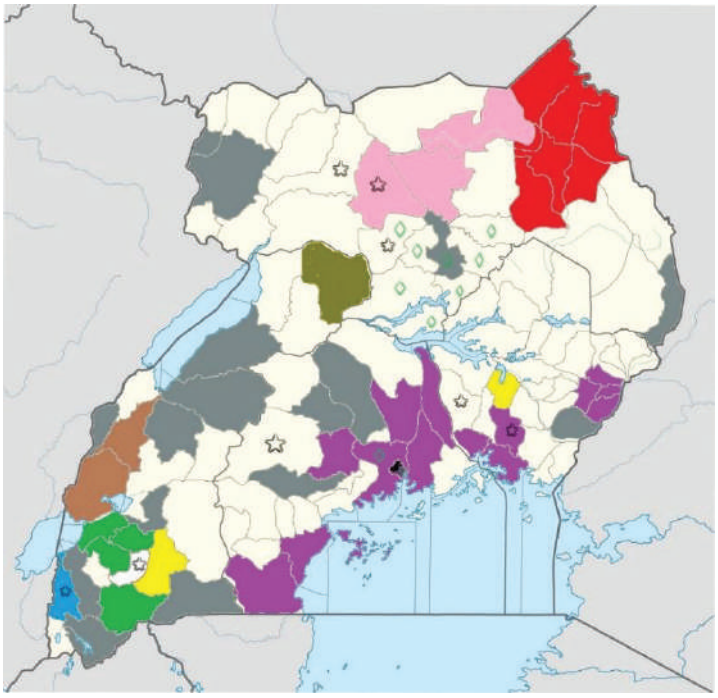
SOCIAL INNOVATION IN HEALTH INITIATIVE

UGANDA CASE COMPENDIUM 2026

CELEBRATING 10 YEARS

Social Innovation in Health, across Uganda



Key

- Amani Family Centre
- Action for Women and Awakening in Rural Environment
- Bwindi Mother's waiting Hostel
- Drug Shop Integrated Management of Childhood Illness
- Healthy Child Uganda
- Imaging the World Africa
- Kyaninga Child Development Centre
- Living Goods Uganda
- Community health and livelihoods enhancement groups
- Ishaka Health Plan
- My Pregnancy Handbook
- Opit Kic Widows Group
- Saving lives through community health insurance
- Social, Emotional, and Economic empowerment through Knowledge of Group Support Psychotherapy

Introduction

Universal health coverage (UHC) is a target of the sustainable development goal (SDG) 3, which aims to improve health by ensuring that all people receive quality health services that meet their needs without experiencing financial hardship. However, the achievement of UHC remains a challenge as half of the world's population, mostly from low- and middle-income countries (LMIC) fails to access essential health services, despite existence of proven treatments. To address inequities in health, we need to actively engage communities as the principal actors in their own health. Social innovation provides solutions to support this.

The Social Innovation in Health Initiative (SIHI) Uganda hub was launched in 2017 with the belief that health of all Ugandans can be enhanced by creative and innovative local solutions. The hub is part of the SIHI global network of partners advancing the understanding and application of social innovation in LMICs to address health care challenges. Launched in 2014, SIHI was developed with evidence that solutions to many health problems can emerge from communities in low-resource settings.

In 2026, we celebrate the achievements of the SIHI Uganda hub. Forty-two (42) social innovation health projects have so far been identified and research has been conducted to document the impact, enablers and scalable attributes. SIHI Uganda implements a fellowship training program which equips innovators with practical skills in effective project management, research, entrepreneurship, communication, fundraising and environmental impact assessment. Seven (7) annual national stakeholder workshops have been conducted to disseminate examples of social innovations in Uganda. Partnerships have been built with key ministries, grassroots innovators, and international collaborators.

This case compendium highlights the potential of social innovations to transform health care delivery in Uganda. Special thanks go to TDR, the Special Programme for Research and Training in Tropical Diseases co-sponsored by UNDP, UNICEF and the World Bank and the Swedish International Development Cooperation Agency (SIDA) which support the SIHI network and the SIHI Uganda hub.

What do we mean by social innovation in health?

Despite remarkable scientific and technological progress towards improving disease diagnosis, treatment, control and also the ambitious global health declarations, access to healthcare services is still a public health challenge. It is estimated that half of the world's population lacks access healthcare mostly from LMIC. In addition, around one billion people worldwide suffer catastrophic health expenditure exceeding 10% of household budget (WHO and The World Bank, 2020) and consequently, they are pushed into poverty.

Beyond the 'what' that gets developed to improve health, the 'how' of implementation remains an expert-driven, top-down approach, which fails to recognise community or frontline participation as a key feature of implementation (Walt & Gilson, 1994; Gillam, 2008; Penn-Kekana et al., 2004; Adam & de Savigny, 2012). As expressed by Herbert and Best (2011), "We need new ways of thinking and of working in order to accommodate the complexity of the challenges, and urgent need for, health system innovation and change."

Social innovation in health presents a lens or an approach that helps countries achieve sustainable, equitable and integrated people-centred health systems and health services

The intended outcome of social innovation is to enhance quality of life, justice and equity for all members of society (Mulgan, 2006; Pol & Ville, 2009). Thus, the social innovation approach could hold the potential to breathe fresh life into the 1978 Alma Ata ideals of equity, social justice and community participation in basic health care delivery (WHO, 1978; Walley et al., 2008) and support the achievement of Universal Health Coverage and the Sustainable Development Goals.

A solution that is not only tangible but also transformational

Social innovations are new services, products, financial models, behaviours and policies that are more inclusive, effective and sustainable than the status quo. The systems transforming dimension of social innovation sets it apart from more common forms of innovation. By challenging social practices, rules and social relationships, social innovation does more than just address a problem. It provides an alternative that changes and makes systems more resilient. Social innovations can be regarded as transformations in complex adaptive systems (Westely, 2011).

Social innovation as a process

The social innovation process embodies a bottom-up view of design and implementation that starts with the belief that all members of society are competent interpreters of their own lives and have the capacity to solve their own problems (Mulgan et al., 2007). This is evident by the fact that community or civil society actors are the creators of a significant number of social innovations (Nicholls & Murdock, 2012; van Niekerk & Bonnici, 2014). It starts with the perspective of the person or community for which the solution is being created and not only engages those affected by the challenge but equips and empowers them. This inclusive nature of social innovation leads to communities with enhanced capacity to act and take ownership of implemented solutions and their own health (TEPSIE, 2015).

SIHI NETWORK : IMPLEMENTING PARTNERS

SOCIAL INNOVATION IN HEALTH INITIATIVE

CELEBRATING 10 YEARS

13 SIHI hubs, supported by the ***SIHI Secretariat*** based in the Philippines.

SIHI hubs

SIHI Secretariat

Our journey towards advancing social innovation in health in low-and middle-income countries (LMICs), through research, capacity and advocacy

SIHI is a global network of diverse partners committed to advancing social innovation in health in LMICs through research to provide evidence on what works and what does not work, capacity strengthening and advocacy.

In 2014, the initiative emerged as a collaborative undertaking between the Special Programme for Research and Training in Tropical Diseases (TDR) co-sponsored by UNICEF, UNDP, the World Bank and WHO, the Bertha Centre for Social Innovation and Entrepreneurship at the University of Cape Town, the University of Oxford and the London School of Hygiene and Tropical Medicine. A driving focus of SIHI is to address the challenges that hinder the potential of social innovation to contribute to health care delivery and ensure no one is left behind. The two foundational premises upon which SIHI was established include:

a) Across LMICs, multiple creative solutions exist (that may not yet be known or researched) that have been developed by non-traditional actors and embedded within communities.

b) Research institutions are well positioned to convene all stakeholders in an inclusive manner, embed research in the process of social innovation and act as catalysts for social innovation to be institutionalized within national health systems, based on evidence demonstrating impact.

In 2017, SIHI expanded to include social innovation research hubs. These hubs are established at reputable universities for example in China, Colombia, Malawi, Uganda and the Philippines. In 2026 there are seventeen SIHI research hubs across the world. The work of these research institutions has been enabled through the contribution of multilateral agencies, foundations and other global networks.

Advancing social innovation in health has been made possible by SIHI's implementing partners, or institutions that organize and carry out SIHI activities in LMICs, and secondly, by SIHI's contributing partners, or collaborators that support the broader SIHI network and its activities.

10-YEAR ACHIEVEMENTS

30

(5 in 2023)
open calls to identify innovations

674

(48 in 2023)
social innovations identified

57

(5 in 2023)
research case studies

47

(5 in 2023)
case films

21

(5 in 2023)
research and training tools

95

(2 in 2023)
publications in international journals

THE SIHI UGANDA HUB

The SIHI Uganda was launched in 2017 and we are based at Makerere University School of Public Health (MakSPH). Our mission is to provide a one stop platform that links social innovators, policy makers, funders, researchers and communities, in order to support the use of community-based solutions for improving health outcomes. SIHI Uganda focuses on 3 areas of operation:

- **Research:** We identify, examine and disseminate examples of social innovation in health to increase awareness, generate consensus and encourage the use of these solutions
- **Capacity Building:** We enhance capacity for research and social innovation in health among stakeholders to improve the design, implementation and impact of health programmes
- **Advocacy:** We advocate for the scale-up and funding for social innovation projects

Identification and learning from social innovation in health in Uganda

As part of the global SIHI network, the Uganda hub regularly engages in a process to identify and study local community-based and citizen-led social innovations in health.

In 2015, the SIHI network conducted the its first round of identification and study in 15 countries including Uganda, resulting to the selection of 3 social innovations from Uganda. In 2017-18, the SIHI Uganda hub conducted a second round of identification in Uganda. This resulted in the identification of 3 top social innovation health projects.

From 2020 - 2026, five more national calls for social innovation in health examples were conducted. The focus of these calls included: sexual, reproductive health and rights, maternal and child health and nutrition. To date, nearly 50 strong examples of social innovation in health in Uganda have been identified, studied, and supported to improve health outcomes.

STEP 1: Crowdsourcing from the Public

To find and identify community-based and citizen-led social innovations, we adopted crowdsourcing as an approach. According to Babham et al (2014): "crowdsourcing is a distributed, problem-solving and production mechanism that uses the collective intelligence of networked communities and non-experts for specific purposes." Furthermore, crowdsourcing is a process where a group of individuals solve a problem and then share selected solutions with the public (WHO, 2018). Using crowdsourcing calls, we invite individuals and organisations from all backgrounds and sectors to share their innovative solutions. The open crowdsourcing calls are usually open for 6 - 8 weeks. Nominations are received via a dedicated online platform. Before and during the open call period, concentrated efforts are taken to promote and advertise the call via direct communication channels, online platforms, print media, radio and television.

STEP 2: Review & Selection

The SIHI Uganda hub appoints an independent panel comprised of experts to support the review of all submissions and to select projects that will qualify as social innovations. The panel reviews each nominated project against pre-defined criteria (see below). Each project is reviewed by at least two-experts. High scoring projects go through a second round of review to determine which cases could contribute significant learning to advance knowledge about social innovation in health and inform key national or global health priority areas.

Appropriateness of the solution to the need
The solution addresses a country health priority and a perceived need in the community.

Inclusiveness
The solution has the potential to enhance equity and access in health, especially for the most excluded or marginalised.

Scalable
Feasibility of the solution to be applied, replicated and scaled-up to other communities with similar problems.

Participation and Co-creation
Participatory approach is evident in the development, implementation, and evaluation of the solution (i.e. contributions from various stakeholders: the patients/families, local health personnel, local leaders.

Sustainable
The financial, organizational and market aspects of the solution are sustainable.

Degree of innovativeness
The solution presents a creative, unconventional or new approach as compared to the status quo.

Affordability
The solution is affordable to those excluded in the local context and presents a more cost-effective alternative as compared to the status quo.

Systems - change
The solution has the potential to effect change within the health or social system.

Effectiveness
The solution has the potential to achieve a positive outcome on the health of the local population AND / OR enhances the capacities of the local population.

STEP 3: Case Study Research – Site Visits & Data Collection

To better understanding how the selected innovations improve healthcare, we conduct research site visits to understand the context, actors, intervention and the organization. A descriptive and exploratory case study research approach is utilized.

Step 4: Case Study Research – Analysing Data to Find Insights

All collected data are de-identified and recorded interviews are transcribed and translated. The case framework guides the descriptive analysis. Full-length descriptive cases can be found at: https://socialinnovationinhealth.org/uganda

Following the compilation of individual cases, a cross-case analysis is undertaken guided by several questions:

- What are the key innovative components that have the potential to be replicated, transferred or scaled?
- How is this case strengthening health care delivery or health systems?
- What are the enablers and inhibitors that facilitated or hindered its implementation?
- How has the local environment responded to this case?
- What relevance does this case hold for national and global health priorities?

The findings from cross-case analyses are published in peer-review publications.

STEP 5: Promoting Social Innovation – Capacity Building, Learning Dissemination and Uptake

A final step in the SIHI identification and learning process is to disseminate the findings and promote the social innovations at global and country-level. This is done in four ways:

1. **Sharing and promoting** online via the SIHI website, newsletters & social media.
2. **Hosting convenings** where social innovators receive the opportunity to share their work such as a national stakeholder's workshop or global social innovation convening.
3. **Producing key peer reviewed publications on lessons and learning** e.g. 2017 TDR-WHO Publication (Social Innovation in Health: Case Studies and Lessons Learned from Low- and Middle-income Countries).
4. **Capacity building training session such as the Uganda social innovation in health fellowship program.**

DRUG SHOP INTEGRATED CARE, UGANDA

Leveraging local drug shops to improve delivery of quality services for malaria, pneumonia and diarrhoea in children

CHALLENGE

Every year over 30 million cases of malaria, pneumonia and diarrhoea in children go untreated in Uganda. Timely access to life-saving preventive and curative health services can reduce the morbidity and mortality due to these treatable infectious diseases. Further, over 50% of households access health care at the level of local drug shops, which vary in quality and ability to offer appropriate care.

INTERVENTION

The Drug Shop Integrated Care Programme aims to improve access to health care and the quality of health services at local drug shops by adapting the WHO/UNICEF strategy for integrated Community Case Management (iCCM) to standardize care. Through the programme, shop attendants are trained to recognize malaria, pneumonia and diarrhoea and then deliver the appropriate diagnostics and treatments that are affordable and accessible to families.

IMPACT ON HEALTH DELIVERY

Evaluation of the introduction of the iCCM strategy at drug shops in Uganda, using a quasi-experimental study, showed exponential improvement in quality of health care and access to care for children with common childhood illnesses, at both the drug shop level and population level.

- 88% of children with fever who accessed care at the intervention drug shops were correctly tested and treated for malaria. This compares with no children at the control drug shops receiving any diagnostic testing.
- The quality of diarrhoea management increased 13-fold, compared with control drug stores.
- The quality of respiratory illness management increased 3-fold, compared with control drug stores.

OPPORTUNITY FOR SCALE

The Drug Shop Integrated Care Programme started in 2 districts in 2011 and has expanded successfully to 20 districts. We are focused on expanding countrywide, to registered, nationally recognised drug shops with an existing mandate to sell over-the-counter medication. Existing medicine supply chains for the rural drug shops are also utilized, enabling greater sustainability for the programme, and supporting scaling efforts.

TOP 3 LESSONS

1. To increase programme sustainability, the Drug Shop Integrated Care Programme utilizes existing subsidized drugs and diagnostics, drug supply chains, and collaborates with an existing network of drug shops.
2. The ministry of health is involved in training and supervising the drug shop attendants, based on the WHO/UNICEF strategy for integrated Community Case Management (iCCM).
3. To improve access and quality of health care for children, it is necessary to update drug shop regulation and policy to allow utilisation of rapid diagnostic tests and antibiotics at drug shops, just as in the iCCM community health worker policy.

SELECTED PUBLICATIONS FROM THE PROJECT

1. Awor P, Gautham M, Peterson S (2018). Delivering child health interventions through the private sector in low and middle income settings: challenges, opportunities and potential next steps. British Medical Journal. BMJ2018;362:k2950
2. Awor P. (2016) Drug shops in integrated community case management of malaria, pneumonia and diarrhea in Uganda: Appropriateness of care and adherence to treatment guidelines. PhD Thesis. Bergen Open Research Archive
3. Awor P, Wamani H, Tylleskar T, Jagoe G, Peterson S (2014). Increased Access to Care and Appropriateness of Treatment at Private Sector Drug Shops with Integrated Management of Malaria, Pneumonia and Diarrhoea: A Quasi-Experimental Study in Uganda. PLoS ONE 9(12): e115440. doi:10.1371/journal.pone.0115440

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UPPSALA UNIVERSITY

MMV Medicines for Malaria Venture

UNIVERSITAS BERGENSIS

KAROLINSKA INSTITUTET

MAKERERE UNIVERSITY

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UGANDA KYANINGA CHILD DEVELOPMENT CENTRE

INTERVENTION

KCDC provides a holistic approach to care for children living with disabilities, and their families, in rural western Uganda. KCDC provides rehabilitative services including physiotheraphy, occupational therapy and speech therapy at a minimal or no cost to children. 70% of the services are delivered in the community - homes, schools or local health centres. Through training programmes and peer-support structures, parents are equipped with the skills and confidence to care for their child at home. Innovative funding mechanisms are adopted to contribute towards sustainability.

IMPACT ON HEALTH DELIVERY

Since KCDC began in 2014, 1041 CWDs have been reached with therapeutic and rehabilitative services. Additionally, 265 medical staff, 30 teachers, 50 community workers and 3500 caregivers have been sensitized on disabilities and trained to give the necessary therapeutic services. More than 425 pieces of specialist adaptive equipment have been provided to CWDs and 40% of school-age children registered with KCDC have been enrolled in school.

OPPORTUNITY FOR SCALE

As most rural families with CWD in Uganda do not have access to any physical or social rehabilitation services, there is need to scale up this approach country wide. However, to implement this solution nationwide requires an increase in the number of qualified rehabilitation therapists, including physiotherapists, occupational therapists and speech therapists who can also provide community-based therapy programmes.

CHALLENGE

In Uganda, more than 12% of children are living with disabilities; their families experience stigma, which discourages them from seeking health care. CWDs also have disproportionately unequal opportunities for other basic needs, for example only 9% of them are enrolled into primary school, compared to 90% of children without disabilities in Uganda.

KEY LESSONS

1. Stronger support systems that incorporate community involvement and community-based rehabilitation (as with KCDC) leads to better physical and psychological outcomes for children with disabilities and their families.
2. Training of health care providers in disability management throughout the entire health care system will contribute to better identification and management of children with disabilities, especially in rural areas.
3. There is need to debunk existing myths that associate disability with “curses”, which perpetuate stigma those with disabilities and their families. Sensitization at all levels is necessary.

KCDC aims at creating equal opportunities for children living with disabilities through utilizing a holistic approach that ensures multi-stakeholder engagement in the management and care of children with disabilities (CWDs).

Image credit: Rachel Hounsell, SIHI, Uganda, 2017

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UGANDA
BWINDI MOTHERS' WAITING HOSTEL

CHALLENGE

Every day, approximately 300 children and 20 women die in Uganda, especially around the time of delivery. Although well-established medical care exists to prevent these deaths, most women and children in remote and hard-to-reach areas cannot access this care. Many women thus suffer severe illness, including maternal and neonatal infections, obstetric fistula, and even death after giving birth in unsafe conditions.

The Mother's Waiting Hostel at Bwindi Community Hospital is a simple and affordable solution addressing the lack of access to skilled health care during delivery by women in remote settings in Uganda.

Image credit: Bwindi Community Hospital

INTERVENTION

Bwindi Mothers' Waiting Hostel identifies high-risk mothers living in hard-to-reach areas through the hospital's community nurse team, which regularly visits all villages in the catchment area, and through antenatal clinics. These women are then encouraged to come and stay in the hostel for up to a month before delivery, depending on the severity of their risk.

Daily monitoring of the mothers is done by midwives. If mothers have any concerns, midwives are available at any time for questions and counselling. Supervised deliveries, antenatal services, emergency obstetric care, and education services are provided to the mothers.

IMPACT ON HEALTH DELIVERY

From 2008 – 2017, the mothers' waiting hostel contributed to a fourfold increase in the utilization of delivery services at Bwindi Community Hospital; and a 10.5% increase in access to delivery services by mothers from the most remote areas like Mpungu sub-county. On average, 150 deliveries are conducted per month, of which 50% of the mothers utilize the waiting hostel. Birth-related complications have reduced among women utilizing the hostel. By accessing the hostel, women are able to access education, social support, and hope. Their babies are being born healthy and they return home with better knowledge about family planning, nutrition.

OPPORTUNITY FOR SCALE

Many remote areas in Uganda can also utilize the approach of a mothers' waiting hostel. After the success of this intervention at Bwindi Community Hospital, Kanungu Health Centre IV and Kisizi hospital have also started their own mothers' waiting hostels. The cost of maintaining the mothers waiting hostel is a small. Expectant mothers also make a little contribution to their stay at the hospital and this can be used for some operational costs.

KEY LESSONS

1. Maternity waiting homes for high-risk pregnant women in remote areas are recommended in national and global health policies, although they are rarestent in Uganda.
2. Maternity waiting homes can contribute to increasing institutional deliveries; reducing obstetric delays; and improving maternal and perinatal health outcomes in remote areas. A waiting home can be self-sustaining, utilizing existing health workforce small contributions from families.
3. The waiting home can also be a basis for health education for the mothers to improve the well-being of the new born children and families.

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ACTION FOR WOMEN & AWAKENING IN RURAL ENVIRONMENT

AWARE-Uganda aims at advancing the health, social, cultural and economic status of women in Karamoja through utilizing a holistic approach to empower women and advocate for their rights in the community.

Image credit: Lindi van Niekerk, SIHI, Uganda, 2017

CHALLENGE

Women in Karamoja disproportionately suffer from high levels of gender-based violence, with 81% of the victims being female; poor access to education, with 79.6% of the girls in Karamoja unable to attain at least a primary leaving education certificate; unemployment; poor financial services; limited access to health care; and a lower voice in decision-making compared to men.

INTERVENTION

AWARE is utilising a holistic approach to improve the health and wellbeing of women and girls in Karamoja through social, cultural, and economic empowerment. Women are equipped with agricultural and business skills, they are sensitized on their rights, and in addition men are being engaged in advocating for women's rights. AWARE has established a multi-purpose women's centre, which has a maternity waiting house where expectant mothers who normally live far away from health facilities can receive health care services and life skills training as they await the time of delivery.

IMPACT ON HEALTH DELIVERY

Approximately 5000 women have been engaged in agricultural production, which this improves their livelihoods. Over 50 girls have been rescued from gender-based violence (GBV). The 20-beds maternity waiting house at AWARE centre is the only one of its kind in the Karamoja region. Since the inception waiting house, over 400 pregnant women have delivered with the help of a skilled birth attendant, which would otherwise not have been the case.

OPPORTUNITY FOR SCALE

This solution has the potential to be scaled in circumstances where there are high rates of gender-based violence, poverty, low-literacy, lack of access to health care, and where communities are willing to offer voluntary services.

KEY LESSONS

1. This case illustrates that to contribute to effective social change, a holistic approach that focuses on solving the needs of the community and ensures their full participation is valuable. The health of a community can be improved through integrating the provision of social services.
2. Past programme beneficiaries can become active providers of services to new beneficiaries and can help address issues around gender-based violence.
3. Working with all community members, including men and children, is integral to this programmes' success.

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UGANDA IMAGING THE WORLD, AFRICA

Imaging the world aims to address the lack of access to diagnostic imaging services, especially in rural areas.

Image credit: Imaging the World, Africa

CHALLENGE

Most rural pregnant mothers cannot access obstetric imaging service in Uganda, due to the insufficient number of radiologists, and sonographers within the health system. In addition patients often have to travel long distances to access such service at public hospitals; or pay the high costs at urban private clinics.

INTERVENTION

Imaging the World, Africa trains registered nurses and midwives working in rural health facilities to be competent in performing antenatal ultrasound scans. Through new technology, the scans can be uploaded electronically and sent via a cellular data network to radiologists abroad to aid with real time interpretation.

IMPACT ON HEALTH DELIVERY

Over 200,000 ultra sound scans have been conducted in the past 6 years with a 70% increase in prenatal visits at participating health centres. 23% of obstetric scans have identified pregnancy complications, which have resulted in women seeking specialized care that they may otherwise have not received. There is a continuous increase in access to the diagnostic service mainly due to its aspects of low cost and proximity; and this has made people more responsive to seeking diagnostic care for their health.

OPPORTUNITY FOR SCALE

The intervention was initially in one health centre in Nawanyago, Kamuli district, Eastern Uganda. It has since been implemented in eight other health centres in Western and South Western Uganda including Kanungu, Sheema, and Mubende. Plans are underway to extend the services to the Northern region.

KEY LESSONS

1. Task shifting can create a sustainable and effective way to deliver ultra sound services to low resource settings. Trained midwives can conduct the ultra sound, which reduces the cost of hiring a sonographer in a low-resource setting.
2. Affordable ultra sound services can be provided in rural areas and at a cost that the users are able and willing to pay, these later become self-sustaining in the area.
3. Integration of e-health in low-resource settings is feasible and provides an opportunity to improve quality of care in these areas.

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UGANDA

HEALTHY CHILD UGANDA, MAMATOTO APPROACH

Healthy Child Uganda's MamaToto Approach is a district-led programme that operationalizes the national community health worker strategy to promote quality maternal, new-born and child health.

Image credit: Ilia Horsburgh

CHALLENGE

Maternal and child mortality remain very high in Uganda, with 368 maternal death per 100,000 live births and 64 child deaths per 1000 live births occurring annually (UBoS 2016). However, the majority of these deaths can be prevented using proven preventive interventions and early treatment of illnesses. Due to severe shortage of health workers, innovative community-level interventions which provide primary health care, need to be scaled up.

INTERVENTION

MamaToto is a district-led programme that operationalizes the Village Health Team (VHT) strategy, and includes health system strengthening, to promote quality maternal, new-born and child health (MNCH) practices. These include antenatal care (ANC), postnatal care (PNC), safe deliveries and proper sanitation in the community. The district leaders develop, implement and monitor their own MNCH priorities in partnership with a network of community health volunteers who conduct home visits, assess and refer patients, provide health education, and mobilize communities to participate in health activities. The MamaToto approach is uniquely characterized by a seven-step process namely: SCAN, ORIENT, PLAN, EQUIP, TRAIN, ACT and REFLECT (SOPETAR), with defined key activities at the district, health facility and community level.

IMPACT ON HEALTH DELIVERY

In one district (Bushenyi), a total of 1,669 community health workers were trained to work in all 563 villages, with retention of 96% after two years. There was also: i) decreased morbidity [presumed pneumonia (-4%), diarrhoea (-7%), underweight status (-3%)] ii) improved household health practices [Vitamin A (+12%), deworming (+20%), and measles vaccine (+10%)] and iii) improved care-seeking practices [antibiotics for pneumonia (+17%); ANC 4+ (+13%), postnatal care <48 hours (+43%), met need for contraception (+15%)].

OPPORTUNITY FOR SCALE

The experiences and results of the MamaToto approach have contributed to streamlining community health worker programs in East Africa including in Tanzania (Mwanza), where the MamaToto model is currently being replicated. A MamaToto health leaders' course has been finalized and is offered by the Maternal, New-born and Child Health Institute at Mbarara University.

KEY LESSONS

1. Healthy Child Uganda's MamaToto approach offers an effective, replicable community health worker engagement package that is suitable for implementation by districts and that can be sustainable through integration into the existing health system structures.
2. A network of effective VHTs can be successfully trained, supervised and retained to address MNCH challenges in their respective communities.
3. Implementing the SOPETAR processes can contribute to increased interaction between the district level, health facilities and the community, which generates multiple feedback loops that are critical for effective implementation of programs.

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OPIT KIC WIDOWS GROUP

OPWIG's Care Group approach enhances social behavior change, nutrition knowledge, and health-seeking behaviors among Kiryandongo's refugees and host communities

CHALLENGE

Uganda is the largest refugee hosting country in Africa, with nearly 1.5 million refugees. There is a high prevalence of malnutrition, poor health seeking behaviour, gender-based violence, violence against children and mental health problems among refugees and internally displaced people in settlements in Uganda

APPROACH

Opit kic widows group (OPWIG) implements a community care group approach to foster positive social & behaviour change among refugee and host communities in Kiryandongo district. With minimal support provided to the volunteers, they are able provide community health education to refugees and host communities.

IMPACT

OPWIG trained 402 volunteers, who in turn disseminate health information to over 6,030 households, leading to better nutrition knowledge, enhanced health-seeking behavior, early case identification, and positive cultural practices.

KEY LESSONS

- Empowering community members as agents of change fosters acceptance and ownership of the approach.
- Peer-to-peer communication is a powerful tool for influencing behavior change within communities.
- The Care Group approach can be integrated into the existing health system for sustained impact.

OPPORTUNITY FOR SCALE

Scaling may be considered where local organizations are willing to support and implement the care group approach; and where there are available and willing volunteers.

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ISHAKA HEALTH PLAN

Community Based Health Insurance

Facilitates access to quality and affordable healthcare services to communities in Bushenyi district, Uganda

CHALLENGE

Despite implementation of health reforms to improve access and affordability of health services in Uganda, out-of-pocket payment for health remaines high - estimated at 50%. Additionally, about 30% of the patients suffer catastrophic health expenditure of more than 10% of their estimated annual expenses and over 70% of these sell property or borrow money to pay for health services. This undermines the efforts towards Universal Health Coverage.

INTERVENTION

Ishaka Health Plan (IHP) is a community-based health insurance scheme which facilitates access to quality and affordable health services to its members through risk pooling. IHP enrols existing burial groups, schools and tertiary institutions into the scheme. To empower its members to be able pay premium, income generating activities such as agriculture and formation of saving groups are supported.

IMPACT

The scheme has over 5,000 members. Over 4,000 people access health services annually. This includes infectious diseases care, cancer care, surgery and other health services. The IHP scheme has been in existence for the last 10 years.

OPPORTUNITY FOR SCALE

Involving scheme members in the premium price setting and improving their income through agricultural trainings ensures that they can pay for their health insurance. For scaling up, it is important to work with pre-existing community groups and self-motivated staff including volunteers.

TOP 3 LESSONS

1. Engaging scheme members in income generating activities facilitates premium payment and consequently improves retention in the scheme.
2. Having strong collaborations with service providers who offer quality health services enhances trust in the scheme.
3. Over 60% of members in pre-existing groups should show commitment and enrol into the scheme. This prevents adverse selection.

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MY PREGNANCY HANDBOOK

A handbook that provides user friendly and trusted health information on pregnancy to mothers and the general public

CHALLENGE

In Uganda, majority (50-90%) of pregnant women attending antenatal care clinics (ANC) do not receive sufficient information related to pregnancy and less than 15 minutes are allocated to health education at ANC clinics. This is explained by the limited staffing of only 40% of the required health workers, coupled with a large number of mothers at ANC clinics. Information given to mothers during ANC visits determines their ability to identify danger signs in pregnancy and respond appropriately.

INTERVENTION

"My pregnancy handbook" is a user friendly portable short handbook that has been prepared to deliver authentic health information concerning pregnancy to pregnant mothers, midwives and the general population. The book covers: preconception care as a key step to pregnancy preparedness, pregnancy and antenatal care, danger signs in pregnancy and labour preparation. The information is adequate for mothers to learn about their pregnancy.

IMPACT

Currently over 300 copies are in circulation and mothers can access additional health information concerning pregnancy at their convenience. The handbook has been adopted by clinics in Kampala and Gulu districts.

OPPORTUNITY FOR SCALE

The project team has plans for scaling up the project at a national level through:

- Partnership with the ministry of health to ensure distribution of the handbook in public health facilities.
- Translating the book into major local languages in Uganda.

TOP LESSONS

1. Access to health education by pregnant women outside the ANC clinic is important for improving maternal and child health outcomes.
2. There is need to design health educational materials in local languages to reach out to a larger population
3. The handbook was reviewed by multi-disciplinary experts from the Ministry of Health and Makerere University College of Health Services who ensured quality of the content.

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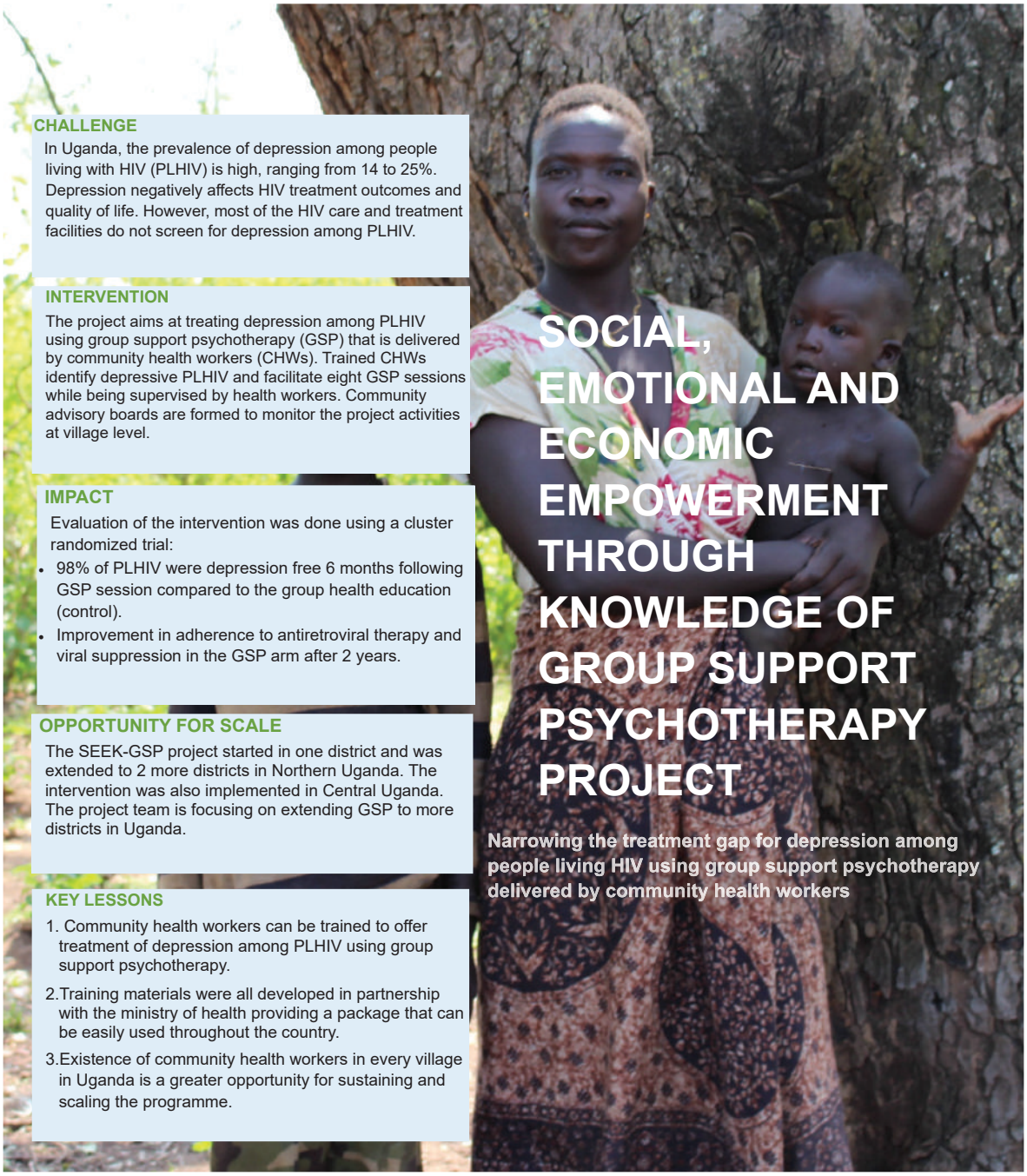

CHALLENGE

In Uganda, the prevalence of depression among people living with HIV (PLHIV) is high, ranging from 14 to 25%. Depression negatively affects HIV treatment outcomes and quality of life. However, most of the HIV care and treatment facilities do not screen for depression among PLHIV.

INTERVENTION

The project aims at treating depression among PLHIV using group support psychotherapy (GSP) that is delivered by community health workers (CHWs). Trained CHWs identify depressive PLHIV and facilitate eight GSP sessions while being supervised by health workers. Community advisory boards are formed to monitor the project activities at village level.

IMPACT

Evaluation of the intervention was done using a cluster randomized trial:

- 98% of PLHIV were depression free 6 months following GSP session compared to the group health education (control).
- Improvement in adherence to antiretroviral therapy and viral suppression in the GSP arm after 2 years.

OPPORTUNITY FOR SCALE

The SEEK-GSP project started in one district and was extended to 2 more districts in Northern Uganda. The intervention was also implemented in Central Uganda. The project team is focusing on extending GSP to more districts in Uganda.

KEY LESSONS

1. Community health workers can be trained to offer treatment of depression among PLHIV using group support psychotherapy.
2. Training materials were all developed in partnership with the ministry of health providing a package that can be easily used throughout the country.
3. Existence of community health workers in every village in Uganda is a greater opportunity for sustaining and scaling the programme.

SOCIAL, EMOTIONAL AND ECONOMIC EMPOWERMENT THROUGH KNOWLEDGE OF GROUP SUPPORT PSYCHOTHERAPY PROJECT

Narrowing the treatment gap for depression among people living HIV using group support psychotherapy delivered by community health workers

SELECTED PUBLICATIONS

1. Nakimuli-Mpungu, E., Musisi, S., Wamala, K., Okello, J., Ndyanabangi, S., Birungi, J., Nanfuka, M., Etukoit, M., Mayora, C., Ssengooba, F., 2020. Effectiveness and cost-effectiveness of group support psychotherapy delivered by trained lay health workers for depression treatment among people with HIV in Uganda: a cluster-randomised trial. Lancet Glob. Health 8, e387–e398.
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ACKNOWLEDGEMENT

Funding from Grand Challenges Canada and the MQ Mental Health Fellowship Award

AMANI FAMILY CENTRE

Provides free, compassionate, dignified, and evidence-based maternity care to mothers in slum communities in Uganda

CHALLENGE

Maternal and child mortality remain high in Uganda, with 189 maternal deaths per 100,000 live births and 36 deaths per 1000 live births respectively. Women in poor urban settings are more likely to lose their babies compared to those in rural areas.

APPROACH

Amani Family Centre (AFC) is a non-profit birth center providing free maternal and child healthcare services to a slum community in Kampala. AFC prioritizes building strong relationships with mothers and the community, offering social support and referral assistance to higher-level facilities. AFC also supports victims of gender-based violence.

IMPACT

Since 2017, over 2,000 mothers have delivered at AFC, and no maternal or neonatal death has been reported. Additionally, about 70% of mothers attended at least six antenatal care visits.

KEY LESSONS

1. A strong midwife-mother relationship is crucial for better pregnancy outcomes.
2. Partnering with high-level health facilities addresses medical capability gaps at AFC.
3. Engaging local leaders and beneficiaries promotes community ownership, and collective responsibility for maternal health.

OPPORTUNITY FOR SCALE

- Many more women in slums in Kampala can benefit from similar projects.
- Building robust partnerships with local stakeholders, organizations, and health facilities is a key scaling and sustainability.

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HEALTHY AND EMPOWERED FOR REPRODUCTIVE HEALTH OUTCOMES (HEROES) PROJECT

Overall Objective:

All young people and women in the nine high burden districts of Uganda fully enjoy their sexual and reproductive health & rights and live in a gender-equal society free from SGBV

Challenge:

Contraceptive use among adolescents and young adults is one of the most cost effective strategies to address many sexual and reproductive health (SRH) challenges including unintended pregnancies, early marriages and sexually transmitted infections. However, uptake and unmet needs of modern contraceptives remain low in Uganda especially among adolescent girls. The 2016 demographic health survey found that 25% of adolescent girls aged 15-19 years in Uganda had begun childbearing yet only 10% of reported using contraceptives (UBOS 2016).

Intervention:

Amref delivers an integrated sexual health program geared towards equipping adolescent girls aged 15-19 years with information and services through adolescent and youth friendly service points at different levels to aid uptake of contraceptives. The program is implemented in Budaka district, Eastern Uganda, in partnership with the district local government, health facilities as well as beneficiary communities and schools.

Impact on health delivery:

By June 2022, 7,646 adolescent girls had accessed family planning services. The program also empowered adolescents to deliver accurate family planning information to peers.

We have surpassed targets for number of people reached through curriculum based learning except for Men Engage (ME).

There is a significant increase in the number of FP users and as a result, teenage pregnancy rates have reduced by 4% as of end of FY 2022/2023

Key Lessons Learnt

Strengthening community and health facility linkages and referral mechanisms enhances utilization of SRHR services across the supported sub counties.

Use of peers at the adolescent and youth friendly service provision point (Adolescents and youth friendly corners) facilitates relationship building between health facility thus enhancing increased accessibility and consequently utilization of SRHR services.

Opportunity for scale:

-Curriculum based learning to enhance social behavioral change

-Differentiated service delivery model where Adolescents and youth friendly corners are strengthened for increased SRHR service uptake by adolescents

-Multi sector collaboration enhances adequate resources mobilization and appropriate response to identified gaps within the adolescent SRHR service delivery.

-Digitalization of the curriculum based learning for adolescents through mobile app

COMMUNITY HEALTH AND LIVELIHOODS ENHANCEMENT GROUPS (CHLEG)

CHLEG aims to improve the health, socio-economic status, and overall well-being of Female Sex Workers in Uganda

CHALLENGE

In Uganda, sex workers face a disproportionately high HIV prevalence of 35%, driven by criminalizing laws, discrimination, and stigma. Economic hardship forces them to prioritize income over health, deepening their vulnerability and perpetuating a cycle of poverty and heightened HIV risk.

INTERVENTION

Community Health and Livelihoods Enhancement Groups (CHLEG), an intervention by the Alliance of Women Advocating for Change (AWAC), provides client-centered, community-led safe spaces for female sex workers (FSWs) in Uganda. These hotspot-based safe spaces address social, health, and economic vulnerabilities. CHLEG members (15–30 per group) receive healthcare, mental health support, economic empowerment, and social protection. Eligibility requires willingness to save, engage in discussions, and support peers, fostering a strong, supportive community.

IMPACT ON HEALTHCARE DELIVERY

To date, AWAC has established 57 CHLEGS across Uganda. In 2023, 4,021 FSWs and AGYW in sex work settings were enrolled on PrEP , and 724 FSWs and AGYW were initiated and retained on ART. 78 clients were re-engaged in ART care, and 788 for PrEP. Counseling services were provided to 988 FSWs experiencing violence, while 28 FSWs with disabilities were trained in sign language and health rights. Emergency contraception services were provided to 288 FSWs.

OPPORTUNITY FOR SCALE

AWAC's CHLEG model has reached 57 districts across Uganda. Scale-up requires integrating with existing health services, and enhancing referral systems. Strengthening partnerships with local authorities, NGOs, and the private sector, developing digital tools, and building the capacity of CHLEG coordinators will ensure sustainability and greater outreach, reaching more FSWs and improving health outcomes.

KEY LESSONS

- Integrating health services with economic empowerment effectively addresses the complex needs of FSWs, improving their overall well-being.
- The CHLEG model demonstrates that community-led interventions empower FSWs to take ownership of their health and economic resilience.
- CHLEGs have reduced stigma and discrimination by providing safe spaces for FSWs to access services, organize, and advocate for their rights.

BABY UBUNTU PROGRAMME

CHALLENGE

6% of children are born with a disability in Uganda. In Nakasongola district , about 2% of the total population have some form of disability (UFDs 2017), including cerebral palsy, physical disability, hearing and visual impairment, spina bifida, cleft lip and palate. There are particularly limited resources for children with cognitive disability, and families often feel isolated from their communities with little to no support that is appropriate for the unique needs of these children.

INTERVENTION:

The program uses participatory learning to build the capacity of caregivers of children with cerebral palsy to use local materials to conduct physiotherapy sessions. In so doing, knowledge and practical skills in positioning, feeding, play, and communication with children with disabilities are built, while communities and affected families explore the understanding of disability and stigma in the process.

IMPACT ON HEALTH DELIVERY:

Up to 100 children with cerebral palsy have shown significant improvement in motor skills, to the delight of their caregivers. The program has also improved community and family attitudes towards children with disabilities. The caregivers' knowledge and skills to care for their child has also improved. One parent remarked; "*the training helped me understand and the thoughts of abandoning my child ceased and my life improved. I no longer feel stressed and sad*."

KEY LESSONS:

1. Need to increase stakeholder engagement - especially at District and government level.
2. Sustainability: maintaining knowledge and skills of caretakers through mentorship and refresher training is important.
3. Need to develop a Monitoring Evaluation and Learning (MEL) strategy to assess impact.
4. Need to develop tablet application for the modules.

OPPOTURNITY FOR SCALE:

Many rural communities and families in Uganda struggle with children with cognitive and physical disability. This cost-effective intervention can therefore be scaled up considering that health workers (including VHTs) are readily available and willing to adopt the skills to support children with cerebral palsy.

Mission:

Early care and support for young children with developmental disabilities to improve their quality of life and their families

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BAITOMBWE COMMUNITY HEALTH INITIATIVE (BACHI)

CHALLENGE:

Masaka region has the highest prevalence of HIV in Uganda at 8.1%. The prevalence is even high in the fishing communities characterised by major financial disparities and gender-based violence. Family conflicts in these communities are a source of sexual and physical violence against women and girls in Uganda, yet HIV transmission among unstable families is high. In addition, high levels of stigma and discrimination affect access to HIV prevention, care and treatment for such individuals.

INTERVENTION:

BACHI builds local capacity of women leaders to prevent and respond to conflict that affect women and adolescent girls. BACHI also improves linkage between the community and district structures responsible for providing services of gender-based violence to victims including legal and health services. The solution also ensures increased participation of the district leadership in conflict prevention processes and response.

BACHI's mission is to enhance community well-being by providing quality medical care, preventive services, and socio-economic support.

IMPACT ON HEALTH DELIVERY:

Since the project began, a total of 1548 individuals (547 male and 990 female) have been reached with messages on conflict prevention, and 1,154 (868 female and 588 male) on HIV prevention, care, and treatment. 392 (177 male and 215 female) conflict survivors have accessed appropriate services through mediation and law enforcement. 121 individuals (26 male and 95 female) have accessed HIV prevention and treatment services through referrals. Overall, there is increased demand for conflict resolution and HIV services in the intervention community.

KEY LESSONS:

1. Engaging diverse stakeholders in project implementation streamlines their tasks and ensures access to necessary resources and support for effective project execution.
2. Collaborating with local structures and entities fosters a sense of ownership and value among community members to drive meaningful change within their communities.
3. Empowering village women leadership enhances accessibility to and influence in effectively preventing and managing family conflicts.
1. Develop mobile application for the modules

OPPORTUNITY FOR SCALE:

- Development and delivery of standardized training modules for local structures to enable replication in diverse geographical areas.
- Implementing a capacity-building initiative targeting local leaders to enhance their leadership capabilities in addressing GBV issues.

CHANGE DEVELOPMENT INITIATIVES: PARENTING FOR RESPECTABILITY (PFR) PROGRAM

Promotes access to quality health and education services, food security and nutrition, economic empowerment and protection of human rights.

CHALLENGE:

Uganda has an exceptionally high rate of GBV with 56% of married women between the ages of 15-39 having experienced some form of GBV (DFID, 2021). Police reports in Luweero district indicate a high violence against women/ girls (VAW/G) prevalence. GBV is aggravated by poor parenting and spousal relationships, and is common where there are chronic diseases like HIV/AIDS and TB.

APPROACH:

The Parenting for Respectability (PfR) programme is an innovative 5-module training that aims at improving family health relations and preventing violence against children, women and girls. The modules, which are delivered within a period of 4 months, include bonding and attachment, discipline, gender, spousal relations as well as men's involvement in parenting. The solution addresses the negative gender norms and harmful practices in families including child marriages, defilement, teenage pregnancies and child battering among others. It also addresses mental and social well-being and emphasizes good health.

IMPACT:

16 Community Based Facilitators (CBFs) were trained on PfR; 30 parenting groups were formed and 878 members receive weekly parenting sessions to improve parenting skills and family relationships. 30 saving groups constituting 618 parents were formed to participate in weekly savings and lending. This has improved their family incomes. 1,178 adolescents were trained in life skills, reporting gender based violence and setting and achieving goals. 16 teachers were trained as protagonists to create a safe and good school environment for children.

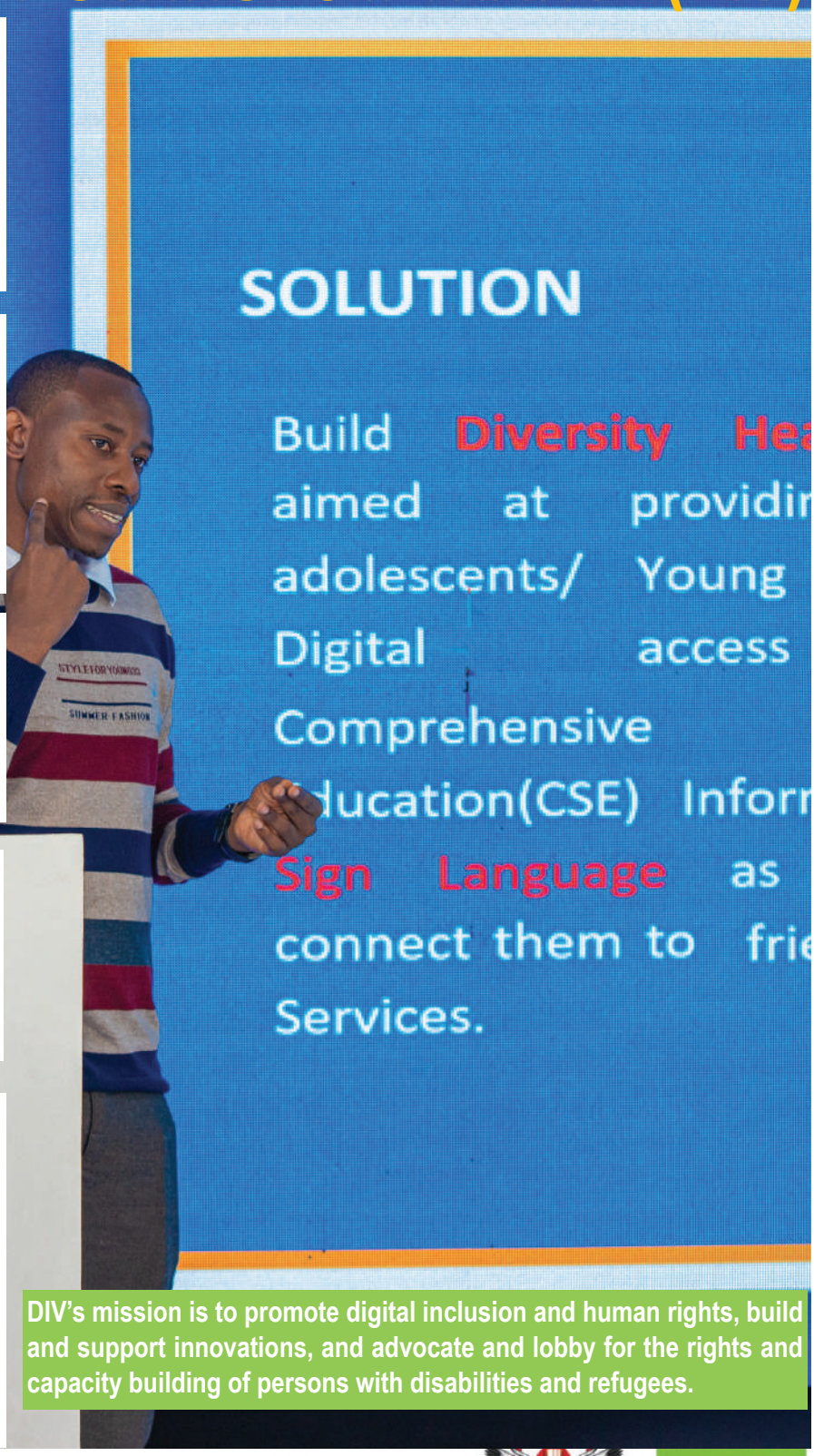
KEY LESSONS LEARNT

1. Addressing GBV requires interdisciplinary collaboration across various sectors, including healthcare, law enforcement, social services, and education.
2. Systems should focus on prevention and early identification of victims GBV and VAW/G.
3. Understanding the impact of trauma is essential for providing effective care to survivors of violence.
4. Partnering with local community organizations and advocacy groups can enhance the reach and impact of prevention efforts of GBV.

OPPORTUNITY FOR SCALE:

With violence against women and children prevalent in the whole country, the PfR program may be replicated or scaled up to the rest of the country.

DISABILITY INNOVATIONS INITIATIVE (DIV)



CHALLENGE:

Persons with disabilities constitute 12.4% of Uganda's total population. According to UBOS 2014 data, there are more than 1,083,649 deaf people in the country. These are often vulnerable, and their Sexual Reproductive Health Rights are violated and neglected, despite existence of a legal framework like the Persons with Disabilities Act 2020, to address their peculiar needs. They face limited access to deaf-friendly/ accessible health care SRH information and services.

INTERVENTION:

Our Digital solution provides young deaf people with access to Comprehensive Sexuality Education (CSE) information in Sign language and links them to deaf-friendly SRH and mental health counseling Services. The mobile app works by enabling access to accurate and easy to understand health content delivered in Sign Language. Users can also reach out to trained health workers/ peer educators with questions or seek clarity using an inbuilt video call feature.

IMPACT ON HEALTH DELIVERY:

With this intervention, 5 Digital learning Videos on SRHR developed and disseminated via DIV YouTube channel which has reached 1,738 users. Additionally, 190 Health workers have been equipped with Sign Language Skills for inclusive Service Delivery. There is therefore improved access to and usage of deaf friendly SRHR information and services, as a result.

Opportunity for scale:

With increasing technological advancement, young deaf persons all over the country can benefit from this innovative solution. This could be through development of a mobile phone application and popularizing it among the deaf community. With the app, deaf young people can have unlimited access to deaf-friendly SRH information and linkage to services.

Key lessons:

1. PWDs have equal SRHR needs but continue to face barriers to accessibility of services and information.
2. Health workers' commitment to serve PWDs is constrained by systemic challenges of disability inclusion and hence the need for capacity building programs for health workers
3. Availability of deaf friendly SRHR information improves awareness which amplifies PWD's demand and utilization of available SRHR Services.
4. Addressing existing health inequalities calls for more inclusive approaches

DIV's mission is to promote digital inclusion and human rights, build and support innovations, and advocate and lobby for the rights and capacity building of persons with disabilities and refugees.

LUCKY GIRL SANITARY PADS

Lucky Girl Sanitary Pads aims to combat period poverty in Uganda, especially among women and girls in rural areas, by producing and distributing affordable, eco-friendly, high-quality disposable sanitary pads

CHALLENGE

In Uganda, 60% of women and girls struggle to meet their menstrual health needs, with 70% of adolescent girls citing it as a barrier to education. Lack of sanitary supplies among girls leads them to miss 3–4 school days monthly, impacting academics, self-esteem, dropout rates, and engagement in productive activities.

INTERVENTION

Lucky Girl Sanitary Pads, a social enterprise established by Volunteer Action Network, combats period poverty in Uganda by producing and distributing affordable, eco-friendly, high-quality disposable sanitary pads. It empowers women and girls through improved access to menstrual hygiene products and menstrual health education in schools and communities, promoting education, gender equality, and sustainable environmental practices.

IMPACT

Since 2017, Lucky Girl Sanitary Pads has distributed 4.9 million disposable pads, supporting 2,520 girls across 24 schools in Gulu, Amuru, Omoro, and Nwoya districts. The enterprise has conducted 8,739 menstrual hygiene education sessions, reaching 11,234 girls, 6,560 boys, teachers, and parents/caregivers. This has improved access to quality pads, reduced menstruation-related infections, and raised awareness on menstrual health.

KEY LESSONS

- Community engagement is essential for enhancing program reach and ensuring that products are tailored to local needs.
- Affordability and accessibility must be prioritized to ensure wide-reaching impact, especially in rural areas.
- Education and awareness programs play a critical role in empowering girls and reducing menstrual-related stigma.

OPPORTUNITY FOR SCALE

Lucky Girl Sanitary Pads has successfully expanded its impact in Uganda, with its products now available in local markets across Northern Uganda and beyond. Scaling requires increased investment, expanded production capacity, and the construction of a high-capacity factory capable of producing over 500,000 pads per month. Strengthening partnerships with local organizations, government, and schools, along with integrating national health and education programs, will enable the enterprise to meet growing demand, create jobs, and foster long-term health and economic empowerment across Uganda and beyond.

COMMUNITY-BASED COMMUNICATION ON IDENTIFYING DANGER SIGNS DURING PREGNANCY FOR ADOLESCENT GIRLS

The social innovation project empowers adolescent girls in Nansana Municipality, Wakiso District with knowledge about pregnancy risks, enabling informed health decisions, reducing unintended pregnancies, and preventing complications and deaths related to pregnancy

CHALLENGE

Adolescents face increased risks during pregnancy and childbirth, including higher rates of pregnancy-related deaths (WHO, 2016). In Uganda, Wakiso district has one of the highest teenage pregnancy rates, with 10,439 cases reported in 2021 (UNFPA). Limited knowledge, along with inadequate access to and utilization of health services, exacerbates this issue.

INTERVENTION

Newlife Adolescent and Youth Organization (NAYO) trains community health workers (VHTs) on recognizing danger signs during pregnancy using approved VHT training manuals. These trained VHTs conduct home visits to educate adolescent pregnant girls on identifying danger signs and attending antenatal care. Girls also receive health information via SMS and social media. Community dialogues are conducted to raise awareness about pregnancy-related danger signs, and the project facilitates referrals to health facilities.

IMPACT

The project has trained 30 adolescent pregnant girls to identify danger signs during pregnancy and understand the importance of antenatal care. Six community meetings were held, improving awareness and attitudes about pregnancy risks among community members. There has been a 50% increase in knowledge of danger signs among adolescent girls, and VHTs have achieved a 60% referral rate of adolescent girls to youth-friendly services at health facilities.

OPPORTUNITY FOR SCALE

Increased home visits can help identify more adolescent pregnant girls with danger signs. Leveraging technology, such as mobile apps and online platforms, can provide reliable health information. Collaborating with local organizations, the government, and international bodies will enhance outreach and ensure sustainable, nationwide impact on adolescent health.

KEY LESSONS

- Community health education programs are crucial in providing accurate, age-appropriate sexual and reproductive health information to empower adolescents in making informed decisions and reducing pregnancy risks.
- Early intervention by addressing pregnancy risks and offering timely medical and emotional support leads to better health outcomes for adolescent girls.
- Youth-friendly services are essential in ensuring healthcare systems provide accessible, confidential, and non-judgmental care so adolescents feel comfortable seeking help.

COMMUNITY CENTERED DEVELOPMENT PROGRAM

Enhancing monitoring skills of Lower-local Government Leaders and Citizen's civic space to improve the quality of healthcare services at Health Center IIIs

CHALLENGE

Limited monitoring of public health services by lower-level government (LLG) leaders has led to persistent accountability gaps including health worker absenteeism, late arrivals, bribery, and the diversion of medical supplies. Local politicians have the potential to address these gaps by actively overseeing service provision at government health centers.

INTERVENTION

Progressive Health Partnership (PHP) implemented the Community-Centered Development Project to address institutional constraints affecting quality healthcare delivery. The intervention involved two key governance strategies: (a) quarterly accountability meetings between citizens and local council 3 (LC3) chairpersons to address health service delivery challenges and (b) a health leadership program for LC3 chairpersons to equip them with skills to effectively monitor local government health centers.

IMPACT ON HEALTHCARE DELIVERY

The Community Centered Development Program (CCDP) project improved healthcare governance and service delivery. Over 80% of LC3 leaders participated in training, enhancing their oversight skills. Citizen-LC3 meetings engaged 19.7% of households. Community members gained a better understanding of their health rights, advocated for improved services, and observed positive changes, including reduced absenteeism, increased drug availability, and more respectful care from providers.

OPPORTUNITY FOR SCALE

Scaling the project could take place in underserved rural and urban settings where governance gaps hinder delivery of quality healthcare services. Enhancing LC3 leaders' monitoring skills improves the functionality of the health facilities thus improving the quality of health services.

KEY LESSONS

- Increasing civic engagement at the local level strengthens community participation in monitoring healthcare services.
- Capacity building equips LC3 chairpersons with the skills to effectively oversee public health facilities and address governance gaps.
- Bottom-up community approaches are essential in addressing healthcare challenges.

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PROVIDING OPPORTUNITIES FOR WOMEN IN ENTREPRENEURSHIP AND REPRODUCTIVE HEALTH (POWER)

POWER is a Young Women Social Entrepreneurship Accelerator Program that nurtures and empowers women to lead, innovate, and build sustainable startups in SRHR/FP

CHALLENGE

Young Ugandans, especially women of reproductive age, face unmet family planning needs currently at 22%, limited entrepreneurship skills, and barriers to healthcare access due to poverty, stigma, distant services, affordability issues, and supply chain disruptions, particularly in essential commodities like modern contraceptives.

INTERVENTION

Action 4 Health Uganda implements POWER, a 3–6-month accelerator program for young women entrepreneurs (18–35 years) in family planning and sexual and reproductive health rights (SRHR). The program includes five core interventions: 1) onboarding to enhance entrepreneurial skills and develop SRHR innovations; 2) graduation, launch, and alumni network setup; 3) access to finance for women-led startups; 4) tailored mentorship and coaching; and 5) project replication with access to markets and incubation services.

IMPACT ON HEALTHCARE DELIVERY

Since 2022, 10,725 young people in 12 districts in Uganda accessed SRH/FP services through 32 women-led startups in family planning and ICT for health. These startups generated revenue of UGX 1.2 billion from services and product sales and private sector investment for SRH, creating 96 jobs and employing 5-8 youths each. Their decentralized approach improved community healthcare access for SRH service in Uganda.

OPPORTUNITY FOR SCALE

The POWER model has been successfully replicated in Tanzania (Dar es Salaam and Arusha) to improve youth access to SRH/FP services. Scaling requires multi-sectoral partnerships, investment financing, tailored mentorship, and integration with youth empowerment programs. The model can benefit Uganda and other high-need countries to strengthen healthcare access, create employment, and support women-led startups in FP/SRHR, fostering both economic empowerment and social impact.

KEY LESSONS

1) Women-led innovations in SRH/FP and ICT promote sustainable solutions, enhance accessibility, and support gender-inclusive growth.
2) Integrated approaches combining entrepreneurship, advocacy, and decentralized services improve healthcare access and address systemic barriers.
3) Multi sectoral partnerships with local stakeholders ensure tailored solutions, sustainable growth, and scalability across Uganda's districts.

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INNOVATING FOR EPILEPSY AWARENESS AND STIGMA REDUCTION

The social innovation project aims to reduce epilepsy-related stigma in Masaka District and improve healthcare-seeking behavior among affected individuals

CHALLENGE

Epilepsy affects an estimated 8–10 per 1,000 people in Uganda, with higher prevalence among children aged 0–5 years. Those living with epilepsy often face stigma and discrimination, limiting their access to healthcare, education, and employment. Reducing stigma is crucial to improving healthcare access and ensuring better outcomes for individuals with epilepsy.

IMPACT

The project has increased epilepsy awareness and community support. It has reached 28 schools, educated 2,300 learners and teachers, and conducted 21 community engagement sessions with 1,102 participants. Additionally, 370 caregivers and community health workers have been trained, along with 398 refugees in Nakivale Refugee Settlement.

INTERVENTION

The Purple Bench Initiative is implementing a social innovation project to reduce epilepsy-related stigma and improve health outcomes in Masaka District. The project engages local leaders, parents, and teachers through community dialogues to dispel myths and misconceptions. School awareness campaigns educate learners and teachers to create epilepsy-friendly environments, while storytelling and media amplify voices and share success stories. Safe spaces are established to provide psychosocial support, and promote inclusion for people with epilepsy and other neurological disorders.

KEY LESSONS

- Effecting positive behavior and attitude change regarding stigma requires a concerted, intersectoral effort from all parties.
- The visibility and active participation of people with epilepsy in stigma reduction efforts is crucial, as it yields positive results through their human stories and experiences.
- Stigma manifests in various forms, and each type may require a tailored approach for effective reduction.

OPPORTUNITY FOR SCALE

Scaling the intervention can be achieved through:

- Partnerships with communities, people with epilepsy, and their caregivers to support implementation.
- Developing epilepsy-friendly materials for schools and workplaces will further broaden reach.
- Strengthening partnerships with healthcare institutions and policymakers to enhance integration into existing systems.

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SANITATION, HYGIENE AND INVESTMENTS FOR THE ENVIRONMENT (SHINE)

Challenge:

Water, Hygiene and Sanitation (WASH) related diseases are among the major causes of death in children under five years of age in Uganda. Majority of the children die from diarrhoeal diseases linked to poor hygiene . Uganda's statistics indicate that not only indicate that 36% of Ugandans wash their hands with soap after visiting the latrine (UBOS 2018) and but also only 28 % of Ugandans have access to hand washing facilities.

Intervention:

The program empowers communities through our trained WASH champions. Groups of 10 people are formed and trained in WASH basic practices (behavioural change); after which SHINE enhances access to clean water by supporting installation of water harvesting technologies (1000 litre tank) to the selected households. We also provide households with fruit and wood trees, ensure construction of tippy taps, provide piggery/poultry projects as well as involve both youth, men and women in self-help groups (VSLAs) to ensure sustainability.

Impact on health delivery:

Since inception, SHINE project has reached to over 846 people from 140 households as direct beneficiaries and 4,200 students from 12 schools. Beneficiary communities now demonstrate improved WASH knowledge, attitudes and practices. There is improved coverage of sanitation and hygiene facilities in 60 households and 3 schools, increased access to clean and safe drinking water to over 1000 people, reduced waterborne diseases and associated costs associated as well as improved safety and productive time for women and girls.

Opportunity for scale:

- Promoting nature-based solutions like using energy saving stoves, planting of trees and permaculture to improve environment conservation.
- Partnership with local communities (cost share) in implementation.
- Distribution of rainwater harvesting tanks to increase access to clean and safe water in other water stressed areas.

Overall Project Objective:

To increase access to safe water, sanitation, and hygiene (WASH) among water stressed sub counties of Kibaale district

Key lessons:

1. Community engagement ensures ownership resulting to involvement in the planning, implementation, and evaluation stages which leads to better uptake and sustainability of health intervention.
2. Strengthening the capacity of WASH champions and community members ensures the long-term success and sustainability of health interventions.
3. Partnerships and Collaboration with local governments and community stakeholders promotes resource mobilization and fosters a sense of ownership and shared responsibility for better outcomes.

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SOLE HOPE

Sole Hope aims to eradicate jiggers and improve the quality of life of marginalized communities

CHALLENGE

In Uganda, 2.4 million people are infected with tungiasis (jiggers) with half from Eastern Uganda. Contributing factors include poor health-seeking behavior, inadequate sanitation, poverty, prolonged dry seasons, and fear of stigmatization. These factors exacerbate the neglect and lack of treatment, leaving communities vulnerable to severe health, social, and economic consequences.

IMPACT

Since its inception in 2010, Sole Hope has treated 96,702 jigger patients and removed 1,478,782 jiggers. Follow-up care showed that 80% of patients remained jigger-free following initial treatment, attributed to positive hygiene practices promoted through community health education. Over 163,954 jean shoes were distributed to affected communities as a preventive measure against jiggers infestation.

INTERVENTION

Sole Hope's approach in addressing jiggers revolves around four pillars: Support, Treat, Empower, and Prevent (STEP). The program include Community Outreach Mobile Clinics, Partner Clinics in government health facilities, the Hope Centre (a specialized residential treatment facility), and a shoe workshop that produces and distributes jean shoes as a preventive measure.

OPPORTUNITY FOR SCALE

Sole Hope's approach to jigger eradication has expanded from Uganda's Busoga and Bugisu regions to Kenya and Rwanda. The model's adaptability to diverse contexts makes it scalable across Uganda and Sub-Saharan Africa as a whole. Scaling requires partnerships, investment, local capacity building, and infrastructure support to empower communities to combat jigger infestations.

KEY LESSONS

- Jiggers infestation is often linked to mental and other health conditions, highlighting the need for integrated treatment approaches.
- Expanding Partner Clinics and Self-Help Groups to more districts and countries improves access, strengthens health systems, and promotes economic empowerment.
- Addressing misconceptions about jiggers, alongside tackling underlying issues like poverty and hygiene is key to achieving sustainable prevention and long-term impact.

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TWEYAMBE EMERGENCY SERVICES

Tweyambe Emergency Services provides free basic pre-hospital care and ambulance transportation to the medically disadvantaged and those in need

CHALLENGE

According to the 2019/2020 Annual Health Sector Performance Report, 123 Ugandans die daily due to delayed access to healthcare facilities. Contributing factors include delayed patient transportation, poorly equipped ambulances, untrained emergency crews, and delays in triaging patients. Strengthening pre-hospital care and emergency response is critical to reducing mortality rates.

INTERVENTION

Tweyambe Emergency Services (TES) is addressing the urgent need for pre-hospital care in Kawempe Division by providing free ambulance services, first-aid, and medical outreach programs. With trained staff, TES ensures timely emergency response and patient transport while also strengthening community health through education, counseling, and capacity-building for responders.

IMPACT

In the past three years, Tweyambe Emergency Services received and responded to a total of 1,948 calls through its dispatch center. Of these, 1,301 were related to obstetrics/ gynecology and neonatal emergencies, 187 involved road traffic or trauma accidents, and 460 were other medical emergencies.

OPPORTUNITY FOR SCALE

TES has expanded its services beyond Kawempe Division to other areas in Kampala. Scaling requires:

- Partnerships with health facilities and community organizations to enhance service reach.
- Training programs for emergency responders and community members strengthens capacity and preparedness.
- Increased investment in ambulances, medical equipment, and trained personnel is essential to improve emergency response.

KEY LESSONS

- Building trust with the community is vital for effective emergency response.
- Continuous training strengthens responders' skills and confidence, leading to better emergency care.
- Partnering with healthcare providers enhances service delivery and reach.

Kolonyi Hospital Community Health Financing scheme (CHI)

CHALLENGE

In Mbale, low-income households struggle to afford healthcare, leading to self-medication and delayed treatment, which results in catastrophic spending. In 2016, 15.3% of Uganda's population faced out-of-pocket payments exceeding 10% of their budgets, forcing families to sacrifice basic needs, sell assets, or borrow money, ultimately causing complications or death for those without means.

INTERVENTION

Kolonyi Hospital CHI scheme is a non-profit initiative providing affordable health insurance for low-income households, reducing out-of-pocket costs for acute conditions. Community groups of over 20 families pool savings to share healthcare expenses, focusing on vulnerable rural populations.

IMPACT ON HEALTH DELIVERY

In 2025:

- 1,511 members subscribed; 502 used OPD services, and 261 were inpatients.
- 65.8% sought early healthcare, with all pregnant mothers attending ANC visits.
- 412 children received successful treatment.

Enrolled patients averaged 5 healthcare visits annually, showing increased usage.

OPPORTUNITIES FOR SCALE

- Create tailored benefit packages for specific health needs, like chronic conditions.
- Implement digital payment methods.
- Expand the scheme to include government health facilities and other private hospitals.

To provide quality, affordable healthcare to 10,000+ vulnerable people, reducing out-of-pocket payments and improving overall well-being in the rural areas of Eastern Uganda

KEY LESSONS

1. Enrollment is driven by trust in Kolonyi Hospital's quality and is boosted by low premiums, copayments, and community involvement in premium setting.
2. Sustainability relies on timely care-seeking by enrolled clients to preserve pooled funds.
3. Challenges include the high consumption risk posed by high-risk groups willingly enrolling and the low buy-in from poor households.

Image Credit: Salem Kolonyi Hospital

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SOCIAL INNOVATION IN HEALTH INITIATIVE

VaxTrack Community

Achieve 95% immunization coverage for all routine and new vaccines by 2030, focusing on high-risk, underserved populations in the Eastern region to reduce morbidity and mortality from vaccine-preventable diseases across all age groups.

Image Credit:Mbale Area Federation of Communities[MAFOC]

CHALLENGE

Uganda is experiencing a high number of zero-dose (ZD) and under-immunised (UI) children, with about 329,359 zero-dose children reported in 2023. However, inadequate and delayed reporting of individual data from various digital platforms results in significant discrepancies in ZD and UI estimates.

INTERVENTION

MAFOC created Vax Track Community, a digital tool to monitor zero-dose and under-immunised children in real-time using authorised MoH defaulter tracking data. This solution is more efficient and user-friendly than traditional hard copy registers. Community Health Extension Workers (CHEWs) receive tablets to track eligible children, with villages assigned to each CHEW for accountability. MAFOC staff conduct weekly support follow-ups with volunteers.

IMPACT ON HEALTH DELIVERY

Between April and December 2025, 11,585 children were connected to immunisation services:

- 1,942 received their first vaccinations.
- 9,643 caught up on missed shots.
- Vaccination coverage increased by 80%.

Districts improved their underperforming classifications, with notable changes such as Busia moving from 4 to 2 and Sironko from 2 to 1.

OPPORTUNITIES FOR SCALE

- Implement the solution in new districts in the Eastern region.
- Organise regional and national dialogues on the Vax-Track community's role in immunisation.
- Facilitate exchange learning on digital platforms nationwide for improvement.

KEY LESSONS

1. User-friendly digital solutions lessen administrative burdens and provide more consistent, accurate real-time tracking of defaulters compared to traditional methods.
2. Addressing the zero-dose burden needs a shift from aggregate DHIS2 data to individualized digital tracking.
3. The intervention showed that underperforming districts can rapidly improve.

FACES PROJECT

Enhance equitable healthcare access for Deaf individuals by improving communication between health workers and Deaf patients through Uganda Sign Language training and digital support tools.

CHALLENGE

Deaf individuals in Uganda encounter significant healthcare access barriers due to communication issues. The National Population and Housing Census 2024 reports around 44,381 Deaf individuals and 287,045 hard of hearing. Regions like Busoga (7%) and Bugisu (7%) have high hearing difficulty rates. However, most healthcare workers lack Uganda Sign Language (UgSL) skills, resulting in miscommunication, poor service quality, and low healthcare utilization among Deaf patients.

INTERVENTION

FACES introduced UgSL training for healthcare workers (HCWs) to enhance communication with Deaf patients. Collaborating with the Uganda National Association of the Deaf and local associations, Deaf instructors conducted training sessions, equipping healthcare workers with basic UgSL skills and Deaf-friendly communication practices. Additionally, the Deaf Assist App was launched to facilitate communication in healthcare, and engagement with District Health Offices.

IMPACT ON HEALTH DELIVERY

Improved communication between HCWs and Deaf patients in supported facilities enhanced understanding, confidentiality, and trust. Over 40 HCWs were trained in UgSL, benefiting around 200 Deaf patients. The inclusion of 8 trained Deaf instructors bolstered local capacity. Consequently, facilities reported better patient-provider interactions and increased HCW confidence.

OPPORTUNITIES FOR SCALE

The model is scalable as it integrates training into current health systems, develops local Deaf trainers, and aligns with Ministry of Health structures. A digital tool enhances adaptability, and with government support, FACES can be included in nationwide health worker training.

KEY LESSONS

1. Training health workers in basic sign language enhances trust and service uptake more sustainably than relying only on interpreters.
2. Engaging Deaf community members as trainers fosters ownership and lowers costs, while digital tools support rather than replace human-centred communication skills.
3. Government engagement at the district level is crucial for sustainability and institutionalization.

TESO WOMEN'S INITIATIVE

Advancing Access to Subcutaneous Depot Medroxyprogesterone Acetate (DMPA-SC) contraceptive injection through the private sector

CHALLENGE

Ngora district in Eastern Uganda continues to grapple with high unintended pregnancies, total fertility rates of 6.3 children/woman, contraceptive prevalence rate of only 35%, and teenage pregnancy rate of 29%. Generally, Ngora is 90% rural, and has limited access to family planning (FP) services, evidenced by unmet need of 47%.

INTERVENTION

The district enhances family planning (FP) uptake by collaborating with licensed private healthcare providers to distribute DMPA-SC to underserved women and girls. Women are trained to self-inject DMPA-SC at home, demonstrating that it is easy and safe to use. This initiative supports the goal of ensuring universal access to sexual and reproductive healthcare services by 2030.

IMPACT ON HEALTH DELIVERY

Ten private healthcare providers have trained 6,203 women of reproductive age on DMPA-SC, with 144 now able to self-inject at home. This community-based method has improved access to family planning (FP) services and empowered women to make health decisions, leading to increased appreciation of this method among those not currently using any FP.

OPPORTUNITIES FOR SCALE

- Provide training for additional Private Health Care providers.
- this intervention foster coordination and collaboration with partners who support Reproductive Health Programs.

KEY LESSONS

1. The private sector is a missed opportunity for expanding access to family planning methods
2. With adequate sensitization, self-injection among WRA is very possible

BUSOGA HEALTH FORUM (BHF)

Image credit: Busoga Health Forum

CHALLENGE

The absence of an accessible, equitable platform for building health workers' knowledge and skills particularly around guidelines and policies undermines quality care delivery. In Uganda, physical trainings are neither cost-effective nor sustainable given the country's 146 districts and over 6,900 facilities. This challenge is underscored by a 2021 Ministry of Health audit, which revealed that less than 40% of frontline health workers were aware of the over 25 new guidelines issued between 2020 and 2024.

INTERVENTION

Since 2021, Busoga Health Forum has delivered consistent weekly specialist-led Zoom Continous Medical Education (CME) sessions every Friday from 8–9 PM. The sessions are accredited by national professional councils and award Continous Professional Developmet (CPD) points for license renewal.

Experts from referral and teaching hospitals share practical, guideline-aligned content with frontline nurses, midwives, clinical officers, and doctors nationwide.

Expanding access to sustainable, community-led, continuous medical education for frontline health workers through consistent weekly webinars.

OPPORTUNITIES FOR SCALE

The next phase involves transitioning to a structured, self-paced digital learning hub that archives accredited sessions, integrates assessments, and expands flexible access. This will improve retention, allow asynchronous participation, and institutionalize continuous learning beyond live webinars.

IMPACT ON HEALTH DELIVERY

In 2025 alone, 50 sessions reached 7,317 participants nationwide, promoting safer, evidence-based practice and strengthening service delivery across multiple levels of Uganda's health system.

The intervention strengthens clinical decision-making by providing frontline health workers with regular access to specialist guidance and updated standards of care. It reduces professional isolation, improves management of high-burden conditions, and supports regulatory compliance through accredited CPD points.

KEY LESSONS

1. Consistent webinars on expert medical knowledge fosters continuous professional development.
2. Multi-council accreditation increases participation by aligning the intervention with national regulatory requirements and license renewal incentives.

LIVING GOODS' DIGITALIZED COMMUNITY HEALTH WORKER PERFORMANCE MANAGEMENT THROUGH PEER SUPERVISION.

CHALLENGE

Community Health workers (CHWs) are pivotal to Uganda's primary healthcare system. However, gaps in supervision, motivation, and performance undermine their effectiveness. Supportive supervision is key in improving CHW's performance and retention but it remains costly to sustain. Annual maintenance costs as high as $711 per CHW in Kisoro District, while the cost per CHW in other 19 operational districts was $273.

INTERVENTION

Living Goods' peer supervision model equips high-performing Community Health Workers (CHWs) as "peer leaders" to coach and support fellow CHWs. Peer-leaders mentor small groups of 5-10 colleagues, review performance data, and provide on-the-job guidance and data verification. The approach uses performance-based incentives, including a post-pay system, which has strengthened CHW engagement, reporting, and overall service quality.

IMPACT ON HEALTH DELIVERY

Significant Cost Savings: The annual cost per CHW reduced from $273 to $176, a 36% overall saving. The rate of CHWs leaving the program dropped from 17% to 10%. Enhanced Empowerment: CHWs feel a greater sense of ownership, confidence, and teamwork due to being led by their peers rather than hierarchical supervisors. Increased Credibility: Peer group visits help certify CHWs in their own villages building greater trust within communities they operate.

OPPORTUNITIES FOR SCALE

The peer-led supervision is an approach proven to be efficient, cost-effective and acceptable to the CHWs. With continued collaboration with government, this approach can be adopted at a larger scale across the country.

Improving CHW performance, motivation, and accountability through a cost-efficient, data- driven, peer-led supervision model integrated with digital tools for real-time tracking and strengthened community health service delivery.

KEY LESSONS

1. Peer-led supervision significantly reduces costs while maintaining high-quality performance monitoring.
2. Digital tools enhance reporting timeliness, data accuracy and accountability
3. Aligning innovations with existing government systems increases sustainability and makes long-term integration easier.

ZOE GIRLS HEALTH INITATIVE (ZGHI)

CHALLENGE

Adolescent pregnancy in Busoga exceeds national averages: 28% of girls 15–19 years are mothers and 16% are currently pregnant. This drives school dropout, early marriage, and maternal mortality. The crisis reveals systemic gaps in adolescent sexual and reproductive health services, emergency obstetric care, and community interventions. A coordinated, context-specific response is urgently needed to address service delivery and the social determinants of teenage pregancy in Busoga.

INTERVENTION

The intervention intergrates sexual and reproductive Health (SRH) education, phsychosocial support and livlihood programs for teenage mothers and adolescents at risk of early pregnancy.
Through Teen Moms' skilling and support to return to school, the girls are empowered to delay childbearing, improve maternal/child health, and break poverty cycles.

IMPACT ON HEALTH DELIVERY

Since 2021, 3,649 girls have been reached with SRH education, 60 girls are currently enrolled in the Teen Moms' Clubs and 16 girls are enrolled in the livlihood program and these have returned to school. Through ZGHI has atenatal visits , facility based deliveries, and modern contraceptive use have increased among adolescent mothers in the communities of operation.

OPPORTUNITIES FOR SCALE

The intergrated approach can be scaled to urban slums with high teenage pregnancy rates and limited access to adolescent-friendly SRH services in the country. The approach also community-based and while liverages collaboration with community leaders, civil society and community extension workers.

KEY LESSONS

1. Teenage mothers are receptive to SRH education but face barriers to utilization associated with stigma.
2. Intergrated approaches including SRH education, physchosocial support and livihood programs are key in empowering girls and delaying pregnancy.

Intergrated approaches for prevention of teenage pregnancy and associated maternal and child mortality among girls aged 11-19.

Image credit: Zoe Girls Health Initiative

KAKUSI PROJECT
Strengthening Home-Based Palliative Care in Eastern Uganda.

Image credit: Kakusi Project

Ensuring that every person facing a life-limiting illness in Eastern Uganda receives compassionate, coordinated care at home through empowering family caregivers, and linkage to accessible palliative care services.

CHALLENGE

In rural Eastern Uganda, one in ten patients with serious illnesses receive palliative care. Palliative services remain city-bound leaving discharged - patients to suffer without pain or symptom management.

Their caregivers, frequently untrained family members are overwhelmed and ill equipped to cope. This cycle leads to preventable hospital readmissions, financial strain, and loss of dignity for patients at the most vulnerable stage of life.

INTERVENTION

This intervention is a structured home-based palliative care support system that identifies patients, conducts holistic needs assessments, and coordinates continuous care. Through home visits, phone follow -ups, caregiver training, and linkage with health facilities.,we provide real-time support and guidance.

IMPACT ON HEALTH DELIVERY

Preventable hospital re-admissions reduced by managing symptoms effectively at home.

- Appox. 1,800 patients are visited annually to provide comfort and preserve dignity
- 50 frontline workers and 100 Village Health Teams VHTs were trained on palliative care.

OPPORTUNITIES FOR SCALE

The intervention is low-cost and leverages existing community systems including VHTs. With strengthened advocacy and partnerships with organizations like the Palliative Care Association of Uganda and it can be scaled across districts to improve access to palliative care and integrated into national community health frameworks.

KEY LESSONS

1. The sustainability of home-based care rests on the shoulders of family caregivers. Providing them with targeted training, psychosocial support is essential.
2. When care is coordinated to address not just physical pain, but also emotional distress, social challenges, and spiritual needs, it profoundly improves outcomes for both the patient and their entire family.

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SICKLE CELL DISEASE RESPONSE PROJECT

Improves the quality of life and reduces preventable complications among children with Sickle Cell Disease (SCD) through community empowerment and strengthened capacity of lower-level health facilities to manage SCD in Mayuge and Kaliro districts.

CHALLENGE

Children in Mayuge District face a high burden of Sickle Cell Disease, with prevalence of 3% which is about 4 times higher than the national prevalence of 0.7%. However, lifesaving screening, diagnosis, and treatment services remain limited at lower-level health facilities, leaving many children without timely care and increasing the risk of preventable complications.

INTERVENTION

The project, implemented by World Vision Uganda in partnership with Mayuge District Local Government, strengthens lower-level health facilities to improve early detection, treatment, and management of Sickle Cell Disease. Communities are empowered through awareness, screening opportunities, and supportive care practices. At the same time, the project builds the capacity of health workers and community structures to identify, refer, and support children with SCD, helping reduce preventable complications and improve their quality of life.

IMPACT ON HEALTH DELIVERY

Since 2023, access to SCD care improved through the establishment of two functional SCD clinics, screening of 12,500 children and enrolment of 282 children into ongoing care. A total of 238 health workers were trained and 182 faith and cultural leaders oriented. Community sensitization reached 2,619 people, while district coordination was strengthened through four multi-stakeholder meetings. These efforts contributed to a 53% increase in children enrolled in SCD care services.

OPPORTUNITIES FOR SCALE

Established SCD clinics, trained health workers, active community structures, and strong district partnerships provide a strong foundation for scaling the intervention. With effective screening systems, increasing care-seeking behaviour, and growing community awareness, the model can be expanded to additional sub-counties and neighbouring districts.

KEY LESSONS

1. Decentralizing SCD services to lower-level health facilities improves access and continuity of care, particularly in rural settings.
2. Engagement of faith and cultural leaders increases community awareness and reduces stigma associated with SCD.
3. Screening programs must be linked to structured follow-up and care systems to achieve meaningful impact.

COMMUNITY BASED REFERRAL AND TELEPHONE TRIAGE SYSTEM FOR OBSTETRIC CASES IN EAST CENTRAL UGANDA

Aims to reduce maternal and newborn morbidity and mortality in Jinja City through early identification of obstetric complications, rapid triage, and timely referral to appropriate health facilities.

CHALLENGE

Maternal mortality remains high in the Busoga region, with about 448 women dying annually from pregnancy-related complications (DHIS2, 2023). The region records 93 deaths per 100,000 live births and neonatal mortality of 28 per 1,000, both above national averages, with Maternal and Perinatal Death Surveillance and Response reports citing delays in recognizing complications and seeking care.

INTERVENTION

Community Childbirth International introduced a 911 obstetric toll-free line in Jinja City to support community triaging of childbirth-related complaints among pregnant women. Through this system, triage midwives provide guidance, support timely decision-making, and link mothers to rapid transport and referral to the nearest appropriate facility. The initiative also mobilizes community actors such as religious' leaders, traditional leaders, boda-boda riders, village health teams, and women's groups—to promote birth preparedness and encourage pregnant women to use the toll-free line for early triaging and referral.

IMPACT ON HEALTH DELIVERY

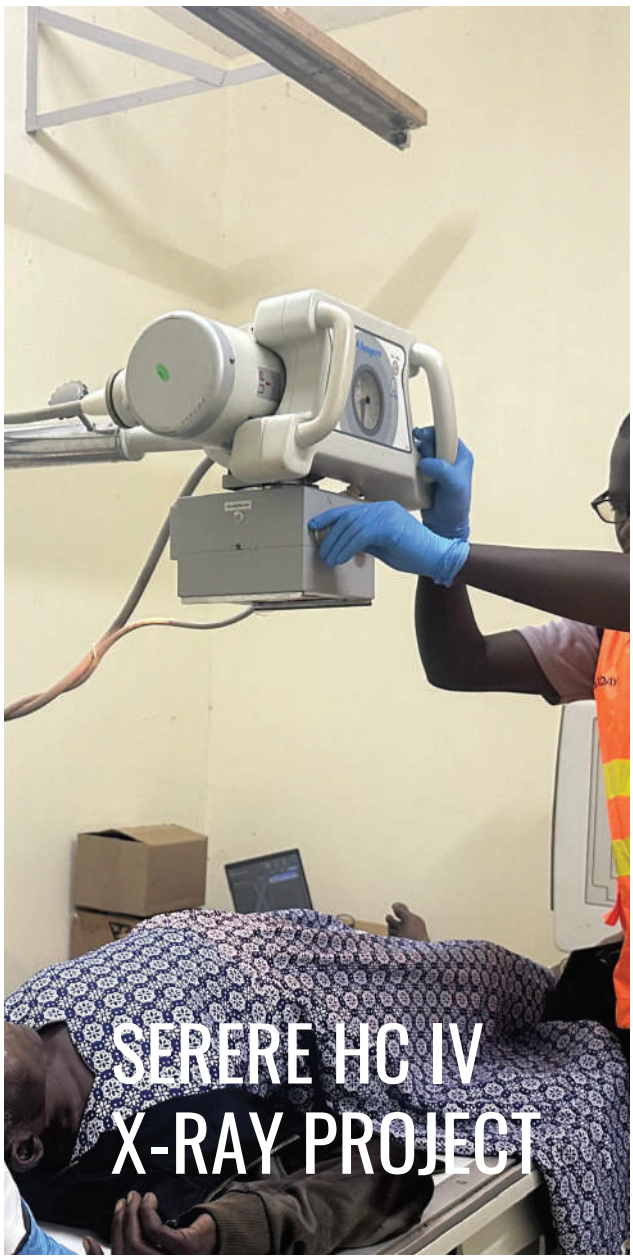
Post-implementation data from 2025 showed an increase in facility-based deliveries by 26% and reduction in maternal and neonatal deaths by 4%. The number of babies born before arrival at health facilities declined from 8 to 3 children per month as mothers sought care earlier. Community participation in maternal and child health activities also increased. Within 10 months, over 4,000 calls were received. Ninety seven percent of users reported helpful advice, beneficial information, willingness to reuse the service, and to recommend it.

OPPORTUNITIES FOR SCALE

The intervention has potential for scale due to its being low-cost, community-driven and use of existing health and communication structures. Expanding the toll-free triage system to other high-burden districts could improve timely referrals and reduce delays in care. Integration into national health systems and partnerships with telecom providers and local governments would enhance sustainability and reach, particularly among underserved rural populations.

KEY LESSONS

1. Community-based obstetric telephone triage improves emergency response and access to timely care.
2. When equipped with appropriate information, transport providers and community leaders significantly improve timely facility delivery.
3. Strong community engagement strengthens maternal health referral systems.



SERERE HC IV X-RAY PROJECT

CHALLENGE

Serere District previously had no functional X-ray services. By 2020, Serere HC IV was treating about 4,000 patients monthly, with nearly 40 patients referred weekly to Soroti and Kumi districts for X-ray services. These referrals caused delays in diagnosis, treatment, and increased costs for patients.

INTERVENTION

A community member donated an X-ray machine to Serere HC IV, but the facility lacked a structure to house it. The community mobilized resources and raised over UGX 100 million to construct an X-ray unit and install the machine. Following installation, the district recruited a radiographer to provide services. A cost-sharing scheme approved by the district council was introduced to support sustainability of the X-ray services at Serere HC IV.

IMPACT ON HEALTH DELIVERY

X-ray services are now available at Serere HC IV. Facility data shows that 1,252 patients accessed X-ray services in FY 2023/2024, improving timely diagnosis and appropriate treatment. Availability of the X-ray service also improved patient satisfaction and strengthened collaboration between the community and the health facility.

OPPORTUNITIES FOR SCALE

The Ministry of Health provided an additional mobile digital X-ray machine, creating opportunities to expand services through outreach sites. Scaling this model can increase access to diagnostic imaging for underserved populations and strengthen diagnostic capacity at HC IV facilities across other districts.

Improves access to diagnostic imaging services by providing functional X-ray services at Serere HC IV for the surrounding community.

KEY LESSONS

1. Diagnostic services such as X-ray can be successfully implemented at HC IV level with adequate support.
2. Availability of diagnostic services improves timely treatment and patient satisfaction.
3. Partnerships between communities and health facilities can accelerate health service improvements.

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