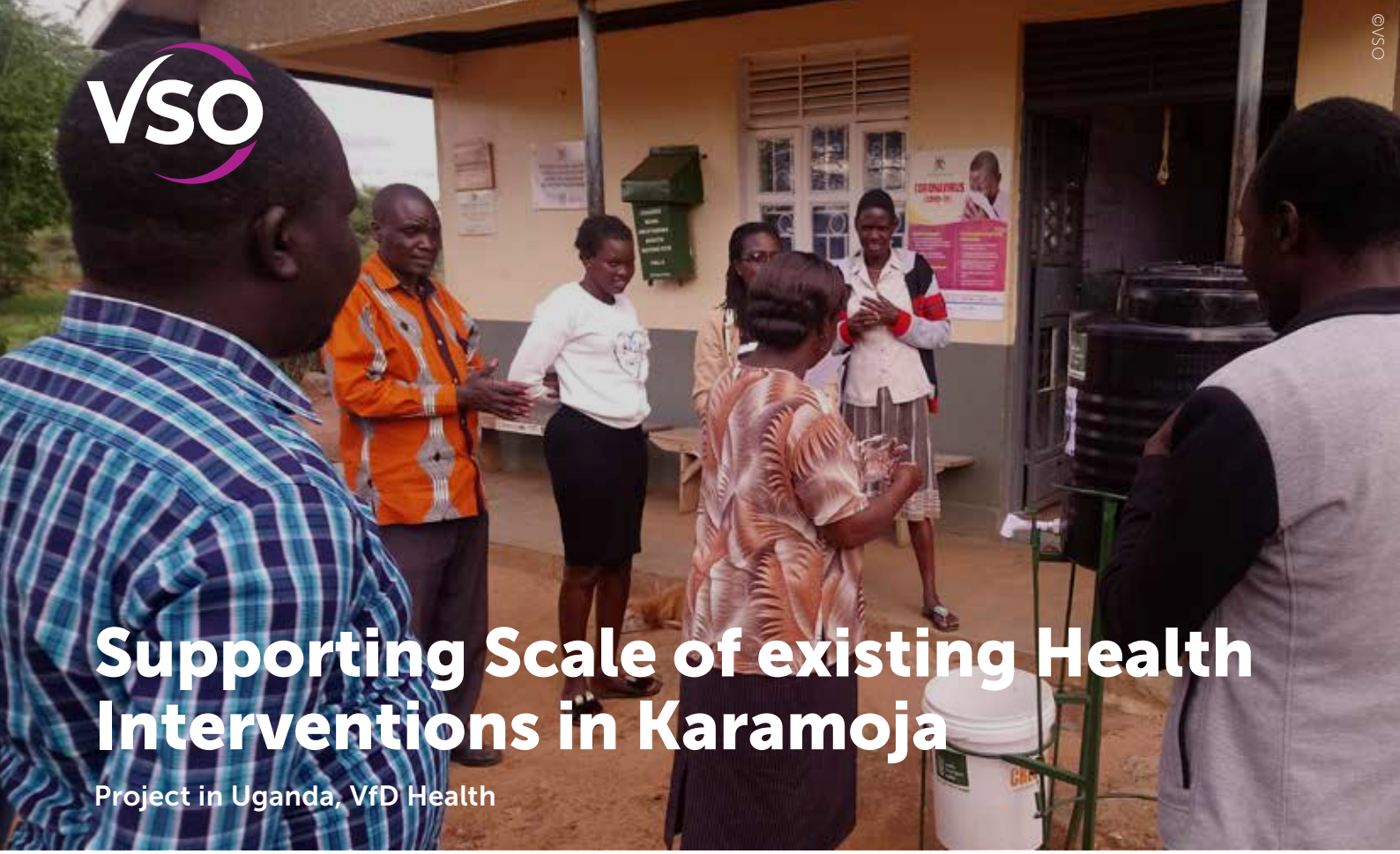

Supporting Scale of existing Health Interventions in Karamoja

Project in Uganda, VfD Health

Name:
Uganda VfD Health project

Location:
Moroto, Napak and Gulu, Uganda

Funded by:
FCDO, UK government

Dates:
2017-2022

Key partner:

Background

The right to health and progress towards achieving universal access to sexual and reproductive health remains a major public challenge in Uganda. The country faces poor health indicators disproportionately affecting the poor and the vulnerable and is overwhelmed by low spending on pro-poor health. These poor and vulnerable groups have tended to be excluded from participating in health decision-making processes that have a direct impact on their lives, yet their participation is key to bottom-up accountability and pro-poor health initiatives. Reproductive health problems are a leading cause of ill health and death for women and girls of childbearing age. Impoverished women suffer disproportionately from unintended pregnancies, unsafe abortion, maternal death and disability, sexually transmitted infections (STIs), gender-based violence, and other related problems. Young people are also extremely vulnerable, often facing barriers to sexual and reproductive health information and care. Uganda's high fertility rate of 6.2% is caused by the high unmet need for family planning of 34%, low contraceptive use of 30%, and high teenage pregnancy of 24% among others.[1] Great disparities exist with poor, rural, uneducated women having lower use and higher levels of unintended births. According to Uganda Demographic and Health Survey (DHS), every four in 10 births are unplanned pregnancies. The high teenage pregnancies are coupled by early marriages, about 49% are married before their 18th birthday.[2] Adolescent fertility rates are high with live births of 159 per 1,000 births,[3] which is more than two times the global average. Unintended pregnancies have been linked to unsafe abortions which accounts for nearly one third of maternal deaths among young people in Uganda.[4] It is reported that Adolescent pregnancy contributes to 30% of primary school drop-out ratio.[5] It is against this background that the project was implemented in Napak & Moroto Districts in Karamoja sub-region,

[1] http://popsec.org/key-facts-on-ugandas-population/ [2] Ministry of Health (2013/2014) [3] SRHR Alliance (Uganda) Strategic Plan 2016 – 2020
[4] Nalwadda G, Nabukere S, Salihu HM: The abortion paradox in Uganda: fertility regulator or cause of maternal mortality. J ObstetGynaecol 2005,25(8):776-780. [5] AODI/UNICEF study (2011)

Medical centre antenatal clinic and HIV/AIDS health clinic. Awach, Uganda.

and it supported **33 health facilities (19 Moroto 14 Napak districts)**. The project was funded by FCDO and the primary actors were adolescents and youth (10- 24 years).

Objectives

The project objectives were to:

i. To engage community and families to address harmful social norms and practices against adolescents and youth health rights
ii. To empower adolescents and youth to exercise their (SRMNCAHR) health rights.
iii. To improve access to comprehensive inclusive quality (SRMNCAHR) health services for adolescents and youth
iv. To capacity strengthen health workers to provide quality SRMNACH services.

Key approaches used

The **Volunteering for Development (VfD)** efforts were focused on improving health outcomes for vulnerable women, new-borns, adolescents, youth, and other marginalised groups by (i) developing capacity of the health workforce through training and mentorship, (ii) engaging communities through dialogues and home visits by peer educators and strengthening referral linkages and using community scorecards to develop **community actions plans** to improve health for adolescent and youth.

Key results and link with the global Theory of Change (ToC)

Increased capacity of the health workforce to deliver on inclusive health (SRMNCAHR) services

1. **42 health workers** were trained on IMNCI -integrated management of neonatal and childhood illness. This has enabled them to manage neonatal and childhood illnesses. This training was conducted using the ICATT computerized application provided by UNICEF.

Improved community attitudes, knowledge, practice, and behavior change

1. **4,303 community members** were sensitized on harmful social norms and practices in the community through home visits by peer educators
2. The **community scorecard** was integrated into two community dialogues and the theme was on how the communities engage on health issues of adolescents and youth living with disabilities ensured social accountability at the family and community level. Community Action Plans were developed because of these engagements.

Adolescents and Youth able to demand for their (SMNRCAHR) health rights

1. **4 people living with disabilities** were trained as SMNRCAHR peer educators and have been creating demand for SRHR and mobilizing their peers to access SRHR services. The peer educators are working in close collaboration with the district representative of people living with disabilities (NUDIPU).
2. Capacity strengthening of **120 adolescents and youth** on SRHR.