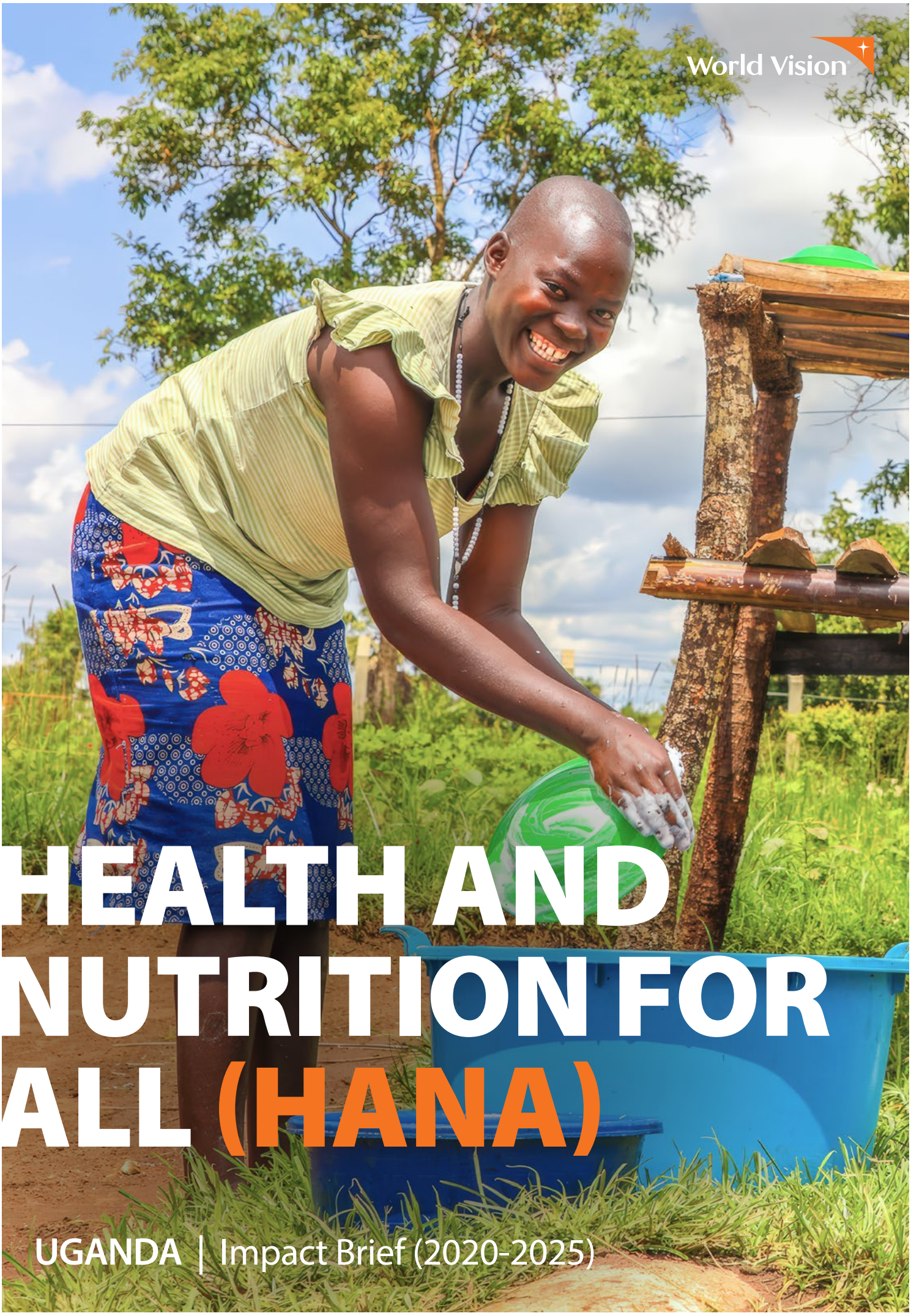

World Vision

HEALTH AND NUTRITION FOR ALL (HANA)

UGANDA | Impact Brief (2020-2025)

About this report

This impact brief summarises results from World Vision Uganda's end of project evaluation of the Health and Nutrition for All (HANA) Project, supported by the Australian Government through the Australian NGO Cooperation Program (ANCP). The contributions of the Judith Neilson Foundation are also gratefully acknowledged. The evaluation was conducted by Whale Consult Limited, while this brief was prepared by Karen Mejos, World Vision Australia. For more information, please contact Steven Dunham, Contract Manager, World Vision Australia. steven.dunham@worldvision.com.au.

Front cover photo: A project participant smiles as she washes her dishes. The project promoted the construction of dish racks and other improved hygiene practices.

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SUMMARY OF FINDINGS

Goal	To end preventable illness, impairment and death among **146,322** adults, young people and children under 5 in Oyam, Omoro and Pader districts through improved and inclusive access to, and utilisation of integrated quality health and nutrition services for all by 2025.
Timeframe	**2020-2025**
Location	Oyam, Omoro and Pader Districts in Northern Uganda

The Health and Nutrition for All (HANA) Project (2020–2025), funded by the Australian Government through Australian NGO Cooperation Program (ANCP) and implemented by World Vision Uganda, worked to eliminate preventable illness and death in Oyam, Omoro, and Pader districts. Reaching 146,322 people, including 11,031 people with disabilities, the project improved access to quality health, nutrition, and WASH services. An end-of-project evaluation confirmed its strong impact, sustainability, and equity outcomes.

Child survival dramatically improved:

- Under-five mortality fell by 69%, from 50 to 15 per 1,000 births
- Infant mortality dropped by 88% from 29 to 3 per 1,000 births

Maternal and child health and nutrition outcomes strengthened:

- Child stunting fell from 36.0% to 17.9%, and wasting from 20.5% to 4.1%
- Exclusive breastfeeding increased by 47.7%, while dietary diversity among children rose by 71.1%

Health services became more accessible and inclusive:

- Antenatal and newborn care coverage increased by 19.6% and 7.6%, respectively
- Contraceptive acceptance rose sharply: from 42.0% to 96.3%
- Child and immunisation and supplementation rates grew significantly

Access to inclusive water, sanitation, and hygiene (WASH) expanded:

- Sanitation coverage nearly doubled, with 30 villages declared Open Defecation Free (ODF)
- Households adopting appropriate handwashing behaviours rose from 65.0% to 82.4%
- Disability-friendly latrines and ramps improved access for all

Equity and inclusion advanced:

- Households became more gender-equitable in childcare and health decisions
- Women with disabilities reported higher gains in dietary practices

Community voice and accountability strengthened

- More people felt able to speak up: 86% of community members said they could share their views freely in meetings
- Community concerns were addressed: 64% of reported issues, such as drug shortages and poor infrastructure, were resolved through increased dialogue and cooperation between community members and health service providers.

"Together, we are not just feeding our children: we are building a healthier future."

– Community leader, Oyam

CONTEXT

Northern Uganda, specifically the districts of Omoro, Oyam, and Pader, has historically faced significant health and nutrition challenges, including high child mortality rates, acute malnutrition, and limited access to essential health services. Severe acute malnutrition (SAM) affected 4.8% of children under five, which is more than double Uganda's national average.[1] Disparities in breastfeeding practices and healthcare access further underscored the urgent need for inclusive and integrated solutions. The vulnerability of the region is compounded by a high prevalence of disability, with rates exceeding national averages—20% in the Lango sub-region and 17% in Acholi.[2] Children and women are disproportionately affected. These issues are rooted in systemic barriers such as poverty, climate shocks, gender inequity, and inadequate infrastructure.

The Health and Nutrition for All (HANA) Project (2020–2025), funded by the Australian Government through Australian NGO Cooperation Program (ANCP) and implemented by World Vision Uganda, was designed to address these challenges. Targeting 146,322 individuals, including 11,031 persons with disabilities, the project aimed to eliminate preventable illness and death by improving access to quality health, nutrition, and water, sanitation, and hygiene (WASH) services.

The project supports this goal by achieving the following outcomes:

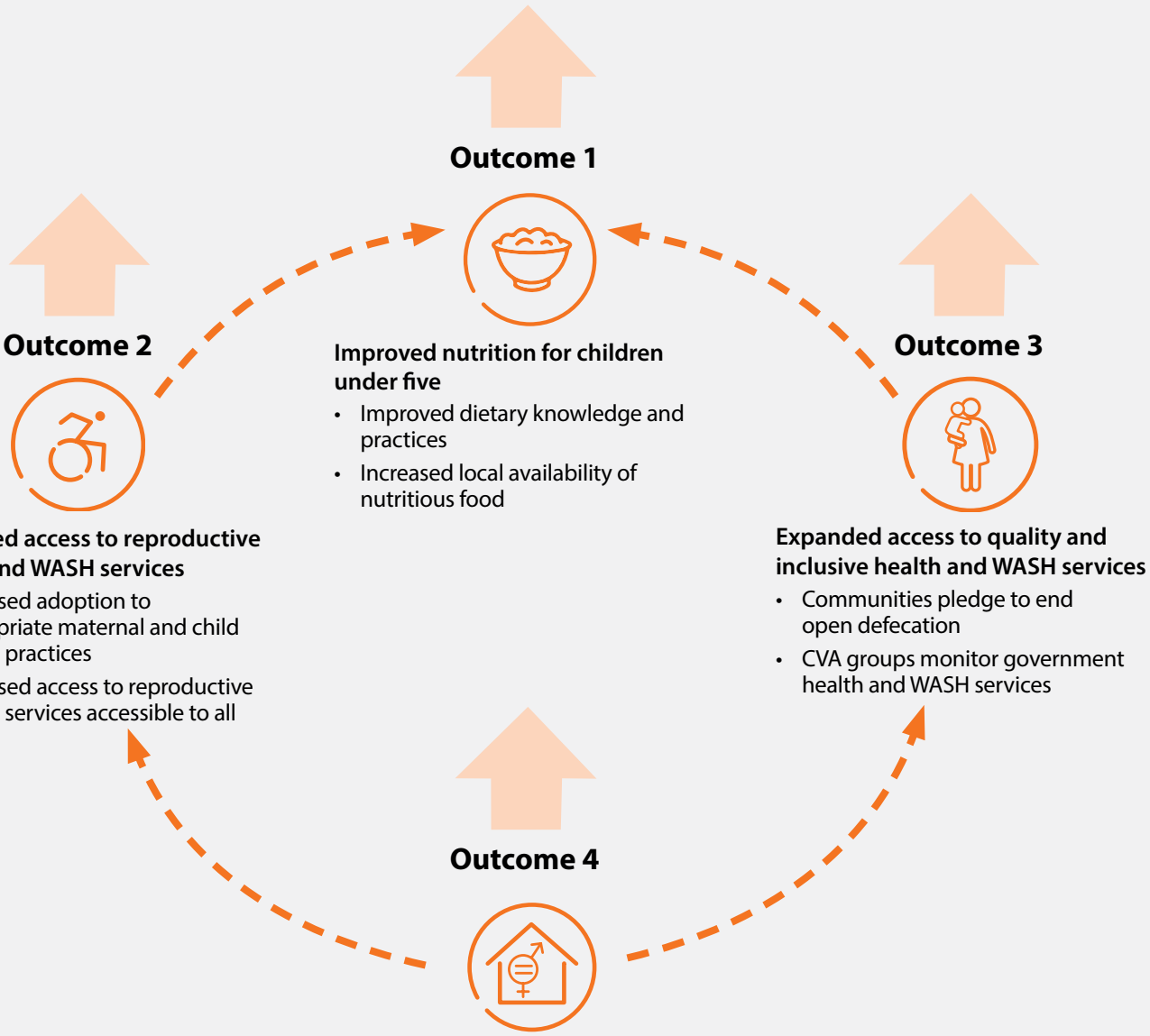
1. Improved nutritional status of all children under 5 years, including those with disabilities, and pregnant/lactating mothers.
2. Increased accessibility and utilisation of basic Reproductive Maternal Neonatal Child Health (RMNCH) services and maternal and child health nutrition practices for all, including those with disabilities.
3. Increased accessibility to and utilisation of improved health and WASH services for all, including those with disabilities.
4. Accessible and inclusive service delivery strengthened through ongoing learning, information sharing and advocacy.

A Nurturing Care Group of mothers meet to share knowledge on nutrition.

1 World Food Programme (2021). *Nutrition and Food Security Analysis in Northern Uganda*. Kampala: WFP.
2 UNICEF (2020). *Disability in Uganda: A study on prevalence and barriers*. Kampala: UNICEF

THEORY OF CHANGE

Goal: To end preventable illness, impairments, and death among 146,322 people by 2025.



EVALUATION OVERVIEW

PURPOSE

This evaluation aimed to assess the following:

i. **Change/Impact:** To evaluate the immediate and long-term effects produced by the project, both intended and unintended, and to identify contributing factors or barriers. This includes documenting who was affected by the project and how, resulting in actionable recommendations for relevant stakeholders.

ii. **Sustainability:** To determine the likelihood of continued long-term benefits from the project's interventions for target participants after project completion and identify which strategies supported or hindered sustainability.

iii. **Equity and Learning:** To assess the extent to which the project promoted gender equality, social inclusion, child protection, and disability inclusion. This area will also document challenges and good practices that can be replicated in future projects.

METHODOLOGY

The evaluation employed a mixed-method approach to capture project outcomes, sustainability, equity and learning.

Quantitative data was collected using a multi-stage sampling design from 768 caregivers and 455 adolescents via multi-stage cluster design (82% women, 13% people with disability) in Omoro, Oyam, and Pader districts. Qualitative data included 39 focus group discussions and 25 key informant interviews with project participants, health workers, community leaders, and people with disabilities. Findings were validated through triangulation across data sources. All data were systematically disaggregated by gender, age, and disability status to assess equity.

LIMITATIONS

The evaluation faced some limitations, including reliance on self-reported data, a short timeframe capturing only immediate outcomes, and findings shaped by Northern Uganda's post-conflict context. Power dynamics in group discussions also posed challenges. These were mitigated through triangulation, careful facilitation, and contextual adaptation, ensuring the evidence remains robust and credible.

A mother smiles with her baby at a Baby Friendly Health Centre as part of the HANA project.

CORE PROJECT MODELS AND APPROACHES

The HANA project implemented core project models that were tailored to local needs and leveraged existing community structures to drive sustainable behaviour change and systems strengthening.

NURTURING CARE GROUPS (NCG)

NCGs facilitated peer learning to promote improved child feeding, hygiene, and care practices. Promoters and Lead Mothers were equipped with skills in nutrition, home hygiene, and kitchen gardening, enabling them to support households with practical, locally appropriate solutions for better health and wellbeing.

TIMED AND TARGETED COUNSELLING (TTC)

Community health volunteers are trained and supported to provide health and nutrition counselling to pregnant women and new mothers through regular home visits and outreach services. Importantly, this method engages both parents and other decision-makers in the home, embracing a family-inclusive and gender-transformative model of child health and development where the positive contribution of fathers are emphasised.

CHANNELS OF HOPE FOR GENDER AND DISABILITY (COH)

Community and faith leaders were mobilised to address harmful norms, reduce gender-based violence, and promote inclusion of people with disabilities. The approach helped strengthen community-level structures to champion gender equality, safer households, and respect for the rights of all community members.

CITIZEN VOICE AND ACTION (CVA)

CVA empowered communities to engage constructively with local government and service providers. Through dialogue and social accountability tools, communities advocated for inclusive and quality RMNCH, WASH, and education services, resulting in increased responsiveness and commitments from duty bearers.

COMMUNITY-LED TOTAL SANITATION (CLTS)

CLTS mobilised communities to eliminate open defecation and sustain improved sanitation practices. Village Sanitation Committees, local masons, and natural leaders played a key role in driving collective behaviour change, supporting households, including people with disabilities, to build and maintain safe, hygienic facilities.

BABY-FRIENDLY HEALTH FACILITY INITIATIVE (BFHI)

The project supported the Uganda Ministry of Health's BFHI accreditation program, aimed at strengthening maternal and child health through improved breastfeeding support. By providing post-accreditation coaching and mentorship to health workers and staff, the project helped boost antenatal care attendance, promote early initiation of breastfeeding, and improve nutrition outcomes for children under five.

Women in a Nurturing Care Group share knowledge and support each other to improve child feeding, hygiene, and family wellbeing.

FINDINGS BY OUTCOME

GOAL

INDICATOR	BASELINE	MID-TERM	ENDLINE TARGET	ENDLINE ACHIEVED	RELATIVE CHANGE
Under Five Mortality Rate (U5 MR) (per 1000 live births)	50	50	30	**15.4**	▼ 69%
Infant Mortality Rate (IMR) (per 1,000 live births)	29	30	17	**3.4**	▼ 88%
Neonatal Mortality Rate (per 1,000 livebirths)	14	13	2	**1.3**	▼ 91%

The project achieved its primary goal of eliminating preventable illness, impairment, and death among 127,341 vulnerable individuals across Northern Uganda's Omoro, Oyam, and Pader districts. Under-five mortality fell from 50 to 15.4 deaths per 1,000 live births, a 69% reduction, while infant mortality dropped by 88% and neonatal mortality by 91%. This success was a result of integrated community health strategies and inclusive service delivery. In remote villages, 208 health outreaches provided immunisations to 5,411 children and treated 2,860 cases of malaria, diarrhoea, and respiratory infections. Fourteen Baby-Friendly Health Facilities improved skilled birth attendance to 94.1%, with Pader District reaching 99.4%. The adoption of the Electronic Community Health Information System (eCHIS) by 227 trained Village Health Teams (VHT) further strengthened disease surveillance and community-level service delivery.

"HANA project has helped us to reduce waiting time at the outpatient health facility and extending services closer to the community, thus reducing the distance covered by patients with its related risks. We are also realising reduced mortality and morbidity amongst children under five through early identification."

– Community health worker

"Perinatal deaths reduced... There has been mentorship and training of health workers especially the midwives; they have been trained and that actually improved that indicator."

– Community health worker

"When you take a walk through the communities that implemented the HANA project, you will not come across any malnourished child."

– Citizen Voice and Action Group member

OUTCOME 1:

Improved nutritional status of children 0-5 years including those with disabilities and pregnant/lactating mothers.

INDICATOR	BASELINE	MID-TERM	ENDLINE TARGET	ENDLINE ACHIEVED	RELATIVE CHANGE
Prevalence of underweight in under 5 children	14.6%	11.6%	24.4%	**5.2%**	▼ -64.4%
Prevalence of wasting in under 5 children	20.5%	7.3%	7.2%	**4.1%**	▼ -80.0%
Proportion of stunting in under 5 children	36.0%	24.40%	24.4%	**17.9%**	▼ -50.3%
Proportion of children born in the last 24 months who were put to the breast within one hour	62.8%	84.4%	80.1%	**84.4%**	▲ 34.4%
Proportion of children 0-6 months who are exclusively breastfed	65.0%	82.5%	91.7%	**96.0%**	▲ 47.7%
Proportion of children 6-23 months receiving minimum dietary diversity	58.0%	37.20%	80.4%	**62.1%**	▲ 7.1%

The project significantly improved nutrition for children under five, pregnant and lactating women, and people with disabilities across three districts. Children under five malnutrition rates dropped sharply: stunting fell from 36% to 17.9%, wasting from 20.5% to 4.1%, and underweight from 14.6% to 5.2%. Vitamin A supplementation, deworming campaigns reaching 18,731 children, and improved sanitation through 30 Open Defecation Free (ODF) villages all contributed to improved child nutrition.

Infant feeding practices saw major improvements. Early breastfeeding within one hour increased from 66% to 80%, and exclusive breastfeeding for infants under six months jumped from 65.0% to 91.7%. Dietary diversity for children aged 6–23 months rose from 58.0% to 62%, far above the national average of 22%, and 94.5% of caregivers understood the importance of complementary feeding. Pregnant women also improved their eating habits. Those who reported eating more during pregnancy rose from 36.7% to 60.2%, with even higher rates (67.3%) among women with disabilities. Through 124 Nurturing Care Groups (NCG), 4,165 caregivers learned how to prepare balanced meals using locally grown foods, supported by the distribution of biofortified seeds like iron-rich beans and orange-fleshed sweet potatoes for kitchen gardens.

Advocacy efforts by Citizen Voice and Action (CVA) groups further raised awareness about dietary diversity. This increased awareness empowered families to take nutrition seriously, resulting in quicker reporting of issues and earlier interventions for at-risk children.

The project also strengthened support for children with disabilities, training health workers and caretakers to manage feeding challenges and forming peer-support groups. Health workers and 72 caregivers were trained to support children with disabilities who have feeding difficulties. At the district level, the project worked with local authorities to plan and monitor nutrition activities through nine coordination meetings.

"CVA advocated for better nutrition education, and now parents are more aware of the signs of malnutrition."

– Female caregiver

"Through the NCGs, I learned how to prepare balanced meals, leading to marked improvements in nutrition for my children. Growing our own vegetables has significantly improved our diets."

– Female caregiver

"Now I have the knowledge to support caretakers of children with disabilities who come to the health facility. I can confidently identify and assist with exclusive breastfeeding, ensuring that these children receive the best start in life."

– Community health worker

"My child struggled with feeding, but through the lessons from the Nurturing Care Group, I learned the importance of exclusive breastfeeding. I ensured my baby was exclusively breastfed for the first six months, and I saw the positive impact on her health—she thrived and looked healthier every day."

– Nurturing Care Group lead mother

OUTCOME 2:

Increased access and utilisation of basic RMNCH services and MCH nutrition practices for all, including those with disabilities.

INDICATOR	BASELINE	MID-TERM	ENDLINE TARGET	ENDLINE ACHIEVED	Relative change
Proportion of children aged 0-23 months who received essential new-born care	82.0%	79.0%	90.0%	**88.2%**	▲ 7.6%
% mother of children 0-59 months who report ≥4 antenatal visits	74.0%	68.4%	86.4%	**88.5%** ▲	▲ 19.6%
Proportion of women report sufficient care from husband during pregnancy	67.0%	81.0%	85.0%	**94.5%** ▲	▲ 41.0%
% households where women/men jointly make health/ nutrition decisions	35.0%	49.0%	50.2%	**55.6%** ▲	▲ 58.9%

INDICATOR	BASELINE	MID-TERM	ENDLINE TARGET	ENDLINE ACHIEVED	Relative change
Proportion of children aged 12-23 months fully immunised	35.8%	79.0%	83.8%	**72.2%** ▲	▲ 101.7%
% children 0-59 months who received Vitamin A supplementation	57.0%	85.0%	89.0%	**90.1%**	▲ 58.1%
Proportion of children 0-59 months with acute respiratory infections (ARI) receiving treatment	80.0%	85.0%	88.0%	**98.5%**	▲ 23.1%
% clients counselled on healthy timing and spacing of pregnancies (HTSP) that accept contraception	42.0%	94.0%	46.0%	**96.3%**	▲ 129.3%
% households with children under five where men are involved in feeding & care	7.0%	15.0%	15.0%	**41.2%**	▲ 448.6%

The project significantly improved reproductive, maternal, newborn, and child health (RMNCH) services and nutrition practices in the target districts. Skilled birth attendance rose to 94.1% from 91%, with Pader achieving near-universal coverage at 99.4%. Essential newborn care improved to 88.2% from 82%, with higher rates (90.9%) among households with disabilities. Antenatal care coverage increased from 74% to 88.5%, and care for HIV-exposed infants improved dramatically, with 90.6% starting treatment within two months of birth (up from 77%). Fourteen health facilities maintained Baby-Friendly Health Facility accreditation, supporting early breastfeeding and maternal care. Contraceptive acceptance soared from 42% to 96.3%, with Pader achieving 100% uptake. These gains were driven by health worker training, community dialogues, especially those led by CVA groups, and 104 NCG sessions reaching over 5,000 households with key health and nutrition messages.

"The biggest change we've seen is in the level of awareness. People now know what services are available and when to go to the health facility. For example, before HANA, many mothers didn't know the importance of antenatal care, but now they attend regularly."

– Village Health Team member

"The project has ensured that vulnerable groups, including women with disabilities, have access to ANC services."

– District Health Officer

Immunisation coverage among children aged 12–23 months more than doubled, increasing from 35.8% to 72.2%, largely due to expanded integrated outreach services that reached over 10,000 children. Similarly, Vitamin A supplementation for children under five reached 90.1%, surpassing the national average. Compliance with diarrhoea treatment remained low at 31.9%, due to persistent cultural beliefs and limited demand for timely care.

The project also promoted gender equality in health. Male involvement in childcare showed a dramatic increase from 7.0% to 41.2%, and joint health and nutrition decision-making rose from 35.0% to 55.6%, reflecting the impact of gender-equitable health project advocacy.

"What HANA has done... is train us to sensitize the community on antenatal care [ANC], and now most women attend ANC, often with their husbands."

– Citizen Voice and Action member

"We used to think that shouting and controlling everything at home was being a man. But after attending several CoH [Channels of Hope] sessions through CHATs [Congregation Hope Action Teams], I learned that love and respect are the foundation of a good home."

– Male participant

OUTCOME 3:

Improved access to and use of inclusive quality health and WASH services.

INDICATOR	BASELINE	MID-TERM	ENDLINE TARGET	ENDLINE ACHIEVED	RELATIVE CHANGE
Proportion of households with year-round access to sufficient safe water	85.0%	71.0%	87.2%	**65.4%** ▼	▼ -22.1%
Proportion of households using basic drinking water facility	85.0%	60.0%	88.2%	**53.4%** ▼	▼ -37.2%
Proportion of households with access to inclusive sanitation facilities	27.0%	26.0%	47.0%	**52.5%** ▲	▲ 94.4%
Proportion of households with appropriate hand washing behaviours	65.0%	27.0%	77.0%	**82.4%** ▲	▲ 26.8%
Proportion of women 20-24 married before 18 (child marriage)	31.0%	10.0%	25.0%	**26.90%** ▼	▼ -13.2%
Proportion of adolescents that report early sexual debut	12.0%	20.0%	8.0%	**16.7%** ▼	▲ 39.2%
Proportion of pregnant women offered HIV counseling and testing and received results	93.0%	86.0%	97.0%	**96.0** ▼	▲ 3.2%

The project delivered mixed results under Outcome 3, achieving transformative gains in sanitation and hygiene but facing setbacks in safe water access and adolescent health. Despite project investment in new water infrastructure, access to safe water fell overall, from 84% to 65.4% as prolonged droughts and aging boreholes installed under other programs reduced water availability across the three project districts. However, water user committees trained by the project were still able to repair 65% of non-functional water supply infrastruture, including a piped system with taps at Iceme Mission in Oyam District.

Sanitation and hygiene coverage exceeded project targets. Household access to inclusive sanitation facilities increased from 27% to 52.5%, propelled by the successful rollout of CLTS in 45 villages. Of these, 30 achieved ODF status, with 17 certified by the Ministry of Health. Appropriate handwashing practices also advanced significantly, with households demonstrating a rise from 65.0% to 82.4%. This success was driven by hygiene education campaigns and reinforced by sanitation committees and peer support from NCGs.

In the area of adolescent health, the project strengthened sexual and reproductive health education through peer educator training and community-based awareness led by Congregation Hope Action Teams (CHATs). Although early sexual debut rose from 12% to 16.7% since baseline, it fell from the midline rate of 20%, showing recent progress.

"The project has implemented CLTS programs, leading to improved sanitation and hygiene practices, which indirectly support better health outcomes for pregnant women."

– District Health Officer

"The new thing I have seen is that they have decided to construct a latrine with a disability-inclusive design for the health centre."

– District Health Officer

"For me, I see a lot of changes in the youths' behaviour and way of life, previously, there were a lot of young people involved in drug abuse... but I am glad with our work, youths have left the drug use and are engaged in productive ventures like agriculture."

– Peer educator

OUTCOME 4:

Accessible and inclusive service delivery strengthened through ongoing learning, information sharing and government engagement.

The project strengthened the accessibility and inclusivity of health and nutrition services through capacity building, community engagement, and government partnerships. Training programs built skills across multiple levels of the health system: 227 VHT volunteers were trained on eCHIS digital reporting, enabling real-time data synchronisation with Ministry of Health systems, while 280 health workers strengthened their ability to provide disability-inclusive care. CVA groups also demonstrated marked gains: 83% of surveyed members reported using their training to influence government and community decisions about health service delivery. of 83.6% in its members.

Community dialogues and feedback sessions engaged 87.7% of participants, with 86.3% feeling free to share their views. Advocacy led to tangible improvements, such as benches and shaded waiting areas at health facilities. Complaints, mainly about drug shortages and infrastructure, were raised by 78.1% of participants, with 64.4% resolved through dialogue and follow-up. Peer education also addressed sensitive issues, including gender-based violence, which prompted responses from schools and local authorities.

Government engagement aligned project activities with national health policies, including integration of eCHIS indicators into the national health management systems. Local structures were strengthened, and inclusive service delivery was prioritised, particularly for marginalised groups, through training on disability inclusion and gender-based violence response. District disability councils adopted inclusive health plans in all three districts, ensuring disability considerations are now embedded in planning processes.

The project demonstrated strong leadership in knowledge sharing by showcasing its learning on both national and international platforms. An abstract accepted for presentation at the International Congress of Nutrition 2025 in Paris highlighted the project's impact, and two other abstracts were presented at Uganda's National Nutrition Symposium, sharing key lessons from the project implementation of NCG and support for BFHI accreditation. Notably, the BFHI presentation stimulated national-level dialogue on how accreditation increases skilled birth attendance, contributing to broader sectoral learning and informing policy uptake.

Community Led Total Sanitation means young people have access to clean water for hand washing in Uganda.

SUSTAINABILITY

The project generated strong evidence that its gains in health, WASH and nutrition are likely to endure beyond the project lifecycle, driven by five reinforcing pillars: institutional integration, community ownership, behavioural change, financial autonomy, and structural accountability.

- **Institutional integration and government anchoring**. Sustainability was reinforced through strong alignment with government systems. A total of 227 VHTs transitioned fully to eCHIS, synchronising real-time data with the Ministry of Health. Two VHTs from Omoro were nationally recognised as *Heroes in Health*. District Disability Councils institutionalised inclusion by embedding disability-responsive plans and budgets in all three districts. Fourteen health facilities independently sustained Baby-Friendly accreditation through district monitoring, demonstrating government ownership.
- **Self-sustaining community systems.** Communities established their own mechanisms to maintain gains. NCGs trained over 4,100 caregivers, who now replant and share biofortified crops without external support. Savings groups evolved into cooperatives financing health services, school WASH facilities and borehole repairs. Women entrepreneurs used savings groups dividends to fund education and nutrition, while 17 ODF villages set up self-funded sanitation committees.
- **Behavioural change and service continuity.** Lasting shifts in health-seeking behaviour are evident: antenatal care attendance remains at 94.1% and handwashing compliance at 98% six months post-intervention. Savings groups have created revolving funds for contraceptives and malaria kits, while Vitamin A supplementation for nearly 19,000 children continues through district campaigns.
- **Financial autonomy and resource resilience.** Communities gained greater autonomy by mobilising their own resources. Savings groups funded 12 borehole repairs and four school WASH upgrades. NCGs sell surplus produce to schools to finance education, and community advocacy secured 2% of Discretionary Development Equalisation Grants for nutrition activities across all districts.
- **Structural reinforcement.** Accountability systems were institutionalised: CVA groups now audit health budgets quarterly, while sub-county disability committees review complaints in monthly community courts. ODF villages enforce sanitation by-laws with strong community backing.

Key challenges. Despite these gains, sustainability is constrained by funding and staffing gaps at health facility level, limited access to health services in more remote communities, and cultural resistance to disability inclusion. Enforcement of sanitation by-laws also generated community tensions in some areas. These highlight the need for continued investment in fiscal support, capacity strengthening, and inclusive governance approaches to sustain momentum.

The HANA project prioritises disability inclusion through assistive devices and support for young people with disability.

EQUITY AND LEARNING

The HANA Project pioneered equity-enabling pathways by tackling barriers of gender and disability, and economic exclusion, simultaneously.

EQUITABLE ACCESS TO SERVICES

The project significantly expanded equitable access to health, WASH, and nutrition services for women, young people, and people with disabilities. Youth-friendly corners in clinics enabled adolescents to access sexual and reproductive health services confidentially, contributing to a 96.3% contraceptive acceptance rate. Disability-friendly infrastructure–such as ramps, widened latrine doors, and sign-language-trained health workers–helped increase service utilisation among people with disabilities by 72%. CVA groups and mobile clinics further reduced geographic and systemic barriers, ensuring feedback loops and outreach to underserved villages. However, households with disabilities continue to face inequities, reflected in the lower safe delivery rates and skilled birth attendance for mothers with disabilities.

GENDER RELATIONS AND AGENCY

The project helped challenge entrenched gender norms and reshape gender dynamics at household and community levels. Women gained financial agency through savings groups and kitchen gardening, with many directing income towards children's education and health. Joint household decision-making on health and nutrition rose to 55.6%, exceeding the national average of 45%. Channels of Hope interventions reframed male engagement in antenatal care as family responsibility, with men reporting greater respect for their partners. Structural barriers persisted, including male dominance among VHTs, where women made up only 21%.

TRANSFORMATIVE CHANGE FOR PEOPLE WITH DISABILITIES

The project catalysed transformative change across access, decision-making, participation, systems, and wellbeing among people with disabilities. Inclusive infrastructure and savings groups expanded autonomy, while wheelchair access reduced mobility dependence by 68%. Caregivers of children with disabilities reported stronger influence in childcare decisions, supported by 'caretaker groups', an innovation developed during project implementation. Formed with the help of local leaders, these peer groups brought together parents of children with disabilities to share mutual support, receive tailored training on adapted feeding, and access assistive devices fitted by local Organisations for People with Disabilities. Linked with savings groups, they also helped families strengthen household income.

People with disabilities gained seats on district disability councils, shaping health budgets and priorities. Participation increased through co-design of community latrines and membership in health unit committees, with 92% of people with disabilities reporting reduced isolation. Systems-level change included the adoption of district health standards mandating accessibility and the integration of disability data into the national eCHIS. Wasting among children with disabilities fell to 3.1% (versus 4.3% in children without disability) through caregiver training in adapted feeding techniques. Beyond health metrics, social acceptance improved as 78% of people with disabilities reported reduced stigma, and psychological empowerment improved, with 18 contested local elections for the first time.

"Assistive devices improved mobility... now I can go to church knowing my child is safe in the wheelchair."

– Mother of a child with disability

"The training helped us to cope and support each other. Before, we were scattered, but now we know we're not alone and have a support structure [in the group]."

– Father of a child with disability

Trained VHTs deliver Timed and Targeted Counselling (ttC) to families, improving health-seeking behaviours, immunisation uptake and health facility deliveries.

GRASSROOTS HEROS; WOMEN SAVING LIVES THROUGH NURTURING CARE GROUPS.

In the heart of Paiula Village, Pader District in Northern Uganda, a determined group of women is leading the charge against maternal and child mortality through the Nurturing Care Groups run by the HANA project. These women, many of whom are mothers themselves, are supporting younger expectant mothers with knowledge, care, and community-driven solutions.

"I gave birth to my first two children at home, assisted by a traditional birth attendant. Back then, I knew nothing about childbirth preparation—not even antenatal care," says 31-year-old Franca, a member of the Paiula Nurturing Care Group.

Now a mother of three, Franca was introduced to the group by her friend Hellen after experiencing unusual symptoms during her third pregnancy—persistent headaches, severe abdominal pain, and fevers. Concerned, Hellen encouraged her to join the NCG, where older women, guided by medical professionals, support expectant mothers throughout their pregnancy journey.

"The day I attended, they were teaching about danger signs in pregnancy. That session opened my eyes—I finally understood what I was going through," Franca recalls. *"Afterwards, I was paired with a lead mother who took me to Pader Health Center IV and followed up to ensure I completed all eight antenatal visits."*

Franca, a member of Paiula's Nurturing Care Group in Pader District, safely delivered her baby after receiving guidance on pregnancy, nutrition, and newborn care.

Through the Nurturing Care Group, Franca and other mothers learned about proper nutrition during pregnancy, newborn care, immunisation, and the importance of sleeping under treated mosquito nets to prevent malaria. Unlike her previous pregnancies, Franca completed all antenatal sessions and delivered her baby safely at the hospital under the care of trained medical staff.

CONCLUSION

The HANA Project achieved transformative health gains, reducing under-five child mortality to 15 per 1,000 live births, halving the project's target of 30 and demonstrating a 69% reduction overall. Success stemmed from integrated approaches combining community outreach, facility-based quality improvement, and nutrition-sensitive agriculture. Importantly, persons with disabilities experienced tangible progress across access, decision-making, participation, systems, and wellbeing, showing that inclusive design can catalyse structural change.

Sustainability is strongest where community ownership aligned with government systems. Over 220 VHTs were integrated into Uganda's eCHIS, 14 health facilities sustained Baby-Friendly accreditation, and disability-inclusive guidelines were adopted across all districts. Communities maintained Open Defecation Free status, replicated kitchen gardens, and financed borehole repairs and contraceptive stocks through savings groups. Risks remain from climate-exacerbated water failures, VHT burnout, and weak accountability in community resource management.

The project also advanced equity and social inclusion. Youth-friendly sexual and reproductive health services drove contraceptive acceptance to 96%, disability-adapted antenatal care expanded access, and male involvement in childcare increased nearly fivefold. Co-design with communities, integration with government systems, and linking economic and health interventions proved critical for sustained change. Persistent inequities include lower skilled birth attendance for people with disabilities and cultural barriers to youth sexual and reproductive health education. Addressing these gaps will be essential for deepening impact and ensuring inclusive progress.

RECOMMENDATIONS

A. For implementers

1. Expand male engagement models (e.g., barbershop dialogues in Pader) to reach 500 men per district annually.
2. Ensure disability inclusion by constructing accessible WASH facilities (3 sites per district) and linking assistive devices to savings group programs.
3. Prevent medical stockouts by pre-positioning iron/folate supplies and diversifying supplier networks.

B. For district governments

1. Allocate 15% of health budgets to retrofit facilities with ramps, accessible latrines, and priority queues.
2. Embed NCGs and savings groups in sub-county plans, ensuring 30% representation of women and people with disabilities.
3. Adopt eCHIS for malnutrition surveillance and conduct biennial disability audits.
4. Climate-proof WASH by elevating borehole aprons in flood zones and installing solar pumps in drought areas (2% of District Discretionary Equalisation Grants financing).

C. For central government

1. Scale HANA's disability-inclusive health guidelines nationally, embedding accessibility standards in facility norms.
2. Ringfence 2% of the national health budget for disability-inclusive programming and health worker training.

D. For donors and development partners

1. Fund solutions bridging health and livelihoods: disability audits, climate-resilient WASH, and savings group-based health funds.
2. Finance two longitudinal studies in three years to generate evidence on economic-health linkages.

E. For all stakeholders

1. Replace punitive policies with community-led enforcement by abandoning sanctions-based sanitation bylaws in favour of peer-monitored compliance, as successfully demonstrated in Oyam's ODF villages.
2. Link savings group to national social protection schemes (e.g., Prospera) to reduce household vulnerability to inflation shocks.

Sabina and Hellen harvest beans and other vegetables from their kitchen garden, a skill learned through the HANA project that is helping families eat healthier meals year-round.

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