



End of Project Report

Community-Based Distribution of
Family Planning Commodities
in Kamuli, Namutumba & Mayuge Districts



Prepared By:
Tekere Girl Child Empowerment (TEGEM)

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Community-Based Distribution of Family Planning Commodities (DMPA-SC)
in Kamuli, Namutumba & Mayuge Districts.

Prepared and Published by:

Tekere Girl Child Empowerment (TEGEM)

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Copies may be obtained from:

Tekere Girl Child Empowerment (TEGEM)
Tororo District, Uganda.
Tel: +256 756 034 856
Email: info@tekeregirlchildempowerment.org
www.tekeregirlchildempowerment.org

Photo Credit:

TEGEM Staff

Concept, Design & Layout:

Joshua Musasizi

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ACRONYMS

CBD	Community-Based Distribution
CHEW	Community Health Extension Worker
CHW	Community Health Worker
DHO	District Health Officer
DHIS2	District Health Information System
DMPA-SC	Depot Medroxyprogesterone Acetate Subcutaneous
DHT	District Health Team
eCHIS	Electronic Community Health Information System
FP	Family Planning
HMIS	Health Management Information System
KII	Key Informant Interview
FGD	Focus Group Discussion
MoH	Ministry of Health
NMS	National Medical Stores
VHT	Village Health Team

ABOUT

Tekere Girl Child Empowerment (TEGEM)



Tekere Girl Child Empowerment (TEGEM) is a non-profit organization, a women and girls-centred initiative dedicated to empowering girls to realize their full potential. What began in 2004 as a community-based organisation in response to the growing health and social needs of the Tororo district community, evolved into a fully registered NGO in 2019.



OUR MISSION

To empower girls and young women through holistic approaches for improved health



OUR VISION

Envision a healthy community of empowered girls/boys and young women for sustainable development



OUR VALUES

- Transparency
- Empowerment
- Growth
- Equity
- Motivation



*Empowered girls today,
stronger communities tomorrow.*



PROJECT IN NUMBERS

Strengthening Community-Based Family Planning
with Emphasis on DMPA-SC in Kamuli, Namutumba & Mayuge Districts



IMPLEMENTATION PERIOD

July 2025 - April 2026

(Initial 6 months + No-cost extension)



DISTRICTS

3

Mayuge, Namutumba & Kamuli



TOTAL STAKEHOLDERS ENGAGED

1,176

across mentorships, review meetings, supervision visits & community dialogues



COMMUNITY HEALTH WORKERS

VHTs & CHEWs

at the heart of service delivery



IMPLEMENTATION SUCCESS RATE

100%

of planned activities implemented.

(except printing of FP registers halted due to shift to electronic systems)



eCHIS REPORTING RATE IMPROVED

+4%

Average reporting in Mayuge & Kamuli improved from 70% to 74%



DMPA-SC UPTAKE INCREASED

significant increase across all districts after project implementation



DMPA-SC SHARE OF FP UPTAKE

~30-39% → >60%

Increased from ~30-39% before implementation to consistently above 60% during implementation



INCREASED UPTAKE

of family planning services at community level

ACKNOWLEDGEMENT

The successful implementation and documentation of the Community based Distribution of Family Planning Project in the districts of Kamuli, Mayuge and Namutumba was made possible through the collaboration, commitment, and support of multiple stakeholders.

We extend sincere appreciation to the Ministry of Health, particularly the Department of Community Health, Division of Health Information, and Department of Pharmaceuticals and Natural Medicines, for their technical guidance, leadership, and alignment with national priorities.

Special recognition goes to the District Health Teams of Kamuli, Namutumba, and Mayuge, whose leadership, coordination, and ownership were instrumental in implementation, supervision, and performance monitoring.

We acknowledge the invaluable role of health facility staff, Health Information Assistants, and Family Planning focal persons who ensured service delivery continuity and strengthened reporting systems.

We are particularly grateful to the Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs) for their tireless efforts in delivering services at community level and serving as a critical bridge between households and the health system.

We also thank community leaders, local influencers, and community members who actively participated in dialogue sessions and contributed to addressing barriers to family planning uptake.

Finally, we appreciate the support of the Uganda Selfcare Project and Makerere University School of Public Health for entrusting the TEGEM team with responsibility of leading on this role and financial support throughout the project lifecycle.

EXECUTIVE SUMMARY

The Community-Based Distribution Project was implemented in Mayuge, Namutumba, and Kamuli districts to strengthen access to family planning (FP) and self-care services through community-based delivery approaches, digital health systems strengthening, and enhanced district coordination mechanisms.

The project focused on supporting Village Health Teams (VHTs), strengthening electronic Community Health Information System (eCHIS) reporting, improving data quality, promoting community engagement, and expanding access to DMPA-SC through door-to-door service delivery and integrated mentorship approaches.

During the implementation period, 100% of planned operational activities were successfully implemented, with the exception of printing FP registers, which was halted following Ministry of Health guidance to transition toward electronic reporting systems. A total of 1,176 stakeholders were directly engaged across mentorships, review meetings, support supervision visits, community dialogues, and community-based distribution activities.

The project contributed to improved eCHIS reporting performance, with average VHT reporting rates in Mayuge and Kamuli increasing from 70% during the pre-implementation period to 74% during implementation. A notable increase in reporting compliance was observed following intensified mentorship and supervision interventions.

Family planning uptake remained generally stable across the implementation period despite fluctuations, while DMPA-SC utilization increased substantially across all supported districts. The proportion of DMPA-SC within the FP method mix increased from approximately 30–39% before implementation to consistently above 60% during implementation, demonstrating improved access to preferred contraceptive methods through community-based delivery.

The project also strengthened district ownership, improved routine data use for decision-making, enhanced coordination between district and national stakeholders, and reinforced community engagement mechanisms that addressed myths and socio-cultural barriers affecting family planning uptake.

The findings demonstrate that integrated community-centered approaches combining service delivery, digital systems strengthening, supportive supervision, and community engagement can significantly improve equitable access to family planning services while strengthening health system responsiveness. Sustaining these gains will require continued investment in commodity security, digital infrastructure, VHT support systems, and institutionalization of community-based family planning within routine health system operations.



INTRODUCTION AND BACKGROUND

Family Planning (FP) remains a critical pillar of Uganda's health and development agenda, contributing significantly to improved maternal and child health outcomes, women's empowerment, poverty reduction, and broader socio-economic transformation. Over the years, the Government of Uganda, through the Ministry of Health (MoH), together with development partners and implementing organizations, has made substantial investments to expand access to voluntary family planning services and commodities across the country. These efforts are aligned with national priorities outlined in the Uganda Family Planning Costed Implementation Plan (CIP), the National Community Health Strategy, the Self-Care Guidelines, and the Digital Health Strategy.

Despite this progress, access to family planning services remains uneven, particularly among rural, underserved, and hard-to-reach communities where geographical barriers, socio-cultural norms, health system limitations, and persistent myths and misconceptions continue to affect uptake and continuity of use. Adolescents and young people remain disproportionately affected, with high rates of teenage pregnancy continuing to pose significant public health and socio-economic challenges in many districts. In addition, health facilities in some settings experience recurrent stockouts of FP commodities, weak last-mile distribution systems, inconsistent reporting mechanisms, and limited use of routine data for decision-making and commodity management.

Subcutaneous Depot Medroxyprogesterone Acetate (DMPA-SC), commonly known as Sayana Press, has emerged as an important contraceptive option within Uganda's FP program due to its convenience, privacy, ease of administration, and suitability for community-based distribution and self-care approaches. The method aligns strongly with Uganda's national self-care agenda, which seeks to empower individuals and communities to take a more active role in managing their health. To increase access to DMPA-SC, the Ministry of Health adopted a community-based distribution (CBD) model that enables trained Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs) to provide FP information, counseling, referrals, and selected contraceptive methods directly within communities.

Community health workers remain a vital link between communities and the formal health system. Their proximity to households, understanding of community dynamics, and ability to deliver services at household level position them uniquely to improve access to FP services among populations that may otherwise face barriers in accessing facility-based care. However, despite the existence of this community platform, implementation challenges have continued to limit the effectiveness and sustainability of the CBD model. These include inadequate supervision and mentorship of VHTs, inconsistent commodity supply, weak accountability systems, limited reporting and data use, low male involvement, and inadequate integration of digital health tools into routine community service delivery.

In parallel, the Ministry of Health has been implementing the electronic Community Health Information System (eCHIS) as part of broader efforts to strengthen digitized community health service delivery and reporting. The eCHIS platform was designed to support VHTs and CHEWs in household registration, service documentation, referral tracking, commodity monitoring, and routine reporting across several program areas including Family Planning, Reproductive Maternal Newborn and Child Health (RMNCH), immunization, nutrition, and integrated community case management (iCCM). Through integration with the national District Health Information System (DHIS2), eCHIS is intended to improve data quality, timeliness, accountability, and evidence-based decision-making from community to national level. Kamuli, Namutumba, and Mayuge districts were among the early adopter districts for eCHIS implementation and community-based distribution of DMPA-SC.

However, emerging implementation experiences highlighted several operational bottlenecks, including low utilization of the FP module within eCHIS, inconsistent reporting by VHTs, weak linkage between commodity distribution and reporting systems, inadequate data use for decision-making, and persistent gaps in community awareness and demand creation for FP services.

It was against this background that TEGEM, in collaboration with the Ministry of Health and with support from partners, implemented the project titled “Acceleration of Community-Based Distribution of Family Planning Commodities with Emphasis on DMPA-SC” in Namutumba, Kamuli, and Mayuge districts. The project was initially designed as a six-month intervention running from July 2025 to December 2025, with the goal of strengthening and institutionalizing a sustainable community-based distribution system for FP commodities while advancing Uganda’s self-care and digital health agenda.



Community health workers remain a vital link between communities and the formal health system, improving access to family planning services at household level.



Improved access to family planning services, empowered communities and stronger health system for a self-reliant Uganda.

The intervention focused on strengthening door-to-door distribution of FP commodities by VHTs and CHEWs, improving uptake of DMPA-SC, facilitating community dialogues to address myths and misconceptions, supporting joint supervision and data quality improvement activities, and strengthening coordination between communities, districts, and national stakeholders. The project also emphasized strengthening the use of eCHIS for FP reporting and promoting data-driven decision-making at community and district levels.

A baseline landscape assessment conducted during the initial phase of implementation identified key systemic, operational, and community-level barriers affecting both community-based FP distribution and routine digital reporting. Findings from the assessment informed adaptive implementation strategies aimed at strengthening mentorship, improving reporting systems, enhancing supervision, supporting commodity accountability, and reinforcing community engagement mechanisms.

Following encouraging implementation experiences and the need to consolidate gains realized during the initial phase, the project received a no-cost extension through May 2026. The extension phase focused on reinforcing sustainability and institutionalization of the CBD model through targeted mentorship of VHTs, CHEWs, and facility-based Health Information Assistants; strengthening use of eCHIS and FP data systems; improving availability of reporting tools and registers; supporting district-level review and learning platforms; and deepening community engagement around FP self-care and informed choice.

Overall, the project contributed to ongoing national efforts to strengthen community health systems, improve equitable access to family planning services, institutionalize digital community health reporting, and enhance community ownership of self-care interventions. By building on existing Ministry of Health structures and systems, the intervention sought not only to improve immediate access to DMPA-SC and other FP services, but also to generate lessons and implementation models that can inform future scale-up of community-based family planning programming in Uganda.

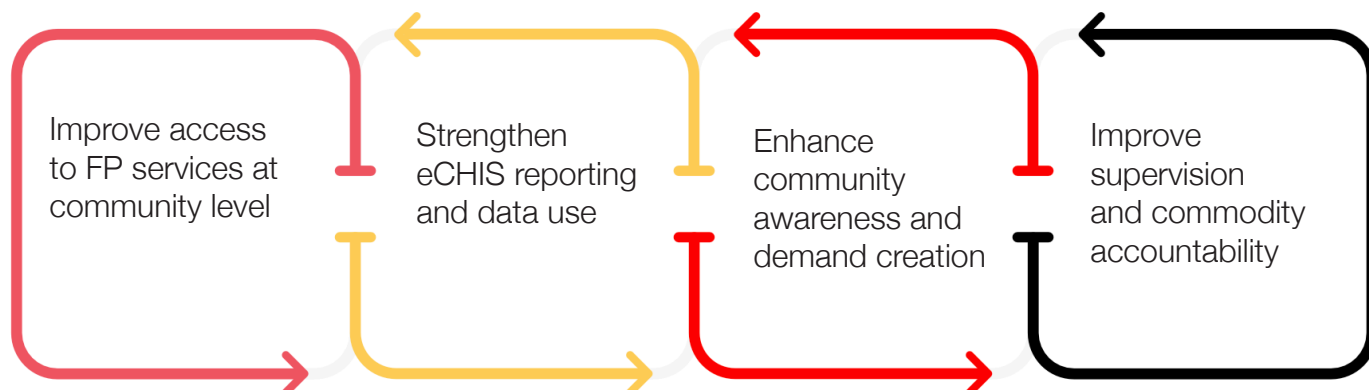
PROJECT OBJECTIVES

Overall Objective

To strengthen and institutionalize community-based distribution of FP commodities with emphasis on DMPA-SC

Objectives

Figure 1: Objectives



METHODOLOGY

Overview

This end-of-project documentation adopted a participatory, mixed-methods approach combining both qualitative and quantitative techniques to assess project implementation processes, document achievements, capture stakeholder experiences, and generate lessons to inform future scale-up of community-based family planning interventions. The methodology was designed to ensure comprehensive analysis of the project's contribution to strengthening community-based distribution (CBD) of family planning commodities particularly DMPA-SC and improving the use of the electronic Community Health Information System (eCHIS) for routine family planning reporting and decision-making.

The approach emphasized systems strengthening and stakeholder engagement, recognizing the interconnected nature of service delivery, commodity management, digital reporting systems, supervision structures, and community participation within the family planning program. Data collection and analysis were conducted in close collaboration with the Ministry of Health (MoH), district health teams, health facilities, community structures, and implementing partners to ensure that findings and lessons reflected operational realities and frontline implementation experiences.

The methodology also built upon findings from the baseline landscape assessment conducted during the initial phase of implementation, allowing for triangulation of implementation experiences, routine monitoring data, stakeholder perspectives, and observed system changes over the project period.



Community dialogue on family planning (FP) convened at Mayuge H/C IV

Project Area and Scope

The project was implemented in three districts within the Busoga sub-region of Eastern Uganda namely Kamuli, Namutumba, and Mayuge. These districts were selected based on existing challenges in access to family planning services, ongoing Ministry of Health efforts to strengthen community-based distribution of DMPA-SC, and early adoption of the electronic Community Health Information System (eCHIS).

The intervention targeted both community and health system structures involved in family planning service delivery and reporting. Key target groups included:

- Women of reproductive age, particularly users and potential users of DMPA-SC and other FP methods.
- Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs) involved in community-level FP service delivery.
- Health facility staff including Health Information Assistants, Family Planning focal persons, facility in-charges, and store personnel.
- District Health Teams (DHTs) responsible for supervision, coordination, commodity management, and reporting.
- Community leaders and influencers engaged through community dialogue platforms.
- National-level Ministry of Health departments and implementing partners supporting FP and digital health programming.

The project interventions focused on strengthening:

- Community-based distribution of FP commodities.
- Uptake and continuity of DMPA-SC services.
- Routine FP reporting through eCHIS and HMIS.
- Community engagement and demand creation.
- Data quality, supervision, and accountability systems.
- Coordination between community, district, and national stakeholders.

Project Design and Implementation Approach

The project employed a systems-strengthening implementation approach anchored on three mutually reinforcing pillars:

1. Community-based service delivery systems.
2. Digital health and reporting systems.
3. Community and stakeholder engagement.

The intervention was implemented through existing Ministry of Health structures and aligned with national frameworks including:

- Uganda Family Planning Costed Implementation Plan (CIP).
- National Community Health Strategy.
- Uganda Self-Care Guidelines.
- National Digital Health Strategy.
- eCHIS implementation guidelines.

The project was initially implemented between July 2025 and December 2025 and later extended through April 2026 to consolidate gains, strengthen sustainability mechanisms, and address implementation gaps identified during the initial phase.

Implementation strategies included:

- Door-to-door distribution of FP commodities by trained VHTs.
- Community dialogues and sensitization activities.
- Joint support supervision and mentorship.
- District review and learning meetings.
- Mentorship of VHTs, CHEWs, and Health Information Assistants.
- Strengthening FP reporting and data use through eCHIS and HMIS systems.

Data Sources

The end-of-project documentation utilized both primary and secondary data sources.

Primary Data Sources

Primary data was obtained through:

- Key Informant Interviews (KIIs).
- Focus Group Discussions (FGDs).
- Stakeholder consultations.

- Community dialogue sessions.
 - Support supervision engagements.
 - District review and learning meetings.
- Secondary Data Sources

Secondary data reviewed included:

- Baseline assessment report.
- Project concepts and implementation plans.
- Routine activity reports.
- Community dialogue reports.
- Mentorship and supervision reports.
- eCHIS reports and dashboards.
- HMIS and DHIS2 reports.
- FP commodity records and stock reports.
- District review meeting reports.
- Ministry of Health guidelines and strategic documents.

Data Collection Methods

Desk Review

A comprehensive desk review was conducted to provide contextual understanding of the project and inform documentation of implementation progress. Relevant project documents, policies, guidelines, strategic frameworks, and routine reports were reviewed to identify implementation milestones, achievements, challenges, and emerging lessons.

Documents reviewed included:

- Baseline assessment report.
- Activity implementation reports.
- Community dialogue reports.
- Supervision and mentorship reports.
- eCHIS and DHIS2 reports.
- National FP and digital health policy documents.
- Community health strategy documents.

The desk review also helped to assess alignment between project implementation and national priorities related to family planning, self-care, community health systems, and digital health.

Key Informant Interviews (KIIs)

Key Informant Interviews were conducted with selected stakeholders at national, district, facility,

and community levels to gather in-depth insights on project implementation experiences, system strengthening efforts, coordination mechanisms, achievements, and operational challenges.

Key informants included:

- Ministry of Health officials.
- District Health Officers (DHOs).
- Assistant DHOs responsible for Maternal and Child Health.
- District Biostatisticians.
- District Medicines Management Supervisors (DMMS).
- Health Assistants.
- Health facility in-charges.
- Family Planning focal persons.
- Health Information Assistants.
- VHT and CHEW coordinators.

The interviews explored themes related to:

- Commodity availability and distribution systems.
- Functionality of eCHIS and reporting systems.
- Community engagement and demand creation.
- Supervision and mentorship.
- Data quality and use.
- Sustainability and institutionalization of project interventions.

Focus Group Discussions (FGDs)

Focus Group Discussions were conducted with VHTs, CHEWs, and selected community members to capture frontline experiences and community perspectives regarding FP service delivery and utilization.

FGDs explored:

- Experiences with door-to-door FP distribution.
- Community perceptions of DMPA-SC and self-care.
- Myths and misconceptions surrounding family planning.
- Barriers to service access and utilization.
- Experiences with eCHIS reporting and documentation.

- Challenges affecting VHT motivation and performance.
- Community recommendations for improving services.

The discussions also provided valuable insights into cultural and gender-related factors influencing uptake of FP services.

Stakeholder Consultations and Review Meetings District-level review meetings and stakeholder consultations were conducted throughout the project period to assess implementation progress, identify bottlenecks, review data trends, and facilitate shared learning.

These engagements involved:

- District Health Teams.
- Ministry of Health representatives.
- Implementing partners.
- Health facility teams.
- Community health workers.

The meetings provided an opportunity to validate findings, strengthen accountability, and support adaptive implementation during both the initial and extension phases of the project.

Data Management and Analysis

Qualitative data collected through KIIs, FGDs, and stakeholder consultations was documented using structured interview guides, field notes, and meeting summaries. The information was reviewed, organized, and analyzed using thematic content analysis to identify recurring patterns, emerging themes, implementation experiences, and stakeholder perspectives.

Quantitative data was primarily obtained from routine project reports, eCHIS, HMIS, and DHIS2 databases. Descriptive analysis was conducted to assess reporting trends, service utilization patterns, supervision coverage, and implementation progress across the three districts.

Data triangulation was employed to improve validity and reliability of findings by comparing information from multiple data sources including:

- Stakeholder interviews.
- Routine monitoring reports.
- eCHIS and DHIS2 records.
- Community dialogue feedback.
- Supervision findings.

This approach enabled the identification of converging findings, implementation gaps, operational bottlenecks, and emerging opportunities for strengthening community-based family planning programming.

Ethical Considerations

The project documentation process adhered to ethical principles governing public health assessments and stakeholder engagement. Participation in interviews, discussions, and consultations was voluntary, and informed consent was obtained from all participants prior to engagement.

Participants were informed about:

- The purpose of the documentation process.
- Intended use of the information collected.
- Confidentiality measures.
- Their right to decline participation or withdraw at any time.

Data collected was handled confidentially and used strictly for project documentation and learning purposes. Personal identifiers were excluded from the analysis and reporting process to protect participant privacy and confidentiality.

The documentation process was implemented in collaboration with the Ministry of Health and district leadership structures to ensure alignment with national and district-level operational and ethical standards.

KEY FINDINGS/ RESULTS

Project Implementation

The project “Community-Based Distribution of Family Planning Commodities with Emphasis on DMPA-SC” was implemented in Kamuli, Namutumba, and Mayuge districts from July 2025 to April 2026. Initially designed as a six-month intervention, the project was later extended to consolidate gains, strengthen sustainability mechanisms, and address implementation gaps identified during the initial phase.

Implementation was carried out through existing Ministry of Health (MoH) community health and family planning structures in collaboration with District Health Teams (DHTs), health facilities, Village Health Teams (VHTs), Community Health Extension Workers (CHEWs), and community leaders. The intervention aligned with national frameworks including the Uganda Family Planning Costed Implementation Plan, National Community Health Strategy, Self-Care Guidelines, and the National Digital Health Strategy.

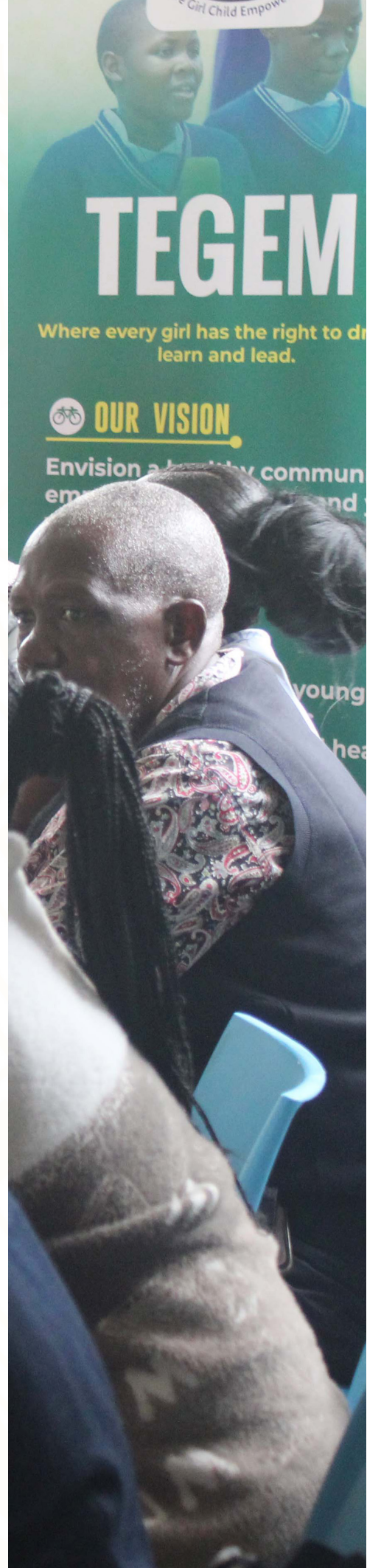
The project adopted a systems-strengthening approach anchored on three mutually reinforcing pillars:

- Strengthening community-based family planning service delivery.
- Improving digital reporting and data use through eCHIS.
- Enhancing community and stakeholder engagement.

Implementation commenced with an inception and baseline landscape assessment to understand operational challenges affecting community-based distribution of DMPA-SC and utilization of eCHIS for family planning reporting. The assessment involved national and district-level stakeholder consultations, review of eCHIS and DHIS2 reporting systems, and community engagements with FP users, VHTs, CHEWs, and health workers.

Key baseline findings identified frequent FP commodity stockouts, weak accountability systems, inconsistent use of eCHIS for FP reporting, limited digital literacy among some VHTs and supervisors, weak supervision and mentorship structures, persistent myths and misconceptions surrounding FP methods, and low male involvement and FP uptake among adolescents and young people. The assessment also highlighted weak linkage between commodity distribution, reporting, and data use for decision-making.

These findings informed refinement of implementation strategies as well as activities and guided adaptive programming throughout both the initial and extension phases of the project.



Project Implementation Performance

Table 1: Implementation Status of Planned Activities

#	Activity	Frequency	# Planned	# Implemented	Completion Rate	Status
1	Support VHTs to undertake Door-to-door distribution of FP commodities	4 months	4	4	100%	Successfully completed
2	District quarterly review meetings involving national team	9	9	9	100%	Successfully completed
3	Community dialogues	6	6	6	100%	Successfully completed
4	Mentorship of VHTs and CHEWs coordinators on eCHIS and FP Self-Care	3	3	3	100%	Successfully completed
5	Mentorship of Facility-Based Health Information Assistants	1	1	1	100%	Successfully completed
6	Support MoH- DHI to conduct support supervision in the 3 districts to ensure data quality and eCHIS roll out	3	3	3	100%	Successfully completed
7	Printing and Distribution of FP Registers	1	1	0	0%	Posed

Note: Due to the ongoing strategic shift towards the electronic registers, MoH guided that activity halted, thus no printing was done

Implementation performance during the reporting period remained strong, with all operational activities successfully delivered across the three districts. The achievement of full implementation for most planned interventions demonstrates effective coordination between district teams, community structures, the Ministry of Health, and implementing partners. The timely execution of activities also reflects strengthened planning, supportive supervision, and responsiveness of local health systems in sustaining community-based family planning and self-care interventions.

The implementation approach prioritized both service delivery and health systems strengthening. Community-level interventions such as door-to-door family planning distribution and community dialogues enhanced demand creation and expanded access to services among underserved populations. At the same time, investments in mentorship, review meetings, and support supervision contributed to strengthening data management systems, accountability mechanisms, and integration of self-care interventions within routine health programming.

The only activity not implemented was the printing and distribution of family planning registers. This followed strategic guidance from the Ministry of Health to transition from paper-based reporting tools to electronic systems under the eCHIS rollout. The adjustment demonstrates the project's flexibility and alignment with national digital health priorities, while also highlighting the strong coordination and trust established between TEGEM, district local governments, and the Ministry of Health throughout project implementation.

Key achievements per activity and summary of the stakeholders engaged

Table 2: Key Achievements per activity implemented

	Activity	Number of Stakeholders Engaged				Comment / Achievement
		Ma-yuge	Namu-tumba	Kam-uli	Total	
1	Support VHTs to undertake Door-to-door distribution of FP commodities	109	123	120	352	Sustained monthly community-based distribution of family planning commodities, improving last-mile access to services and reducing barriers to uptake, particularly among hard-to-reach populations.
2	District quarterly review meetings involving national team	91	91	92	274	Nine district performance review meetings were conducted, providing a platform for data-driven decision-making, performance monitoring, identification of implementation bottlenecks, and alignment of district priorities with national reproductive health objectives.
3	Community dialogues	91	96	102	289	Six community dialogue sessions were conducted, strengthening community awareness, addressing myths and misconceptions, promoting informed choice, and enhancing community ownership of family planning and self-care interventions.
4	Mentorship of VHTs and CHEWs coordinators on eCHIS and FP Self-Care	38	36	36	110	Refresher mentorship sessions enhanced competencies in electronic Community Health Information System (eCHIS) utilization, data reporting, data quality assurance, and integration of self-care interventions within community health service delivery.
5	Mentorship of Facility-Based Health Information Assistants	27	35	29	91	Capacity of facility-based data personnel was strengthened to improve completeness, accuracy, timeliness, and utilization of reproductive health and self-care data for program management and reporting.
6	Support MoH- DHI to conduct support supervision in the 3 districts to ensure data quality and eCHIS roll out	18	23	19	60	Three integrated support supervision visits were conducted across the three districts, improving adherence to eCHIS implementation standards, strengthening data quality management practices, and addressing identified system gaps through on-site coaching and mentorship.
	Total	374	404	398	1,176	

Implementation of the planned interventions generated significant programmatic and systems-level achievements across Mayuge, Namutumba, and Kamuli districts. The interventions collectively strengthened community engagement, improved access to family planning services, enhanced data quality systems, and reinforced district stewardship for reproductive health and self-care programming.

A major achievement of the project was the sustained engagement of community health structures, particularly Village Health Teams (VHTs), which played a central role in extending family planning services closer to communities. Through continuous community-based distribution and dialogue sessions, the project contributed to increased awareness, improved referral linkages, and reduction of socio-cultural barriers that often limit uptake of reproductive health services.

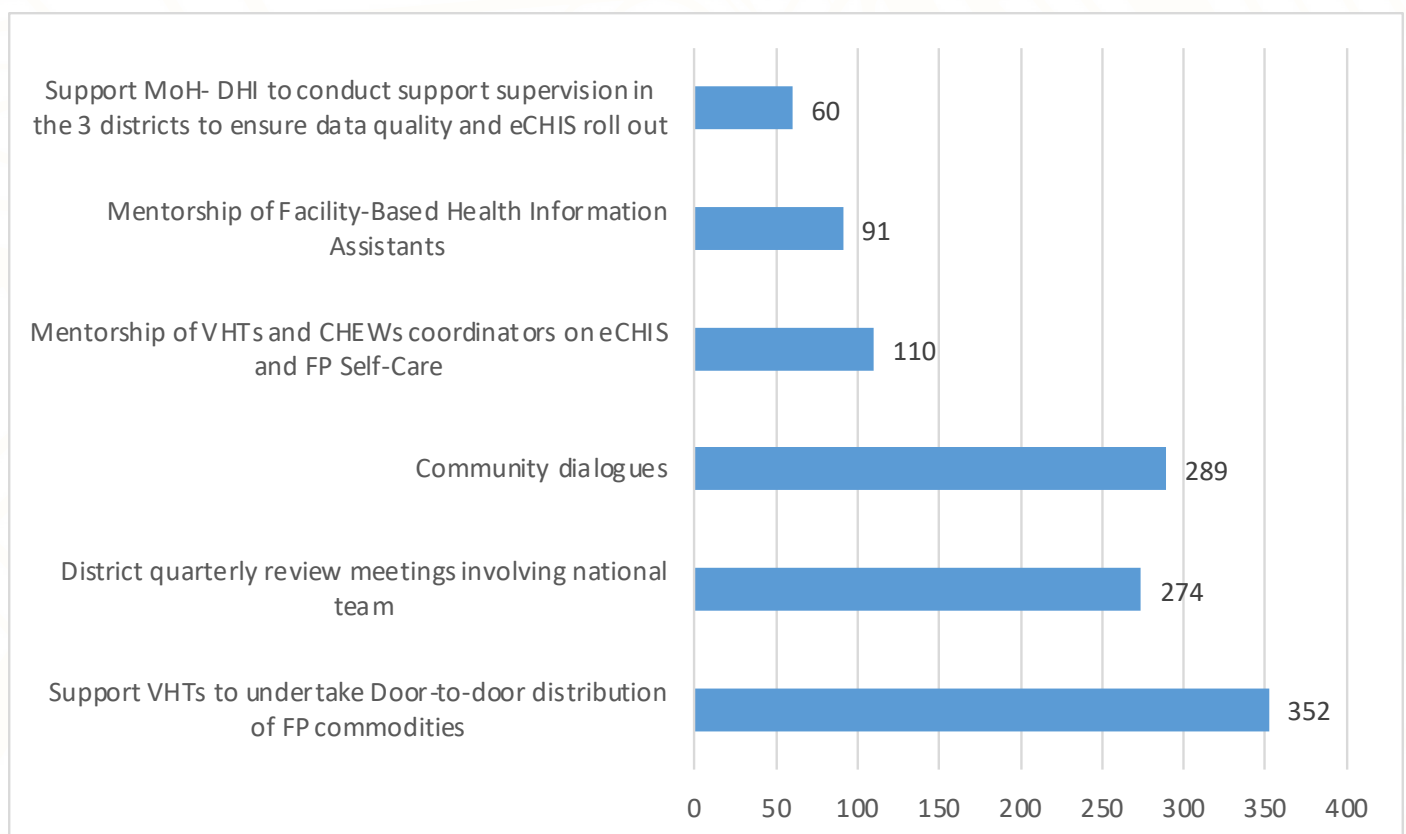
The quarterly performance review meetings further strengthened coordination between district leadership, implementing teams, and national stakeholders. These engagements promoted routine use of data for decision-making, enabled timely identification

of implementation gaps, and facilitated harmonization of district priorities with national reproductive health strategies. This contributed to improved accountability and ownership of program outcomes at district level.

The mentorship and support supervision interventions were instrumental in strengthening the quality and utilization of health information systems. Continuous coaching of VHT coordinators, CHEWs, and facility-based data personnel improved competencies in eCHIS utilization, reporting accuracy, and data quality assurance. The integrated support supervision visits also provided an opportunity for on-site problem solving, reinforcement of implementation standards, and strengthening of digital reporting systems in preparation for wider electronic health information system adoption.

Overall, the engagement of stakeholders across multiple levels of the health system demonstrates a deliberate and integrated implementation approach that combined community empowerment, systems strengthening, and institutional capacity building to support sustainable delivery of family planning and self-care interventions.

Figure 2: Disaggregation of number of stakeholders engaged per activity



The distribution of stakeholders engaged across activities highlights the project’s strong emphasis on community-centered implementation and grassroots health system strengthening. Over 77% of the participants were engaged through activities involving Village Health Teams (VHTs), community dialogues, and district performance review meetings, reflecting the strategic recognition of community structures as critical entry points for expanding access to family planning and self-care services.

The high engagement of VHTs underscores their continued importance in bridging the gap between health facilities and communities, particularly in hard-to-reach and underserved areas. By strengthening the capacity of frontline community health workers, the project enhanced last-mile service delivery, community mobilization, and continuity of reproductive health information and commodity distribution.

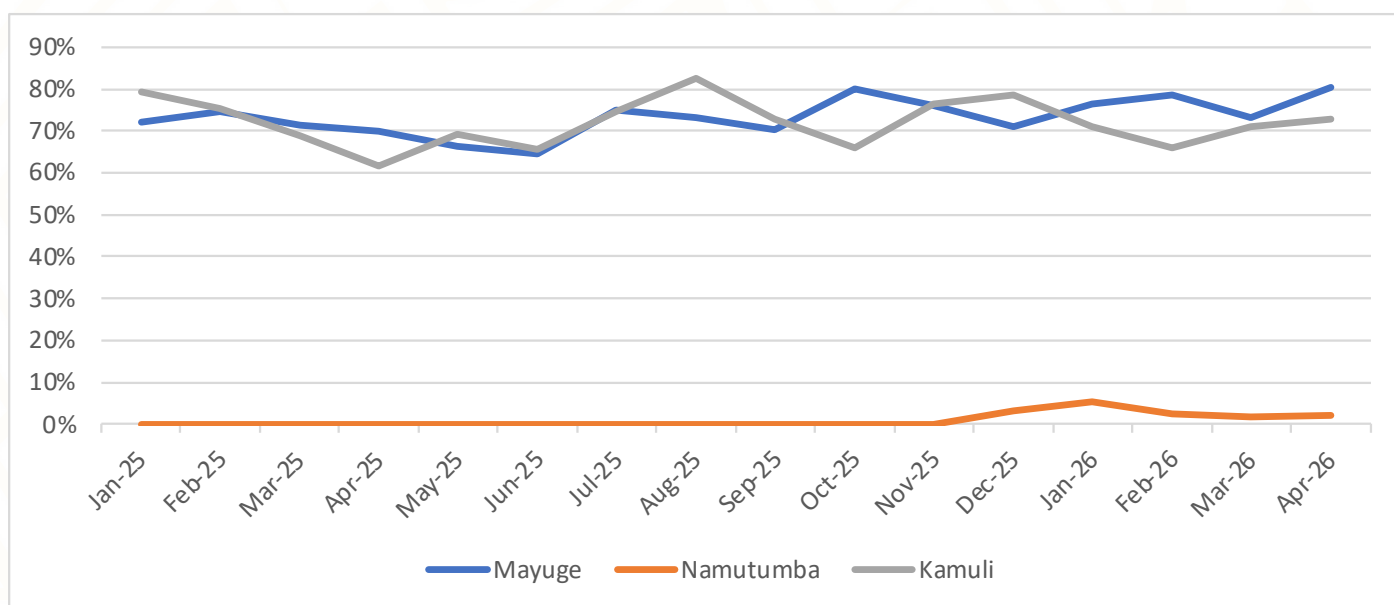
Similarly, the substantial participation observed during community dialogue sessions demonstrates the project’s commitment to strengthening community ownership and social accountability. These engagements created platforms for addressing myths, misconceptions, and socio-cultural barriers that often affect uptake of family planning services, while promoting informed decision-making and acceptance of self-care interventions.

The district review meetings also emerged as a key coordination mechanism that strengthened collaboration between district leadership, Ministry of Health representatives, implementing partners, and community structures. These forums facilitated harmonization of priorities, promoted evidence-based planning, and enhanced collective accountability for program performance across the three districts.

Overall, the stakeholder engagement profile demonstrates that the project adopted a balanced implementation model that simultaneously strengthened community demand generation, frontline service delivery capacity, and health system governance mechanisms necessary for sustainable reproductive health programming.

Trend Analysis for eCHIS Reporting Rate for VHTs

Figure 3: Trend Analysis for eCHIS Reporting Rate for VHTs



The project contributed to notable improvements in eCHIS reporting performance among Village Health Teams (VHTs) across the supported districts. In Mayuge and Kamuli districts, the average reporting rate increased from 70% during the six months preceding project implementation to 74% during the implementation period, reflecting strengthened engagement with community health structures and enhanced support for digital reporting systems.

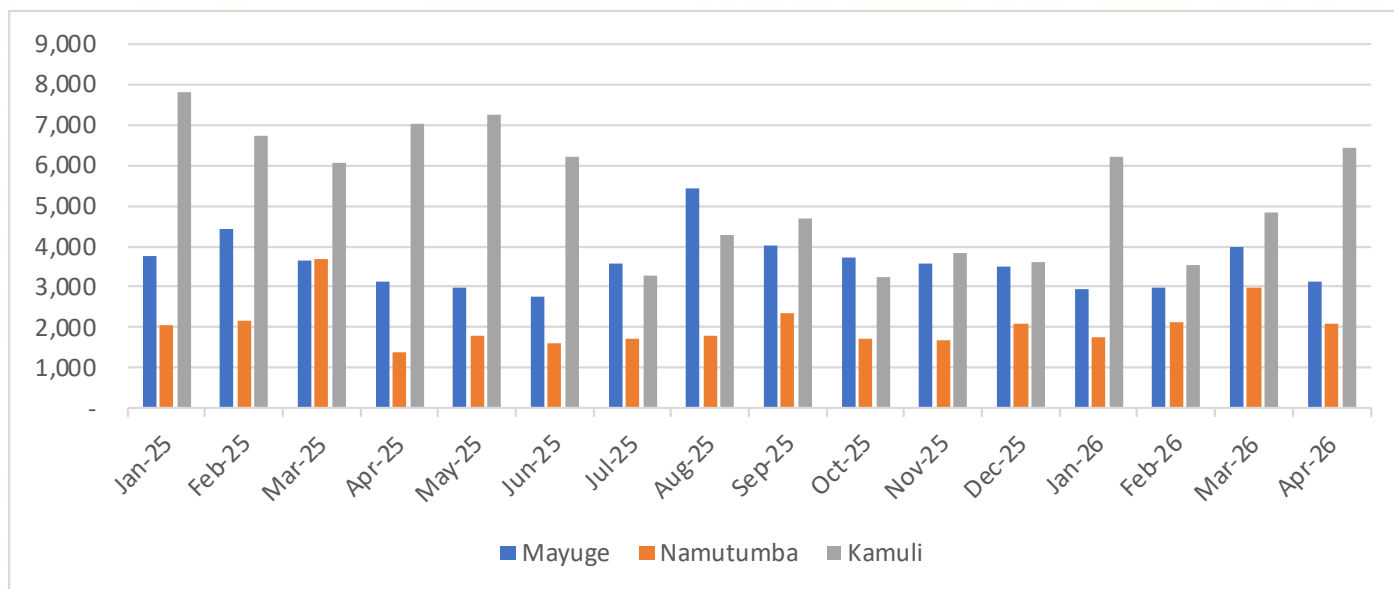
A particularly significant improvement was observed between the June and July reporting periods, where reporting rates increased by 10 percentage points following the rollout of intensified project interventions. This improvement demonstrates the positive contribution of the project’s mentorship, support supervision, and continuous follow-up mechanisms in strengthening reporting compliance and utilization of the eCHIS platform among VHTs.

Although monthly fluctuations in reporting performance were observed, the overall reporting trend remained consistently higher during the implementation period compared to the pre-project baseline. This indicates improved system responsiveness and sustained engagement of community health workers in routine reporting processes despite operational and contextual implementation challenges.

In Namutumba district, onboarding of VHTs onto the eCHIS platform was completed in November 2025 following sustained coordination and engagement between TEGEM and the Ministry of Health. This milestone represented an important step towards harmonized electronic community health reporting across all supported districts and laid a foundation for improved real-time data visibility, reporting consistency, and integration of community-level reproductive health information into the national digital health ecosystem.

Trend Analysis for Family Planning Uptake

Figure 4: Trend Analysis for Family Planning Uptake



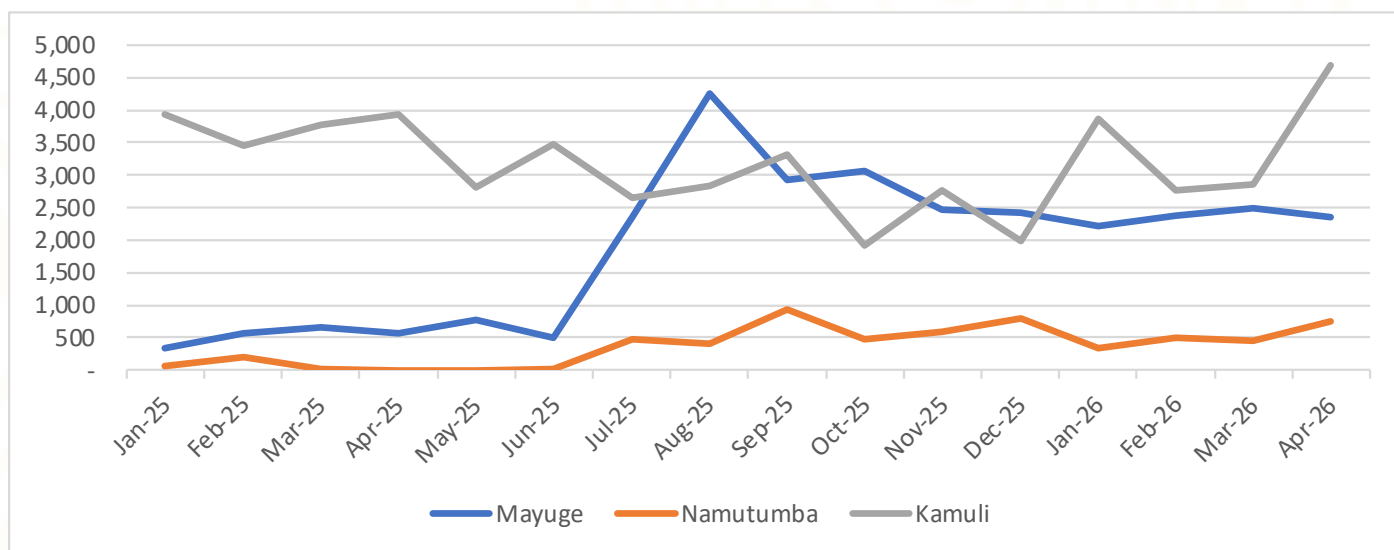
Family planning uptake across the three districts demonstrated fluctuating but generally sustained service utilization throughout the reporting period. During the first half of 2025 (January–June), uptake trends were characterized by gradual declines in some districts, particularly Mayuge and Kamuli, despite relatively high baseline volumes. However, following the rollout of intensified project interventions from July 2025 onwards, the reporting period showed signs of recovery and stabilization, with several months registering improved uptake across the districts.

Mayuge district recorded a notable rebound in uptake during the implementation period, including a sharp increase in August 2025, suggesting improved community access and demand for family planning services. Namutumba, although recording comparatively lower volumes overall, demonstrated progressive improvement during the latter months of implementation, with uptake increasing steadily towards the end of the reporting period. Kamuli maintained the highest overall uptake volumes across the three districts, though with considerable month-to-month fluctuations, reflecting both the large service coverage area and varying patterns in service utilization.

Comparatively, the July 2025–April 2026 period reflected improved stabilization of family planning uptake relative to the January–June 2025 period. This trend suggests that the combined community-based distribution, stakeholder engagement, mentorship, and strengthened reporting systems contributed to sustaining service access and utilization despite periodic fluctuations across the districts.

Trend Analysis for DMPA-SC Use

Figure 5: Trend Analysis for DMPA-SC Use



Overall, DMPA-SC use shows a clear shift from low uptake in early 2025 to a sharp scale-up and sustained higher use from mid-2025 onward, with some district-level variability in stability and recovery patterns.

Looking at the 6 months preceding the project, DMPA-SC use was generally low and uneven across all districts:

- Mayuge recorded modest but gradually increasing use, rising from 334 in January to a peak of 765 in May, before declining slightly in June. Uptake remained below 800 throughout this period.
- Namutumba had extremely low uptake, with several months near zero (as low as 1 in April and May), indicating minimal method penetration or access challenges.
- Kamuli, in contrast, maintained consistently high use (2,800–3,900 range), demonstrating that DMPA-SC was already well established in this district compared to the others.

Overall, this period reflects a baseline characterized by limited adoption in Mayuge and Namutumba, but strong performance in Kamuli.

Following the commencement of the community-based distribution project by TEGEM from mid-2025 onward, there is a marked and sustained increase in DMPA-SC use, particularly in Mayuge and Namutumba:

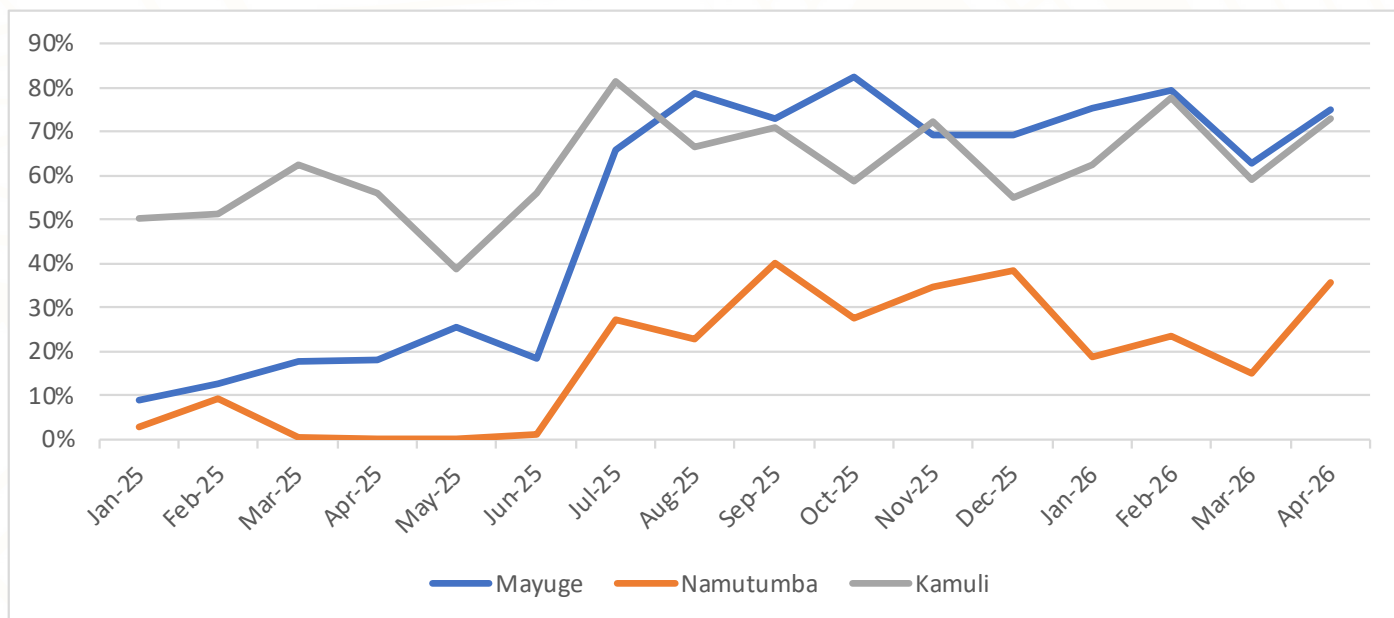
- Mayuge experienced a dramatic surge, jumping from 507 in June to 2,353 in July and peaking at 4,266 in August. After this spike, uptake stabilized at around 2,200–3,000, representing a new, significantly higher baseline than in early 2025.
- Namutumba also showed substantial improvement, increasing from near-zero levels to 400–940 between July and December, with continued moderate use into 2026. Although still lower than Mayuge, this reflects a major relative increase and successful uptake expansion.
- Kamuli showed a temporary decline after June 2025 (dropping to 1,910 in October), followed by recovery in 2026, culminating in a peak of 4,684 in April 2026, the highest recorded level in the dataset.

This suggests resilience and renewed growth after a mid-period dip.

The data strongly suggests a programmatic turning point around July 2025, after which DMPA-SC use expanded substantially across all districts. While Kamuli remained a consistently high performer, the most notable progress occurred in Mayuge and Namutumba, where uptake transitioned from minimal levels to sustained moderate–high use. By early 2026, all districts show improved and more balanced adoption, though variability persists.

DMPA Use as a proportion of FP Uptake

Figure 6: DMPA Use as a proportion of FP Uptake



Assessment of DMPA-SC use as a proportion of total FP uptake provides important insights into method mix dynamics and the strategic contribution of community distribution to method choice and access. Comparing the pre-implementation period (January–June 2025) with the implementation period (July 2025–April 2026) reveals a substantial and sustained shift in method composition in favor of DMPA-SC, particularly in districts that previously had limited access.

Prior to the Community Distribution Project, DMPA-SC accounted for a relatively small share of total FP uptake in Mayuge and Namutumba, while Kamuli again stood out as an exception:

- Mayuge recorded a gradual increase from 9% in January to 26% in May, before declining slightly to 18% in June. Despite this improvement, DMPA-SC remained a minor component of the overall method mix.
- Namutumba showed negligible contribution, with DMPA-SC representing 0–9% of FP uptake, including months where it effectively contributed no meaningful share (0–1%), indicating severely constrained access and limited method availability.
- Kamuli demonstrated a well-established preference or availability, with DMPA-SC contributing 39–62% of FP uptake, suggesting that injectable contraceptives were already a dominant method within the district's method mix.

Overall, this period highlights significant inequities in method access and choice, with DMPA-SC largely unavailable or underutilized in two of the three districts.

Following the introduction of community-based distribution, there is a marked increase in the share of DMPA-SC within total FP uptake, indicating not only increased volumes but also a shift in client preferences and improved access to preferred methods:

- Mayuge experienced the most dramatic transformation, with DMPA-SC's share increasing sharply from 18% in June to 66% in July and peaking at 82% in October. Sustained high levels (63–79% through early 2026) demonstrate that DMPA-SC became a dominant method, suggesting strong acceptability and effective last-mile delivery.
- Namutumba similarly showed significant gains, rising from near-zero contribution to 23–40% during the implementation period, with peaks of 40% in September and 38% in December. Although more variable than Mayuge, this shift represents a substantial improvement in method availability and client uptake.
- Kamuli, while already high-performing, experienced an increase in peak contribution (up to 81% in July and 78% in February 2026), reinforcing DMPA-SC as a central component of the method mix, even as fluctuations persisted.

The observed changes in method shares provide strong evidence of system-level transformation driven by the Community Distribution Project:

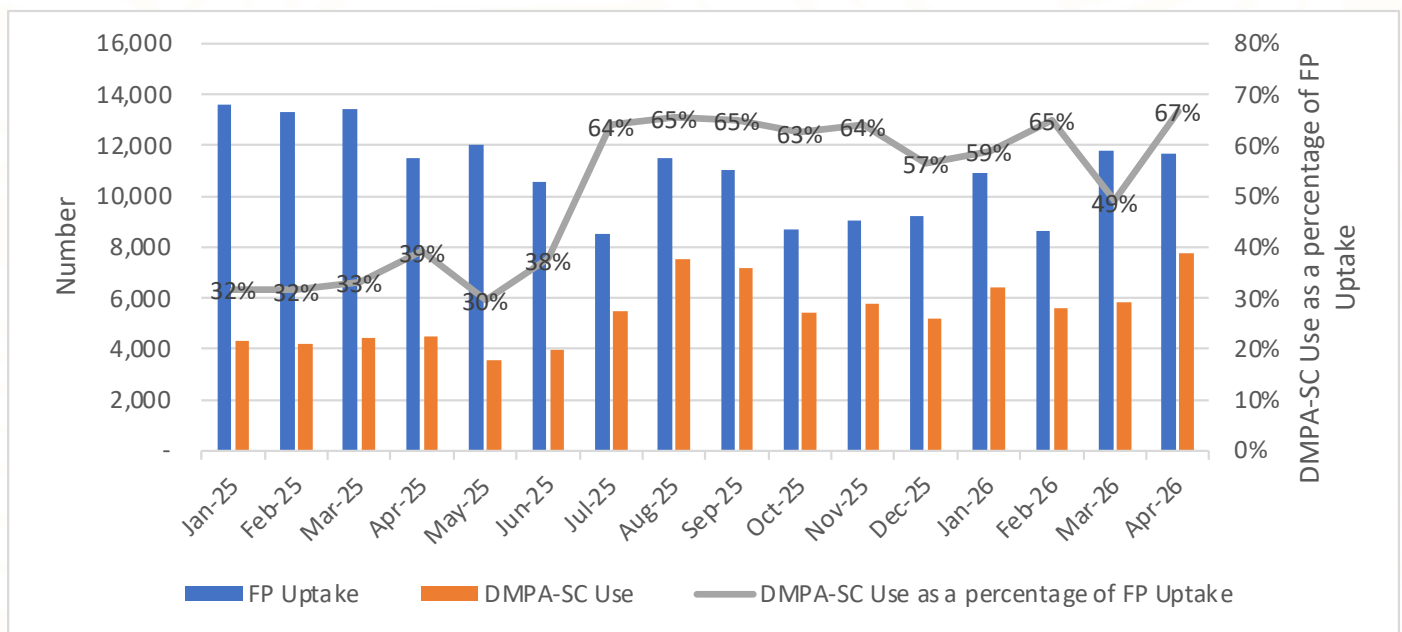
- **Expansion of Method Choice and Access:** The sharp increase in DMPA-SC share, particularly in Mayuge and Namutumba, indicates that the intervention successfully addressed supply-side barriers, allowing clients to access a method that was previously limited or inaccessible.
- **Latent Demand for Injectables:** The speed and magnitude of uptake suggest that client demand for DMPA-SC was already present but unmet, and that community-based delivery effectively unlocked this demand.
- **Shift Toward Client-Preferred Methods:** The dominance of DMPA-SC in the method mix (especially in Mayuge) implies that bringing services closer to communities enables greater alignment between service provision and client preferences, particularly for discreet, convenient methods.

- **Equity Gains Across Districts:** The convergence in DMPA-SC share between districts demonstrates reduced inequities in method availability, although Namutumba’s continued variability suggests ongoing differences in implementation intensity or system capacity.
- **Risk of Method Skew:** While increased uptake is a positive outcome, the high proportion of DMPA-SC (exceeding 70–80% in some months) highlights the need to monitor method mix balance to ensure informed choice and avoid over-reliance on a single method.
- **Implementation Sensitivity and Adaptation:** Fluctuations across months, particularly in Namutumba and Kamuli, point to the importance of consistent commodity supply, supportive supervision, and community engagement to stabilize gains.

The Community Distribution Project has had a transformative impact on the role of DMPA-SC within the FP method mix, shifting it from a marginal method in some districts to a leading contributor to FP uptake. The intervention not only increased overall access but also reshaped method utilization patterns, aligning service delivery more closely with client needs. Going forward, sustaining these gains will require continued investment in supply chains, community health systems, and method choice counseling to ensure both high uptake and balanced, rights-based family planning services.

FP Uptake Vs DMPA-SC Use

Figure 7: FP Uptake Vs DMPA-SC Use



The comparison between overall family planning (FP) uptake and DMPA-SC utilization demonstrates a significant shift in both contraceptive use patterns and method contribution following the commencement of the Community Distribution Project in July 2025. During the six months preceding project implementation, overall FP uptake remained relatively high but gradually declined from 13,614 clients in January 2025 to 10,572 clients in June 2025. Over the same period, DMPA-SC utilization remained moderate and relatively stable, fluctuating between 3,573 and 4,513 users. Consequently, DMPA-SC accounted for only 30–39% of total FP uptake during this period, indicating that although the method was available, it had not yet become a dominant contributor to the contraceptive method mix. This pattern reflects a predominantly facility-centered service delivery model where access to injectable contraception remained limited for many community members, particularly those in underserved and

Hard-to-reach areas.

Following the rollout of the Community Distribution Project in July 2025, a distinct shift was observed in both overall FP uptake patterns and DMPA-SC utilization. Overall FP uptake initially declined sharply from 10,572 clients in June to 8,545 in July 2025 during the implementation transition period. However, uptake subsequently recovered and stabilized, consistently ranging between approximately 8,600 and 11,800 clients through April 2026. In contrast, DMPA-SC utilization increased substantially immediately after implementation began, rising from 3,993 users in June 2025 to 5,466 in July, before peaking at 7,521 users in August 2025. Importantly, DMPA-SC uptake remained consistently high throughout the remainder of the implementation period, establishing a significantly higher utilization baseline compared to the pre-project period.

Most notably, the contribution of DMPA-SC to the overall FP method mix nearly doubled during project implementation. Whereas DMPA-SC contributed approximately 30–39% of total FP uptake prior to the intervention, its contribution increased to consistently above 60% during implementation, reaching as high as 67% by April 2026. This trend demonstrates that while total FP uptake showed only moderate fluctuations across the two periods, DMPA-SC utilization followed a clear and sustained upward trajectory following project implementation.

The findings strongly suggest that the Community Distribution Project significantly improved access to injectable contraception through community-based service delivery approaches. The sharp increase in DMPA-SC utilization despite only modest growth and stabilization in overall FP uptake indicates that the intervention not only expanded contraceptive access but also substantially shifted the contraceptive method mix toward DMPA-SC. This suggests that latent demand for injectable contraception already existed within communities and was unlocked once barriers related to distance, service availability, and community-level access were reduced.

The observed trends also highlight the resilience and adaptability of the supported health system during implementation transition. Despite the temporary decline in overall FP uptake observed in July 2025, service utilization quickly stabilized across the subsequent months, reflecting effective coordination between community structures, district health teams, and implementing partners. Furthermore, the sustained contribution of DMPA-SC at levels exceeding 60% of overall FP uptake demonstrates both improved accessibility and strong client preference for the method when made available at community level.

However, while the increasing dominance of DMPA-SC within the method mix reflects successful expansion of access to preferred contraceptive methods, it also underscores the importance of maintaining balanced family planning counseling and ensuring availability of a broad range of contraceptive options to support informed choice and prevent unintended method skew. Continued strengthening of commodity supply systems, supportive supervision, digital reporting mechanisms, and community engagement will therefore be critical to sustaining these gains and ensuring that increased access translates into comprehensive, equitable, and rights-based family planning services.

Overall, the data demonstrates that the Community Distribution Project had a transformative impact on DMPA-SC utilization, substantially increasing both its absolute uptake and its relative contribution within total FP uptake. The findings further confirm the effectiveness of community-based distribution approaches in expanding access to preferred contraceptive methods and strengthening responsiveness of reproductive health services to community needs.

LESSONS LEARNED



Community-based distribution significantly improves access

Bringing FP services closer to households increased uptake, particularly among underserved and hard-to-reach populations, confirming the effectiveness of door-to-door service delivery.



Latent demand for family planning exists

Rapid increases in DMPA-SC uptake following improved access indicate that low utilization was largely due to access barriers rather than lack of demand.



VHTs are central to last-mile service delivery

Village Health Teams played a critical role in service provision and community mobilization, but their performance depends on continuous mentorship, supervision, and reliable commodity supply.



Digital systems require continuous support

Improvements in eCHIS reporting were achieved through ongoing mentorship and supervision, highlighting the need for sustained capacity building and user support.



Data use strengthens accountability and performance

Routine review meetings and data use improved decision-making, commodity planning, and overall program responsiveness.



Community engagement is key to demand creation

Dialogue platforms were effective in addressing myths, improving awareness, and increasing acceptance of family planning services.



Improved access influences method choice

The rapid shift toward DMPA-SC demonstrates that clients adopt preferred methods when they become accessible.



Integrated approaches yield stronger results

Combining service delivery, digital systems strengthening, supervision, and community engagement was critical to achieving program outcomes.



Commodity availability is essential for continuity

Service delivery gains depend on consistent supply chains, as stockouts directly affect uptake.



Sustainability depends on system alignment and ownership

Embedding interventions within Ministry of Health structures and strengthening district ownership enhanced the potential for long-term sustainability.

CHALLENGES AND RECOMMENDATIONS

Key Challenges	Recommendations
Inconsistent commodity supply and weak last-mile distribution systems	Strengthen national and district-level supply chain systems, including integrated forecasting, timely redistribution, and linkage between eCHIS and commodity management data.
Uneven implementation and performance across districts	Scale up the model using a context-sensitive approach, ensuring tailored support for lower-performing districts and phased expansion strategies.
Risk of method skew toward DMPA-SC	Institutionalize balanced FP counseling and expand availability of a wider range of methods to ensure informed choice and method mix diversity.
Limited digital infrastructure and eCHIS functionality gaps	Invest in digital infrastructure (devices, connectivity) and strengthen system usability, while ensuring integration between eCHIS and HMIS/DHIS2.
Low and inconsistent eCHIS reporting compliance	Institutionalize routine mentorship, supervision, and performance feedback mechanisms to sustain reporting improvements.
Persistent socio-cultural barriers, myths, and low male involvement	Scale up community engagement strategies, including male involvement initiatives and targeted communication for adolescents and young people.
Limited data use for decision-making at sub-national levels	Strengthen data use culture through regular district review meetings, dashboards, and capacity building in data analysis and interpretation.
VHT support systems remain weak (motivation, supervision, logistics)	Formalize and resource VHT support structures, including incentives, supervision frameworks, and continuous capacity development.
Short-term disruptions during implementation transitions	Adopt structured change management approaches during scale-up, including stakeholder engagement, phased implementation, and continuous monitoring.
Dependence on project-driven support mechanisms	Strengthen government ownership and financing mechanisms to institutionalize interventions within routine health system operations.

SUSTAINABILITY

The project demonstrated strong potential for sustainability through integration within existing Ministry of Health systems and district health structures. Capacity strengthening of VHTs, CHEWs, facility staff, and district teams contributed to institutionalization of key implementation approaches.

Routine district review meetings, mentorship systems, and support supervision mechanisms established during implementation provide a foundation for continued performance monitoring and learning beyond the project period.

Notably, Kamuli district demonstrated innovation through integration of family planning services within chronic care clinics, expanding access points and reinforcing opportunities for service integration.

The project further demonstrated a scalable implementation model capable of informing national expansion of community-based family planning and self-care interventions, particularly in underserved and hard-to-reach settings.

CONCLUSION

The Community-Based Distribution Project demonstrated that integrated community-centered approaches can substantially improve access to family planning services, strengthen digital health reporting systems, and enhance district-level stewardship for reproductive health programming.

The significant increase in DMPA-SC uptake, particularly in districts where access had previously been limited, provides strong evidence that community-based delivery models can effectively address unmet need and expand equitable access to preferred contraceptive methods. At the same time, improvements in eCHIS reporting performance, routine data use, mentorship systems, and stakeholder coordination illustrate the broader systems-strengthening value of the intervention beyond commodity distribution alone.

Despite implementation challenges related to commodity security, digital infrastructure limitations, and variability in district performance, the intervention established a strong foundation for sustainability through alignment with Ministry of Health systems, strengthened district leadership, and institutionalized review and mentorship mechanisms.

Overall, the project presents a practical and scalable model for advancing Uganda's family planning, self-care, and community health agenda, with strong potential to inform national scale-up and policy direction.

APPENDICES

eCHIS Reporting by VHTs

Monthly Reporting by VHTs

District	# VHTs	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Mayuge	1,304	941	972	932	914	866	844	976	957	915	1,045	992	925	999	1,023	954	1,049
Namutumba	1,154	-	-	-	-	-	-	-	-	-	-	-	37	63	29	18	26
Kamuli	989	784	745	682	610	683	648	740	817	722	651	756	777	702	654	701	722

Monthly Reporting Rates by VHTs

Mayuge	72.2%	74.5%	71.5%	70.1%	66.4%	64.7%	74.8%	73.4%	70.2%	80.1%	76.1%	70.9%	78.5%	76.6%	78.5%	73.2%	80.4%
Namutumba	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	5.5%	2.5%	1.6%	2.3%
Kamuli	79.3%	75.3%	69.0%	61.7%	69.1%	65.5%	74.8%	82.6%	73.0%	65.8%	76.4%	78.6%	66.1%	71.0%	70.9%	70.9%	73.0%

District Reporting rates in eCHIS

Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Mayuge	72%	75%	71%	70%	66%	65%	75%	73%	70%	80%	76%	71%	77%	78%	73%	80%
Namutumba	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	5%	3%	2%	2%
Kamuli	79%	75%	69%	62%	69%	66%	75%	83%	73%	66%	76%	79%	71%	66%	71%	73%

FP Uptake Overtime																
Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Mayuge	3,749	4,414	3,666	3,120	2,996	2,757	3,584	5,423	4,011	3,720	3,557	3,514	2,943	2,979	3,974	3,145
Namutumba	2,047	2,148	3,698	1,363	1,795	1,606	1,703	1,785	2,339	1,732	1,676	2,083	1,769	2,113	2,989	2,089
Kamuli	7,818	6,739	6,058	7,042	7,253	6,209	3,258	4,292	4,677	3,249	3,818	3,602	6,201	3,546	4,854	6,422

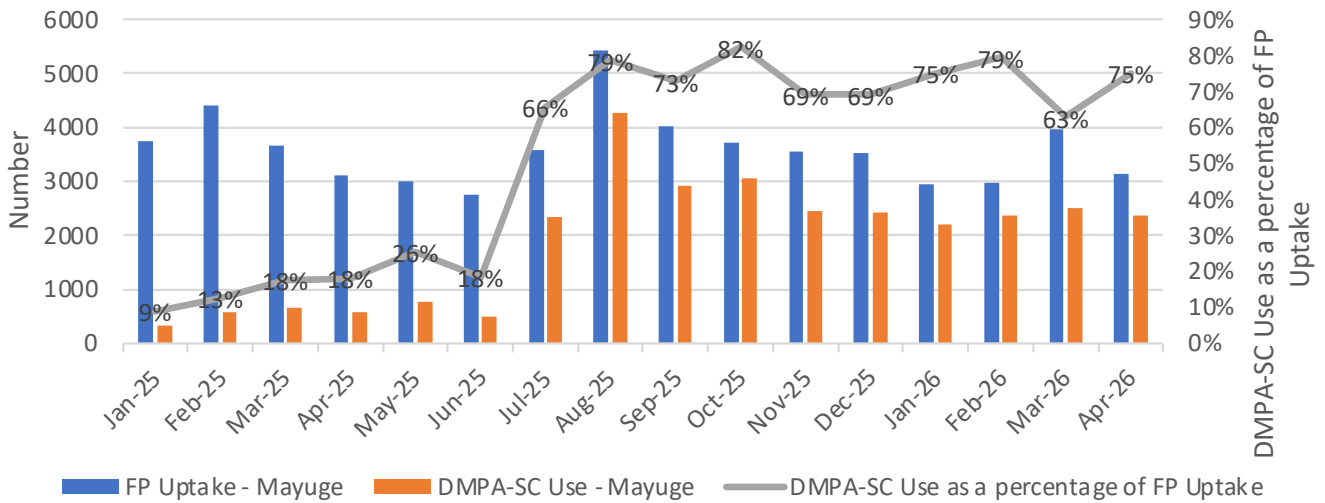
DMPA-SC Use Overtime																
Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Mayuge	334	564	648	566	765	507	2,353	4,266	2,922	3,062	2,461	2,428	2,212	2,367	2,496	2,359
Namutumba	55	198	21	1	1	16	466	409	940	476	579	798	333	493	448	747
Kamuli	3,924	3,444	3,782	3,946	2,807	3,470	2,647	2,846	3,315	1,910	2,760	1,977	3,876	2,758	2,865	4,684

DMPA-SC Use as a percentage of FP Uptake																
Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Mayuge	9%	13%	18%	18%	26%	18%	66%	79%	73%	82%	69%	69%	75%	79%	63%	75%
Namutumba	3%	9%	1%	0%	0%	1%	27%	23%	40%	27%	35%	38%	19%	23%	15%	36%
Kamuli	50%	51%	62%	56%	39%	56%	81%	66%	71%	59%	72%	55%	63%	78%	59%	73%

FP Uptake Vs DMPA-SC Use																
Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
FP Uptake	13,614	13,301	13,422	11,525	12,044	10,572	8,545	11,500	11,027	8,701	9,051	9,199	10,913	8,638	11,817	11,656
DMPA-SC Use	4,313	4,206	4,451	4,513	3,573	3,993	5,466	7,521	7,177	5,448	5,800	5,203	6,421	5,618	5,809	7,790
DMPA-SC Use as a percentage of FP Uptake	32%	32%	33%	39%	30%	38%	64%	65%	65%	63%	64%	57%	59%	65%	49%	67%

FP Uptake Vs DMPA-SC Use - Mayuge District																
Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
FP Uptake	3,749	4,414	3,666	3,120	2,996	2,757	3,584	5,423	4,011	3,720	3,557	3,514	2,943	2,979	3,974	3,145
DMPA-SC Use	334	564	648	566	765	507	2,353	4,266	2,922	3,062	2,461	2,428	2,212	2,367	2,496	2,359
DMPA-SC Use as a percentage of FP Uptake	9%	13%	18%	18%	26%	18%	66%	79%	73%	82%	69%	69%	75%	79%	63%	75%

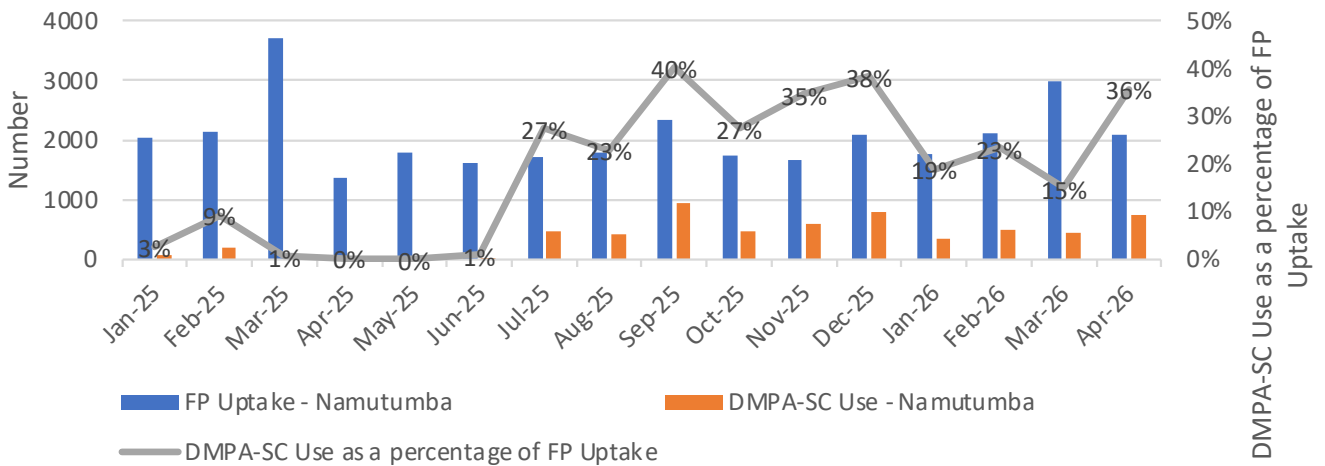
Trend Analysis for FP Uptake Vs DMPA-SC Use - Mayuge District



FP Uptake Vs DMPA-SC Use - Namutumba District

Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
FP Uptake	2,047	2,148	3,698	1,363	1,795	1,606	1,703	1,785	2,339	1,732	1,676	2,083	1,769	2,113	2,989	2,089
DMPA-SC Use	55	198	21	1	1	16	466	409	940	476	579	798	333	493	448	747
DMPA-SC Use as a percentage of FP Uptake	3%	9%	1%	0%	0%	1%	27%	23%	40%	27%	35%	38%	19%	23%	15%	36%

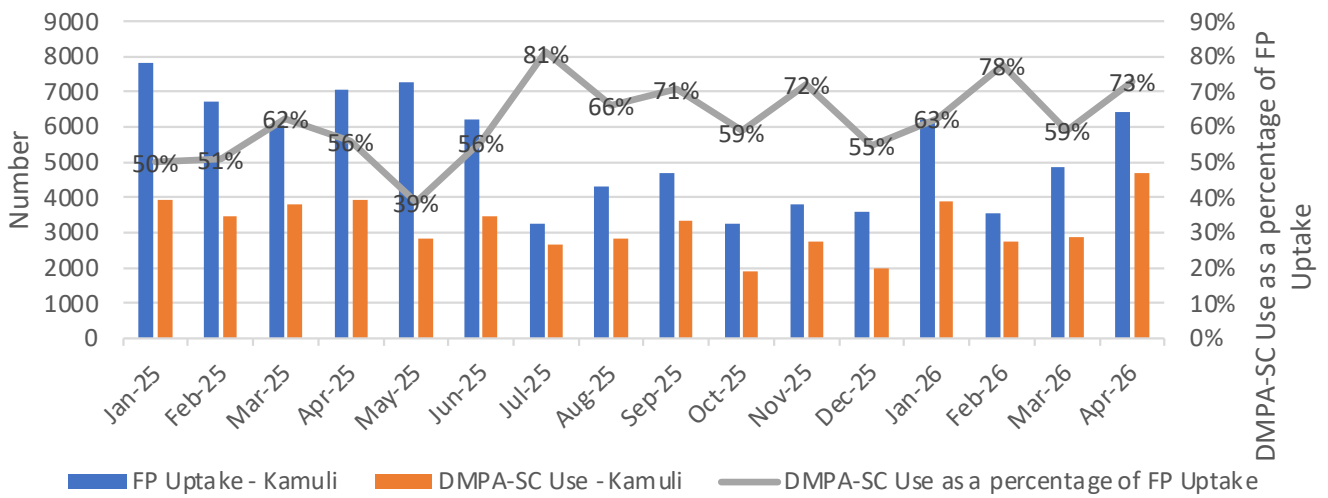
Trend Analysis for FP Uptake Vs DMPA-SC Use - Namutumba District



FP Uptake Vs DMPA-SC Use - Kamuli District

Month	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
FP Uptake	7,818	6,739	6,058	7,042	7,253	6,209	3,258	4,292	4,677	3,249	3,818	3,602	6,201	3,546	4,854	6,422
DMPA-SC Use	3,924	3,444	3,782	3,946	2,807	3,470	2,647	2,846	3,315	1,910	2,760	1,977	3,876	2,758	2,865	4,684
DMPA-SC Use as a percentage of FP Uptake	50%	51%	62%	56%	39%	56%	81%	66%	71%	59%	72%	55%	63%	78%	59%	73%

Trend Analysis for FP Uptake Vs DMPA-SC Use - Kamuli District



PICTORIALS

Community-Based Distribution of Family Planning Commodities (DMPA-SC) in Kamuli, Namutumba & Mayuge Districts.



CHEWS and VHT capacity building in session in Namutumba District



The ADHO-MCH for Kamuli District (Mr Moses Lyagoba) addressing participants for a community dialogue



Training for VHTs, CHEWS in Namutumba District



One of the District Quarterly Performance Review meeting in Kamuli District



One of the VHTs during a home visit in Namutumba District



Training of Health Assistants In Mayuge District.



Tekere Girl Child Empowerment (TEGEM)

Tororo District, Uganda.

Tel: +256 756 034 856

Email: info@tekeregirchildempowerment.org

www.tekeregirchildempowerment.org