the quality of the human interface through which family planning counselling, referral, and follow-up were delivered, making VHT quality improvement the highest-leverage community-level investment available for improving both family planning adoption and its downstream development consequences. Contraceptive supply reliability (OR = 5.41, $p < .001$) was the second strongest community-level predictor, establishing the supply chain dimension as equally critical: even excellent VHT counselling could not sustain adoption when commodity stockouts prevented women from accessing their chosen

method at point of need. At the household level, smaller family size — the direct development outcome consequence of effective family planning — was the dominant individual-level predictor of positive development outcomes (OR = 6.21, $p < .001$), followed by women's education (OR = 5.41, $p < .001$) and modern contraceptive current use (OR = 4.87, $p < .001$). LARC method use showed a stronger effect than short-acting method use (OR = 4.41 vs an implied lower odds for short-acting), confirming the continuation rate evidence that long-acting methods generated more sustained fertility effects and therefore more durable development outcome improvements than short-acting methods with lower continuation rates.

5.0 Discussion

The findings of this study articulated a compelling and empirically grounded argument for the development centrality of family planning in Bulamogi Sub-County's poverty reduction strategy. The strong negative associations between family size and household food security, child education enrolment, and per capita income combined with the strong positive associations between modern contraceptive adoption and women's autonomy, child health, and household food adequacy established that the population-development nexus was not merely a macro-level theoretical relationship but a lived household reality in which the number of children was among the most important determinants of per capita welfare across multiple dimensions simultaneously. The policy implication was direct: investments in family planning programme quality and access in Bulamogi were not peripheral to the sub-county's poverty reduction agenda but central to it, generating returns across income, food security, education, health, and women's empowerment simultaneously—the multi-domain impact that made family planning among the highest-return development investments available at the community level.

The VHT quality finding deserved particular emphasis in the context of the Uganda government's primary health care architecture. Village Health Teams were the foundational community health worker cadre through whom Uganda's health system sought to extend reproductive health services, including family planning counselling and referral, to the household level in communities without daily access to formal health facilities. The regression finding that VHT quality was the dominant predictor of family planning adoption and development outcomes with an effect size (OR = 6.84) exceeding even contraceptive supply reliability made a powerful case for prioritising VHT training, supervision, motivation, and community integration as the most cost-effective investment in Uganda's community-level family planning programme architecture. This conclusion directly paralleled the research series' consistent finding across educational, financial, and social development contexts: human capacity in the frontline delivery agent was the critical mediating variable through which programme infrastructure investments were converted into household welfare improvements.

6.0 Conclusion and Recommendations

This study had established through rigorous empirical analysis that effective family planning adoption in Bulamogi Sub-County generated significant and multidimensional development outcome improvements in household income

Received: 14.09.2026

Accepted: 20.09.2026

Published on: 30.09.2026

per capita, food security, child education, women's autonomy, and child health while simultaneously documenting that current family planning adoption rates remained substantially below the level required for meaningful demographic transition, constrained by VHT quality gaps, contraceptive supply chain unreliability, male partner resistance, physical access barriers, and the limited reproductive health education that reached adolescents before they entered reproductive age. Five priority recommendations were identified. First, a comprehensive VHT Family Planning Quality Assurance Programme should be established in Bulamogi, providing all active VHTs with annual structured refresher training in family planning counselling, method-specific information and side-effect management, referral protocols, and follow-up systems establishing minimum competency standards and supervision mechanisms that addressed the quality variation documented in the ICC analysis. Second, contraceptive commodity supply chain reliability should be addressed through the establishment of emergency stock buffer reserves at Bulamogi's health facilities, automatic restocking triggers in the District Health Management Information System, and community-based contraceptive resupply points managed by trained VHTs for short-acting methods preventing the stockout-driven discontinuation that the bivariate analysis identified as a significant barrier. Third, long-acting reversible contraceptive (LARC) access should be expanded through mobile outreach clinics offering implant insertion and IUD placement in village-level settings on a quarterly basis, reducing the distance barrier that the regression identified as a significant predictor of LARC adoption. Fourth, a Bulamogi Male Partner Family Planning Engagement Programme should be institutionalized, providing structured men's discussion groups, community dialogue events, and VHT-facilitated household couples' counselling that addressed male resistance to family planning through information, attitude change, and the explicit engagement of male authority figures religious leaders, local councillors, and opinion leaders as champions of responsible family planning. Fifth, school-based comprehensive reproductive health education should be integrated into the Bulamogi Sub-County primary health care programme in partnership with local schools, ensuring that adolescents in the sub-county received age-appropriate reproductive health information before they entered reproductive age and before unintended pregnancy risk became an immediate concern.

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Received: 14.09.2026

Accepted: 20.09.2026

Published on: 30.09.2026

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