

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH



4th HEALTH PROMOTION & **DISEASE PREVENTION** **Conference**

**PROGRAM AND
ABSTRACT BOOK**

THEME:

**“Strategic Positioning of Community Structures
as the Foundation of Primary Health Care and
Health Security”**

**14TH – 16TH
OCTOBER 2026**

**Speke Resort Hotel,
Munyonyo**

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WORD FROM THE MINISTER FOR HEALTH



Dr. Chris Baryomunsi Minister for Health

It is my great honour and pleasure to welcome you to the 4th Health Promotion and Disease Prevention Conference, held under the theme, “Strategic Positioning of Community Structures as the Foundation of Primary Health Care and Health Security.” This theme is both timely and central to our efforts to build a healthier, more resilient Uganda.

I am pleased to join the Ministry, our partners,

health workers, community leaders, and other stakeholders in advancing an agenda that positions community structures at the centre of health promotion, disease prevention and health security. The strength of our health system ultimately depends on the capacity of our communities to prevent disease, seek appropriate care, respond to health threats and participate actively in improving their own health.

Uganda has gained valuable experience in preparing for and responding to public health emergencies. These experiences have demonstrated that global health security begins at the community level. Early detection, timely reporting, accurate information and rapid response are critical in containing outbreaks and protecting lives.

Community Health Workers and other community structures are uniquely positioned to connect households with the health system. By equipping them with the knowledge, skills, tools and support they need, we can strengthen community-based surveillance, promote healthy behaviours, counter misinformation, facilitate early referral and ensure that communities are better prepared to prevent and respond to public health emergencies.

This conference provides an important platform to reflect on our progress, share evidence and innovations, learn from our experiences, and identify practical actions for strengthening community structures as a foundation for Primary Health Care and health security.

I commend the Department of Health Promotion and Education for convening this important conference and extend my appreciation to all partners and participants. I wish you fruitful deliberations and look forward to implementing the resolutions from this conference.

MESSAGE FROM THE PERMANENT SECRETARY



Dr. Diana Atwine
Permanent Secretary,
Ministry of Health

It is my pleasure to welcome you to the 4th Health Promotion and Disease Prevention Conference, convened under the theme, “Strategic Positioning of Community Structures as the Foundation of Primary Health Care and Health Security.”

Uganda continues to make important investments in strengthening Primary Health Care and building resilient health systems that are responsive to the needs of its population. Yet the effectiveness of our health system ultimately depends on our ability to connect policies, programmes and services with the communities they are intended to serve.

Community structures provide this critical connection. They support health promotion, disease prevention, early identification of health threats, referral to appropriate services, community feedback and the adoption of healthier behaviours. Recent public health emergencies have further demonstrated that communities are not merely beneficiaries of health interventions; they are indispensable partners in protecting population health.

This conference therefore provides an important platform for government, local governments, communities, researchers, academia, civil society, development partners and the private sector to examine how community structures can be better positioned, supported and integrated within the health system.

I encourage participants to use the discussions and evidence presented during these three days to identify practical solutions that can be translated into policy and implementation. Particular attention must be given to sustainable financing, coordination, accountability, capacity development and the meaningful participation of communities in decisions affecting their health.

On behalf of the Ministry of Health, I thank the National Organising Committee, our partners, presenters and all institutions that have contributed towards this conference. I wish you productive deliberations and a successful conference.

MESSAGE FROM THE DIRECTOR GENERAL HEALTH SERVICES



Prof. Charles Olaro
Director General Health Services

Health promotion and disease prevention remain fundamental to achieving better health outcomes and reducing avoidable pressure on our health services.

The theme of this year's conference draws attention to an essential component of an effective health

system: the capacity of community structures at national, sub-national and grassroots levels to participate actively in protecting and improving health.

Community structures are often the first point at which health information is shared, risks are recognised, misconceptions are addressed and individuals are linked to health services. They are equally important in routine programmes such as immunisation, maternal and child health, nutrition and prevention of communicable and non-communicable diseases, as they are during outbreaks and other public health emergencies.

Strengthening these structures requires clear linkages with health facilities and local governments, trained and supported community-level actors, functional referral and feedback mechanisms, effective surveillance and communication systems, and the systematic use of community-generated evidence to guide decision-making.

This conference provides an opportunity to examine evidence, innovations and experiences emerging from Uganda and elsewhere and to identify approaches that can be adapted and scaled within our health system. I encourage participants to focus on solutions that are practical, evidence-informed, scalable and sustainable.

The knowledge presented in this conference book represents an important contribution to that process. I commend all authors, researchers, implementers and communities whose experiences have informed it, and I wish all delegates fruitful discussions and productive engagements.

MESSAGE FROM THE COMMISSIONER / CONFERENCE CONVENER



Dr. Richard Kabanda

**Commissioner, Health Promotion,
Education and Communication.
Conference Convener**

Dear Distinguished Delegates,

It gives me great pleasure to welcome you to the 4th Health Promotion and Disease Prevention Conference. Held every two years, the conference provides an opportunity to take stock of best practices, lessons learnt and recommendations for empowering communities and community structures

as the foundation of Primary Health Care and Health Security.

Our theme this year deliberately places community structures at the centre of Primary Health Care and health security. Health promotion does not begin within the walls of a health facility. It begins where people live, learn, work, worship and interact.

Across Uganda, Community Health Extension Workers, Village Health Teams and other community structures, community leaders, schools, cultural and faith institutions, health workers, civil society organisations, the media and community networks play a vital role in influencing health behaviours, generating demand for services, identifying health concerns and building trust between communities and the health system.

The challenge before us is therefore not simply to recognise these structures, but to determine how they can be strategically positioned, adequately supported and systematically connected to the formal health system.

Over the three days of this conference, we will hear evidence from research and programme implementation, examine innovations, share experiences and engage in discussions across the different conference tracks. I invite every participant to contribute actively, share lessons and build partnerships that continue beyond this conference.

I acknowledge the team that has worked tirelessly to put this conference together, our partners for their support, abstract authors for their contributions, and every delegate for helping to make the conference a success. Welcome to the 4th Health Promotion and Disease Prevention Conference.

ABOUT THE CONFERENCE

Conference Theme

Strategic Positioning of Community Structures as the Foundation of Primary Health Care and Health Security.

Conference Focus

The three-day programme places community structures at the centre of discussions on Primary Health Care, health security, community health workers, social and behaviour change, digital transformation, RMNACH, non-communicable diseases, HIV prevention, WASH, immunisation and emergency preparedness.

Conference Tracks Reflected in the Programme

Track 1: Strengthening Community Integrated Service Delivery through Community Health Workers.

- Track 2: Leveraging Digital Transformation for Community Engagement and Systems.
- Track 3: Promoting Community Systems for Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNACH).
- Track 4: Building Community Resilience for Health Security (Preparedness, Response & Recovery).
- Track 5: Advancing Social Behaviour Change for Health Promotion and Wellbeing

CONFERENCE PROGRAMME

Masters of Ceremonies: Allan Ssempebwa and Marion Natukunda

Plenary venue: All plenary sessions take place in the Victoria Ballroom

Key	Plenary sessions	Community Health Workers Summit	Abstract presentations (oral and poster)	Side events and concurrent sessions
Rooms	Victoria Ballroom	Royal Palm Ballroom	Albert Hall	Meera Hall
				Sheena Hall

Day 1: Wednesday, 14 October 2026

Time	Activity	Facilitator / Speaker	Session Chair
8:00 – 9:00 am	Arrival, registration and tea/coffee		Secretariat
8:00 – 9:00 am	Gallery walk in the Exhibition Arena	Poster presentations on Tracks 1 and 5 Exhibitions	
9:00 – 9:10 am	Delegates take their seats	Event Host	
9:10 – 9:20 am	Arrival of the Guest of Honour	Director General Health Services and Conference Convener	
9:20 – 9:30 am	Opening Remarks by the Conference Convener, & Commissioner Health Services – Health Promotion	Conference Convener: Dr. Richard Kabanda	
9:30 – 9:40 am	Opening remarks by the Director General Health Services	Prof. Charles Olaro	Hon. Dr. Charles Ayume
9:40 – 9:50 am	Brief documentary	Tony Kizibwe and Mohammed Kasule	Minister of State for Health (Primary Health Care)
9:50 – 10:00 am	Keynote address	Dr. Fouzia Shafique, Associate Director for Health, UNICEF Headquarters	

Time	Activity	Facilitator / Speaker	Session Chair
10:00 – 11:20 am	Official Opening Ceremony		
	Remarks by the Permanent Secretary, Ministry of Health (5 minutes)	Dr. Diana Atwine	
	Remarks by the UN Resident Coordinator (5 minutes)	Mr. Leonard Zulu	
	Remarks by the Chair, Health Development Partners (5 minutes)	H.E. Anna-Maria Olsson	
	Remarks by the Ambassador of the Kingdom of the Netherlands (5 minutes)	H.E. Angèle Samura	
	Remarks by the Ambassador of the Republic of Korea (5 minutes)	H.E. LEE Sang-ho	
	Remarks by the United States Head of Mission (5 minutes)	H.E. Mike Cheverley	
	Remarks by the Minister of Health	Hon. Dr. Chris Baryomunsi	
	Address by His Majesty, the Kyabazinga	His Majesty, William Gabula Nadiope IV	
	Official address by the Speaker of Parliament	Rt. Hon. Jacob Marksons Oboth	
	Official address by the Vice President	H.E. Maj. (Rtd) Jessica Alupo	
	Entertainment Interlude		
	Brief presentation on the ISBCS and the CHWIF	Dr. Richard Kabanda	
	Launch of the Integrated Social Behaviour Change Strategy (ISBCS) 2026–2031	His Majesty, William Gabula Nadiope IV	
	Launch of the Community Health Workers Implementation Framework (CHWIF) 2026–2031	Vice President of the Republic of Uganda	

Time	Activity	Facilitator / Speaker	Session Chair
	Brief presentation on National Cost of Inaction for WASH in Uganda: Implications and Policy Direction – [5 Minutes]	Dr Nabassa Herbert, CHS Environmental Health	
	Launch of the National Cost of Inaction for WASH in Uganda	Rt. Hon. Jacob Marksons Oboth	
11:20 – 11:30 am	Official photographs	By invitation	Marion Natukunda
11:30 am – 12:30 pm	Leveraging Community Structures to Address Prevailing Health and Social Issues: A case of Teenage Pregnancies	Insights from Buganda Kingdom on Promotion of Social and Health Services in Communities – Owek. Robert Waggwa Nsibirwa [15 minutes]	Ms. Kristine Blokhuis, UNFPA Country Representative
	Plenary panel discussion	• Dr. Kedrace Turyagyenda, Permanent Secretary, Ministry of Education and Sports • Mr. Ben Kumumanya, Permanent Secretary, Ministry of Local Government • Mr. Aggrey Kibenge, Permanent Secretary, Ministry of Gender, Labour and Social • Namboozo Abigail (Age: 23) Reflections from a Young Person Closing Insights: H.E Anna-Maria Olsson - Ambassador of Sweden to Uganda	
12:30 – 1:30 pm Victoria Ballroom	Re-awakening the HIV Prevention Agenda through Community Structures	High level updates from UPHIA 2025 – Dr. Robert Mutumba. Program Manager, AIDS Control Program.	

Time	Activity	Facilitator / Speaker	Session Chair
	Plenary panel discussion	• Apostle Grace Lubega, Phaneroo Ministries International • Dr. Peter Ssebutinde, District Health Officer, Mbarara District • Dr. Daniel Byamukama, Head of HIV Prevention, Uganda Aids Commission	Hon. Grania Hope Nakazibwe - Vice Chairperson, Health Committee, Parliament of Uganda
1:30 – 2:30 pm	Lunch		
2:30 – 3:30 pm	Status of CHWs program scale up – 10 Minutes	Dr. Ronald Miria Ocaatre <i>Assistant Commissioner Health Services, Health Promotion and Strategic Health Communication</i>	Dr. Robin Nandy UNICEF Country Representative
	Panel Discussion: Implementation insights from stakeholders on the CHW Programme	• Cosma Valanta Oyuki, <i>CHEW, Mayuge District</i> • Dr. James Kirya, <i>District Health Officer, Namutumba District</i> • Dr. Stella Kanyerere, <i>Country Director, Living Goods</i>	
	Questions and Answers	All	
3:30 – 5:30 pm Sheena Hall	Concurrent Session Strengthening Primary Health Care through Immunisation and Cold Chain Equipment (CCE) Financing in Uganda	PATH	Dr. Turyahabwe Stavira, Commissioner – CDP & C

Time	Activity	Facilitator / Speaker	Session Chair
3:30 – 5:30 pm Royal Palm Ballroom Global Health Security Session 1 <i>By invitation only</i>	Side Event: Engagement with South Western and Central Region Leaders Theme: Preparedness and Response for Public Health Emergencies in Border and High-Risk Districts	Opening remarks: WHO Country Representative Uganda. Presenters: • Dr. Allan Muruta (<i>Commissioner – Integrated Surveillance and Public Health Emergencies</i>) • Benjamin Sensasi (Technical Advisor, Health Promotion and Social Determinants of Health, WHO). • Atek Kagirita, Incident Commander, BEVD Closing remarks: Minister of Health	Hon. Dr. Charles Ayume
3:30 – 5:30 pm Albert Hall	Breakout Session 1 Track 1: Strengthening Community Integrated Service Delivery through Community Health Workers	Calvin Kaweesi. Community Health Workers Test Before They Treat: Presumptive Antimalarial Treatment across Community, Public and Private Providers among Febrile Children in the 2024–2025 Uganda Malaria Indicator Survey Anne Agaba. Integrating Eye Health into Uganda’s Community Health Worker Platform: Feasibility and Early Outcomes from a Pilot in Kaliro District Robert Muwonge. Taking TB Screening to the Streets: A Mobile Van Model for Active Case Finding in Kisenyi Slums, Kampala, Uganda Moses Okech. Community Treatment Surpassing Facility Care: Evidence of Last-Mile Disease Prevention from a Digitally Enabled Community Health Model Supporting Wakiso District, Uganda Justine Tumusiime. Strengthening Community Integrated Service Delivery: Lessons from Expanding Community-Based Contraceptive	Bonny Natukunda District Health Educator, Wakiso

Time	Activity	Facilitator / Speaker	Session Chair
		Implant Services Using Community Health Extension Workers in Uganda Babrah Nuwamanya. Institutionalising Integrated Community Health Workforces for Dual-Burden Disease Prevention in Rural Uganda	
3:30 – 5:30 pm Meera Hall	Breakout Session 2 Track 5: Advancing Social Behaviour Change for Health Promotion and Well-being	Ssanyu Kalibbala and the DMI Team. Messaging on What Matters: A Data-Driven Approach to Prioritise High-Impact Beliefs for Malaria Vaccine Uptake in Uganda Chrispus Mushabe Bakunda et al. Behavioural and Social Drivers of Measles-Rubella Vaccine Uptake among Caregivers of Children in Kyegegwa District, January–April 2026 Ronald Kibonire et al. A Secret for Survival: Covert Contraceptive Use and the Burden of Male Resistance to Family Planning in Kigezi Hamdan Kivumbi. Malaria Vaccine Uptake among Children Under Five Years and Associated Factors in Kiryandongo District, Western Uganda: A Community-Based Cross-Sectional Study Brenda Angom. Uptake of the R21/Matrix-M Malaria Vaccine among Children Aged 6 to 18 Months and Associated Factors in Apac District, Uganda Daniel Oceng and Leonard Opeto. Community Health Workers as Catalysts for Social Behaviour Change: Improving Household Sanitation and Health in 52 Communities in Kamwenge	Miriam Lwanga UNICEF

Time	Activity	Facilitator / Speaker	Session Chair
		Sharifuh Yiga and Rita Bakesima. Role of Community Health Workers in Delivering Social Behaviour Change Interventions for the Prevention of Adolescent Alcohol and Substance Abuse in Northern Uganda	
3:30 – 5:30 pm	Community Health Workers Summit		Dr. Immaculate Ddumba U.S. Department of State
3:30 – 3:40 pm	Opening remarks	Dr. Daniel Kyabayinze Director Public Health	
3:40 – 4:05 pm	The Evidence Base: presentation of data on VHT/CHEW performance in FY 2025/26	Dr. Meddy Rutayisire	
4:05 – 4:20 pm	Presentation of success stories and best practices CHEWs increase demand for and access to family planning: Implanon	Fiona Walugembe, PATH Uganda	
4:20 – 5:30 pm	Discussion & Closure	Assoc. Prof. David Musoke, Makerere University	
5:30 pm	Evening tea, networking and departure at leisure		

Day 2: Thursday, 15 October 2026

Time	Activity	Facilitator / Speaker	Session Chair
8:00 – 8:30 am	Arrival, registration and breakfast		Secretariat
8:50 – 9:00 am	Recap of Day 1	Edward Muganga	
9:00 – 9:15 am	Validation of the Self-Care Application: A Public Social Tool for Health Promotion	Dr. Roselline Achola	
9:15 – 10:15 am	Brief on the RMNCAH+N Sharpened Plan 2026–2031	Dr. Richard Mugahi Commissioner Health Services, Maternal and Child Health	Prof Olaro Charles, DGHS
	Sustainable Financing for Women's Health: Innovative and Sustainable Financing for Sexual and Reproductive Health (SRH) to accelerate access to modern contraceptives and address the high rate of teenage pregnancy in Uganda	Twambilire Mwabungulu, FP2030	
	Insights on the implementation of the RMNCAH+N Sharpened Plan (5 minutes each)	- Dr. Sabrina Kitaka, Makerere University - Isaac Wonyima Okello, Assistant District Health Officer – MCH, Nwoya DLG - Jackie Katana, 3FHI - Ms. Kristine Blokhuis, UNFPA Country Representative	
10:15 – 10:25 am	Launch of the RMNCAH+N Sharpened Plan	Official launch: The Minister of Health	

Time	Activity	Facilitator / Speaker	Session Chair
10:25– 11:00 am	Fireside Chat: Regional and Continental Insights on Digital Health Innovations Uganda's journey in advancing digital health	- John Wanyungu, Deputy Head, Community Health Services, Ministry of Health, Kenya - Paul Mbaka, Assistant Commissioner, Division of Health Information, Ministry of Health, Uganda - Dr. Ryan Nyotu, Executive Director, Medic Afya, Kenya	John Kauta Commissioner - HISME
11:00 – 11:30 am	Tea break		
11:30 am – 1:30 pm Royal Palm Ballroom Global Health Security Session 2 <i>By invitation only</i>	Side Event: High-Level Engagement with Members of Parliament	Opening Remarks: Dr. Julius Monday Rude Chairperson, Parliamentary Committee on Health	Hon. Dr. Chris Baryomunsi Minister of Health
	Uganda's journey in addressing public health emergencies	Hon. Dr. Charles Ayume	
	Current Preparedness Efforts to curb the Ebola Virus Disease Outbreak	Prof. Charles Olaro and Atek Kagirita	
	Discussion	All Members of Parliament	
	Financing landscape for Health Promotion and Disease Prevention Initiatives (<i>CHWs, SBC, disease surveillance, early screening for NCDs, and WASH</i>)	Dr. Richard Kabanda	
	Discussion and commitments	All Members of Parliament	
11:30 am – 1:30 pm Sheena Hall <i>Open invitation</i>	Side Event: Engaging MAAIF on the Integration of Routine Immunisation and Animal Vaccination in Pastoral Communities with Zero-Dose and Under-Immunised Children	PATH	PATH

Time	Activity	Facilitator / Speaker	Session Chair
11:30 am – 1:30 pm Albert Hall	Breakout Session 3 Track 3: Promoting Community Systems for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)	Paul Lwevola. Taking Health to the Lake: Extending Integrated Health Services to Mobile and Hard-to-Reach Populations through the MV Sigulu Ferry Clinic in Namayingo District, Uganda Sharon Sandrah. Strengthening Adolescent Maternal Mental Health through Trained Mama and Papa Ambassadors: A Community-Based Peer Support Model in Rural Uganda Michael Akol. Institutionalising the Community Health Workforce as the Foundation of Primary Health Care and Health Security Fred Ndikolaki. Bridging Geographic Inequities in Maternal Health: The G2PP Antenatal Care Satellite Model in Hard-to-Reach Malongo Sub-county, Mayuge District, Uganda Brenda Bwenge. Strengthening High-Risk Pregnancy Antenatal Care through Access to Ultrasound Services at Kalisizo Hospital	DHO, Mbale District
11:30 am – 1:30 pm Meera Hall	Breakout Session 4 Track 4: Building Community Resilience for Health Security (Preparedness, Response and Recovery)	Martha D. Nalweyiso. Knowledge, Attitudes and Practices on Mpox among Pilgrims during the Martyrs' Day Commemoration in Namugongo Town Council, Uganda, June 2025 Forum for Health Inclusion Practice Uganda. Strengthening Community-Led Health Facilities: A Baseline Assessment of Allied Health-Staffed Health Units Serving Key Populations in Uganda Moses Okech. Breaking Silos: Strengthening Community Event-Based Surveillance through Electronic Community Health Information System	Dr Kamya Ivan, DHO Kiruhura DLG

Time	Activity	Facilitator / Speaker	Session Chair
		(eCHIS) Integration in Wakiso District, Uganda Alhassan Mubarak. Building Community Resilience for Health Security	
1:30 – 2:30 pm	Lunch		
2:00 – 2:30 pm	Gallery walk in the Exhibition Arena	Poster presentations on Tracks 2, 3 and 4 Exhibitions	Programme Directors
2:30 – 3:00 pm Victoria Ballroom	Advancing Surgical Services in the Community as a Health Promotive and Preventive Intervention	Prof. Moses Galukande Association of Surgeons of Uganda	Dr. Rony Bahatungire, <i>Commissioner - Clinical Services</i>
	Discussion – All		
3:00 – 5:30 pm Albert Hall	Breakout Session Track 2: Leveraging Digital Transformation for Community Engagement and Systems	Richard Rukakaza Muganzi et al. From Paper to Pixel: Leveraging Real-Time Digital Surveillance to Optimise the TB Care Continuum and Health Security in Kiruhura District Agatha Nshabire. User Experiences and Factors Associated with Electronic Community Health Information System (eCHIS) Use among Village Health Teams in Wakiso District, Uganda Gracie Nakazzi et al. Using Generative AI on WhatsApp to Link Ugandans to Family Planning Information and Services Geoffrey Kasumba et al. Utilising QR Codes to Improve Reporting of HIV Self-Testing Results and Linkage to Care during the Nyege Nyege Music Festival	Dr. Stella Kanyerere, <i>Country Director, Living Goods</i>
3:00 – 5:30 pm	Breakout Session 5	Nives Mbabazi. Community Health Extension	Dr. Flavia Mpanga

Time	Activity	Facilitator / Speaker	Session Chair
Meera Hall	Track 3 (continued): Promoting Community Systems for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)	Workers as a Bridge between Facility and Home: Strengthening Continuity of Care for Small and Sick Newborns through the Hospital-to-Home Model in Uganda Shamim Namagembe. Mobile Cervical Cancer Prevention Outreaches: Partnering with Local Communities to Increase HPV and Cervical Cancer Awareness and Advocacy in Mid-Western Uganda Julius Kayizzi. Utilisation of Family Planning Methods among Teenage Mothers in Lira District: Prevalence and Associated Factors Harriet Atuhairwe. Strengthening Community-Based Maternal Health Care through Mobile Health Technologies: Experiences of Midwives and Community Health Workers in Rural Western Uganda Chris Katiisa. Harnessing Community Theatre to Shift Sociocultural Norms on Teenage Pregnancy: A Desk Review of Evidence from Sub-Saharan Africa J. Semmambo. Health Facility–Community Linkages for Postpartum Follow-up of Women with Adverse Pregnancy Outcomes: A Feasibility Study in Mayuge District, Uganda	UNICEF
3:00 – 5:30 pm Victoria Ballroom	Community Health Workers Summit		

Time	Activity	Facilitator / Speaker	Session Chair
3:00 – 3:10 pm	CHWs as a career pathway in Uganda - evaluating opportunities, structural gaps and youth integration	Edrine Kalemeera , YouthAlive	Phoebe Namulindwa, RDC – Kassanda DLG
3:10 – 3:20 pm	New evidence and findings from a five-year CHW implementation project as a national model	Prof. Nazarius Mbona Tumwesigye, KOFIH	
3:20 – 4:30 pm	Breakaway sessions For an ideal CHW workforce: What is the current gap, and what is the suggested solution? Group 1: Motivated and effective CHWs; well-supervised CHWs	Scovia Fokushaba, District Health Educator, Kazo	
	Group 2: District and facility ownership and coordination; national programme alignment and integration	Dr. Muwanga Edward, DHO, Kyotera	
	Group 3: Standardisation, reporting and digitalisation; performance and professional development; medicines and supply chain	Allen Nabanooba, UNICEF	
4:30 – 5:30 pm	Plenary: group presentations (10 minutes per group) and discussion	Amy Kakiza, Living Goods	
5:30 pm	Evening tea, networking and departure		

Day 3: Friday, 16 October 2026

Time	Activity	Facilitator / Speaker	Session Chair
8:00 – 8:50 am	Arrival, registration and breakfast	Registration Team	Master of Ceremonies
8:50 – 9:00 am	Recap of Day 2	Abirahmi Kananathan	Dr. Diana Atwine
9:00 – 9:10 am	Results of the Client Satisfaction Survey: Insights for Local Government Leaders	Dr. Rachel Beyagira Commissioner, SCAPP	Permanent Secretary, Ministry of Health
9:10 – 9:20 am	Presentation on the Social Services Committee Manual	Brenda Nakanwagi, SPO, Ministry of Health (HPE&C)	
9:20 – 10:00 am	Address: How to Leverage Local Government Community Structures to Improve Accountability for Primary Health Care	Hon. Balaam Barugahara Minister for Local Government	
10:00 – 10:20 am	Discussion, questions and answers	All	
10:20 – 11:00 am	Presentation: Leveraging Community Structures to Address the Rising NCD Burden in Uganda	Presenter: Dr. Jackson Orem, PhD, Executive Director, Uganda Cancer Institute Panellists: • Ritah Namyalo, Executive Director, Healthy Heart Foundation • Dr. Andrew Balyeku, Minister for Health, Busoga Kingdom • Community Health Worker	Dr. Juliet Ndibazza Uganda Martyrs University
11:00 – 11:30 am	Tea break		

Time	Activity	Facilitator / Speaker	Session Chair
11:30 am – 1:30 pm Royal Palm Ballroom Global Health Security Session 2 <i>By invitation only</i>	High-Level Side Event: Leveraging the Power of the Private Sector to Address the Burden of Preventable Diseases in Uganda	- Dr. Daniel Kyabayinze - Dr. Richard Kabanda - Joshua Musasizi	Dr. Diana Atwine Permanent Secretary
11:30 am – 1:30 pm Albert Hall Global Health Security Session 3 <i>By invitation only</i>	Side Event: Preparedness and Response to Outbreaks in Urban Communities	- Opening remarks: Lord Mayor Ronald Nsubuga Balimwezo, Mayor of Kampala - Atek Kagirita, IC BEVD - Dr. John Baptist Waniaye, CHS Emergency Medical Services, MoH - Dr. Miriam Nanyunja, WHO - Closing remarks - Hon Minister of Kampala	Mayor, Hoima City
11:30 am – 1:30 pm Victoria Ballroom	Community Health Workers Summit		
11:30 – 11:40 am	Recap	Bonny Natukunda	DHO Omoro DLG
11:40 am – 12:00 pm	Brief on the bottleneck analysis of CHEWs implementation.	Emmanuel Kayongo, Melmo Service Solutions	
12:00 – 12:20 pm	Engaging Young People for Better HIV Outcomes: The Contribution of AHF's Girl Act Program to Retention and Viral Suppression	Dr. Kawooya Sulaiman, AHF	
12:20 – 12:40pm	Discussion	All	
12:40 – 1:00 pm	Male Engagement Strategy Dissemination	Dr. Olive Sentumbwe Mugisa	

Time	Activity	Facilitator / Speaker	Session Chair
1:30 – 2:30 pm		Lunch	
2:30 pm	Closing, and Awards Ceremony	Conference Convener Development Partners Director General Health Services Permanent Secretary, Ministry of Health Hon. Minister of Health	Hon. Dr. Charles Ayume, Minister of State for Health – Primary Health Care

SPEAKER PROFILES

H.E. Maj. (Rtd) Jessica Alupo **Vice President of the Republic of Uganda**

H.E. Maj. (Rtd) Jessica Alupo is a Ugandan politician, educator, former military officer and public-sector leader who serves as Vice President of the Republic of Uganda, a position she has held since June 2021. In May 2026, she was approved by Parliament to serve a second term as Vice President. She is also the elected Woman Member of Parliament for Katakwi District. H.E. Alupo holds a Bachelor of Arts degree in Linguistics and Political Science and a Master of Arts in International Relations and Diplomacy from Makerere University, as well as postgraduate training in Public Administration and Management. Before entering national political leadership, she



worked as a teacher and served in the Uganda People's Defence Forces, including as an instructor and intelligence officer. Her political and public service career has included serving as Minister of State for Youth and Children Affairs and, from 2011 to 2016, as Minister of Education and Sports. As Vice President, H.E. Alupo supports the President in the execution of national responsibilities and represents Uganda in high-level national, regional and international engagements, with her public service spanning governance, education, youth development, diplomacy, peace and security, and socioeconomic development.

**Rt. Hon. Jacob Marksons Oboth****Speaker of the 12th Parliament of the Republic of Uganda**

Rt. Hon. Jacob Marksons Oboth is the Speaker of the 12th Parliament of the Republic of Uganda, having been elected to the position on 25 May 2026. He is a lawyer, legislator and former Cabinet Minister with extensive experience in parliamentary leadership, governance, public administration and legal affairs. He has served as a Member of Parliament since 2011, representing West Budama in Tororo District. During his parliamentary career, he has held several leadership positions, including Chairperson of the Committee on Legal and Parliamentary Affairs, the Committee on Rules, Discipline

and Privileges, and the Committee on Natural Resources. He also previously served as Minister of Defence and Veteran Affairs. Rt. Hon. Oboth holds a Bachelor of Laws degree from Makerere University, a Postgraduate Diploma in Legal Practice from the Law Development Centre, and a Master of Laws degree from the University of Minnesota, United States. As Speaker, he presides over parliamentary proceedings and provides leadership in legislative business, oversight and institutional accountability. His experience spans law, governance, public policy and national leadership.

Dr. Chris Baryomunsi**Minister of Health, Uganda**

Dr. Chris Baryomunsi is a Ugandan physician, public health specialist and demographer serving as Minister of Health. His career spans clinical medicine, international development and national governance, including previous Cabinet service in ICT and National Guidance and Housing. He has championed public health legislation, including the Prohibition of Female Genital Mutilation Act and the Tobacco Control Act, and has held technical roles with UNFPA and German Technical Cooperation. He holds a Bachelor of Medicine and Surgery, postgraduate qualifications in HIV/AIDS management and demography, a Master's degree in Demography from Makerere University, and a PhD in Public Health. His work has focused on public health, maternal health, HIV/AIDS integration and population dynamics.





Dr. Diana Atwine, MBChB, MMed
Permanent Secretary, Ministry of Health Uganda

Dr. Diana Atwine Kanzira is the Permanent Secretary of Uganda's Ministry of Health, providing leadership and stewardship of the country's health resources. A physician and specialist in internal medicine, she has championed reforms focused on ethics, quality, accountability and improved health outcomes. Her professional background includes postgraduate training in project planning and management and quality improvement, as well as experience in clinical trials, bioethics and HIV/AIDS. Before her appointment as Permanent Secretary, she served as Director of the Health Monitoring Unit under State House, where she promoted a more responsive and accountable health system.

Hon. Dr. Charles Ayume
Minister of State for Health – Primary Health Care, Uganda

Hon. Dr. Charles Ayume is a Ugandan medical doctor, legislator and health-sector leader serving as Minister of State for Health in charge of Primary Health Care and as Member of Parliament for Koboko Municipality. Before joining Cabinet, he chaired Parliament's Committee on Health, providing oversight of health policy, financing and service delivery. His professional interests include health systems strengthening, health-sector reform and global health, and he has advocated for stronger attention to antimicrobial resistance and other priority health issues. In his ministerial role, he supports national leadership and policy oversight for primary health care, preventive and community-based health services, health workforce capacity and equitable access to essential services.





Hon. Anifa Bangirana

Minister of State for Health – General Duties, Uganda

Hon. Anifa Bangirana is a Ugandan politician, administrator and public-sector leader serving as Minister of State for Health in charge of General Duties and as Member of Parliament for Mawogola West County.

Her public service career has included roles in the Constituent Assembly, local government leadership and parliamentary service. She holds a Bachelor of Arts in Development Studies and a Master's degree in International Relations and Diplomacy.

In the health sector, she supports political leadership and oversight across health-sector governance, institutional strengthening, specialised health services and implementation of national health priorities.

Prof. Charles Olaro

Director General Health Services, Ministry of Health Uganda

Prof. Charles Olaro is the Director General of Health Services at Uganda's Ministry of Health and a senior health-sector leader with more than 25 years of experience in health systems strengthening and global health security. A Senior Consultant Surgeon and public health specialist, his expertise spans Primary Health Care, epidemic preparedness, humanitarian response and multisectoral coordination. He has supported initiatives aimed at strengthening health service delivery and advancing Universal Health Coverage, and holds advanced qualifications in surgery, health services management and business administration.



**Dr. Richard Kabanda, MPH, MBA,
PhD, F.A.I.P.H**
**Commissioner, Health Promotion, Education
and Communication, Ministry of Health
Uganda • Conference Convener**



Dr. Richard Kabanda is a distinguished Public Health Specialist with extensive expertise in Health Promotion, Disease Prevention, Public Health Risk Communication and Community Health Systems Strengthening. He heads the Department of Health Promotion at Uganda's Ministry of Health, where he provides national leadership in policy development, strategic advocacy, public health interventions and the implementation of Community Health Worker programmes, including Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs).

At the continental and global levels, Dr. Kabanda serves as an Expert Advisor to the WHO Global Advisory Group of Experts on Health Promotion and Well-being (since 2024) and Chair of the Africa CDC Continental Community Health Technical Working Group (since 2023). He previously co-chaired the Africa Public Health Risk Communication and Community Engagement Community of Practice (2021–2023). His contributions to health governance include serving as Chair of the Buganda Kingdom Health and Gender Committee and Chair of the Nkozi Hospital Board of Governors (since 2013 and 2023 respectively), Member of the Mubende Regional Referral Hospital Board (since 2023), and Member of the Health Sector Skills Expert Committee under Uganda's TVET Council.

An accomplished academic and researcher, Dr. Kabanda has served as a Lecturer, Senior Lecturer and Academic Consultant at Uganda Martyrs University. He has mentored and supervised over 50 postgraduate MSc and MPH candidates to completion, with ongoing PhD supervision at Uganda Martyrs University and Strathmore University, Kenya. He has also served as an external examiner for Mountains of the Moon University and King Ceasor University and authored or co-authored several peer-reviewed publications on public health, disease prevention, community engagement and health systems strengthening.

In 2022, he received special recognition for his exceptional contribution and leadership in Uganda's Health Promotion and Disease Prevention agenda. Dr. Kabanda holds a PhD in Public Health, a Master of Public Health and a Master of Business Administration, alongside professional qualifications in Dentistry, Health Promotion and Health Services Management. He is a Fellow of the African Institute of Public Health and a member of the International Society for Global Health, Edinburgh, United Kingdom.



Her Excellency Anna-Maria Olsson Ambassador of Sweden to Uganda

Her Excellency Anna-Maria Olsson is a Swedish diplomat serving as Ambassador Extraordinary and Plenipotentiary of the Kingdom of Sweden to Uganda, having assumed office in August 2026. Her experience spans diplomacy, international development, peace and security, and multilateral cooperation. Before her ambassadorial appointment, she served as Head of the Group for Southern, Eastern and Central Africa within Sweden's Ministry for Foreign Affairs. She has previous professional experience in Uganda and has also served at Sweden's Permanent Representation to the European Union and the Folke Bernadotte Academy. Her work has focused on international cooperation, sustainable development, peace and security, regional affairs and partnership building.

H.E. Lee Sang-ho Ambassador of the Republic of Korea to the Republic of Uganda

H.E. Lee Sang-ho is a South Korean diplomat who serves as Ambassador of the Republic of Korea to the Republic of Uganda, having taken up his posting in 2026. As Ambassador, he leads the Republic of Korea's diplomatic mission in Uganda and works to strengthen the longstanding bilateral relationship between the two countries, which established diplomatic relations in 1963. His mandate encompasses political and diplomatic relations, trade and investment, development cooperation, education, health, agriculture, digital transformation, public-sector capacity building and cultural exchange. He also supports partnerships implemented through Korean institutions and programmes that contribute to Uganda's national development, including initiatives in healthcare, agricultural productivity, education and vocational training, technology and human-capital development. H.E. Lee's diplomatic engagement in Uganda places particular emphasis on expanding mutually beneficial cooperation, strengthening institutional and people-to-people ties, and promoting



knowledge and experience sharing between Korea and Uganda in support of sustainable development and shared prosperity



His Majesty the Kyabazinga

Isebantu Kyabazinga of Busoga

His Majesty William Wilberforce Kadhumbula Gabula Nadiope IV is the reigning Isebantu Kyabazinga of Busoga and cultural leader of the people of Busoga. He was elected Kyabazinga by the Busoga Royal Chiefs in 2014 and enthroned the same year. He holds a Bachelor of Arts in Economics from Kyambogo University, a Master of Business Administration from Coventry University and, as stated in the supplied profile, a Master of Advanced Studies in Global Affairs from Yale University. Before ascending the throne, he worked as an economist with Uganda's Ministry of Energy and Mineral Development. His Majesty champions education, health, youth empowerment and socioeconomic development, using the cultural institution to mobilise communities around health and social priorities.

Mr. Leonard Zulu

United Nations Resident Coordinator in Uganda

Mr. Leonard Zulu is an international development and humanitarian affairs leader serving as United Nations Resident Coordinator in Uganda, a position he assumed on 1 November 2024. He brings more than 20 years of experience in humanitarian action, refugee protection, human rights, peacebuilding and sustainable development. Previously, he served as UNHCR Representative in Afghanistan, Representative for the South Africa Multi-Country Office and Deputy Director of UNHCR's Regional Bureau for Southern Africa. He holds a Master's degree in International Law from Lund University and a Bachelor of Laws (Honours) from the University of Zimbabwe. In Uganda, he leads and coordinates the UN Country Team in support of national development priorities and the Sustainable Development Goals.





Ms. Kristine Blokhuis

UNFPA Representative in Uganda

Ms. Kristine Blokhuis is an international development professional and United Nations leader serving as UNFPA Representative in Uganda, a position she assumed in September 2025. She brings more than 20 years of experience spanning sexual and reproductive health and rights, gender equality, population and development, and humanitarian response. Before her appointment to Uganda, she served as UNFPA Representative in Bangladesh and held leadership and technical roles with UNFPA, UNDP and other international organisations. She holds a Master's degree in Development Studies from the London School of Economics and Political Science and a double Bachelor's degree in Political Science and French from the University of Warwick.

Dr. Fouzia Shafique

**Associate Director for Health, UNICEF Headquarters.
Global Lead, Community Health**

KEYNOTE SPEAKER

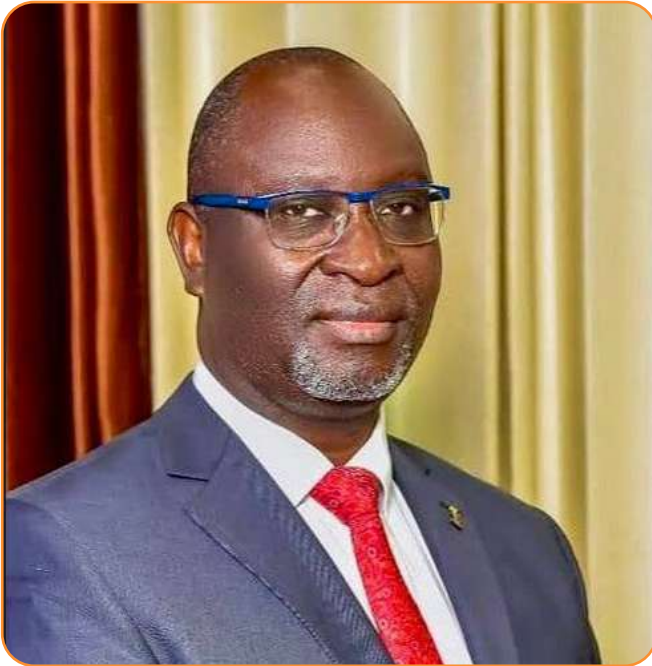
Dr. Fouzia Shafique is Associate Director for Health at UNICEF Headquarters and UNICEF's global lead for Community Health. She oversees work spanning maternal, newborn, child and adolescent health; Primary Health Care and health-system strengthening; and digital health and information systems. Previously, she led UNICEF health programmes in Afghanistan and health and nutrition programming in Yemen, and from 2019 to 2021 led UNICEF's global work on health in humanitarian settings and emergencies. An alumna of Aga Khan University and the London School of Hygiene & Tropical Medicine, she began her public health career with Pakistan's Ministry of Health and has supported maternal and child health and vaccine-preventable disease initiatives across Africa and Asia.



Mary Borgman
Global Health Diplomacy
Director, U.S. Embassy in
Uganda



Mary Borgman is a public health and international development professional who joined the U.S. Embassy in Uganda in 2022 and currently serves as Global Health Diplomacy Director. She provides strategic leadership for the U.S. health foreign assistance portfolio in Uganda, overseeing implementation of the five-year, USD 2.3 billion bilateral Memorandum of Understanding on health cooperation signed in December 2025. She leads the design and implementation of health assistance programmes focusing on HIV, tuberculosis, malaria, maternal and child health, polio surveillance and global health security, in alignment with the America First Global Health Strategy. Previously, she served as PEPFAR Country Coordinator in Uganda and held a role within the Bureau of Global Health Security and Diplomacy. Before joining the U.S. Department of State in 2018, she worked in child protection, integrated health services, community-based children and family services, and foreign assistance. A licensed clinical social worker, she has dedicated her career to strengthening public health systems and improving access to healthcare for medically underserved populations.

**Owekitiibwa Robert Waggwa Nsibirwa**

**Second Deputy Premier (Katikiro)
and Minister for Finance, Investments,
Planning & Economic Development,
Buganda Kingdom**

Owekitiibwa Robert Waggwa Nsibirwa is an economist, entrepreneur and public servant with extensive experience in corporate governance, economic development, education and community empowerment. He currently serves as Second Deputy Premier and Minister for Finance, Investments, Planning & Economic Development in the Buganda Kingdom, where he champions investment, public-private partnerships, youth empowerment and sustainable economic growth. He holds several institutional leadership positions, including Chairman of Greenhill Holdings, Chairman of World Class Team Limited, Trustee of King's College Budo and Board Member of Busoga College Mwiri, contributing to quality education and institutional governance. A committed community development advocate, he serves as Chairman of Habitat for Humanity Uganda and is a Past Rotary District Governor (District 9211, Uganda and Tanzania), supporting affordable housing, youth development and peacebuilding initiatives. In the business sector, he is Co-Founder and Group CEO of the Africa Coffee Academy, promoting agricultural entrepreneurship, coffee trade, export marketing and price risk management. He also co-founded Ashland Motors Africa Ltd. and Rich Farmers Uganda Ltd. and serves as Adjunct Faculty at Strathmore University Business School, mentoring emerging leaders in corporate governance. His leadership is grounded in integrity, service, institutional excellence and creating sustainable opportunities for communities and future generations.

Dr. Jackson Orem, PhD

Executive Director, Uganda Cancer Institute

Dr. Jackson Orem is a Ugandan medical oncologist, researcher and health-sector leader serving as Executive Director of the Uganda Cancer Institute. He trained in medicine and internal medicine at Makerere University, undertook specialised training in haematology and oncology at Case Western Reserve University, and completed a PhD in cancer science at Karolinska Institutet. He has led the Uganda Cancer Institute since 2004, supporting its development as a regional centre for specialised cancer care, research and training. His professional interests include infection-related cancers, clinical oncology, cancer research and effective cancer-care models for resource-limited settings.



Hon. Balaam Barugahara Ateenyi

Minister for Local Government, Government of Uganda

Hon. Balaam Barugahara Ateenyi is a Ugandan politician, entrepreneur and public-sector leader serving as Minister for Local Government, following his appointment to Cabinet in May 2026. He previously served as Minister of State for Gender, Labour and Social Development in charge of Youth and Children Affairs. He holds a Bachelor of Commerce degree in Marketing from Makerere University and a Master of Business Administration from Cavendish University Uganda. As Minister for Local Government, he provides political leadership to the ministry responsible for guiding, coordinating, mentoring and supporting local governments to strengthen decentralised governance and public-service delivery.

Dr. Roselline Achola**Senior Technical Advisor, SRHR/Family Planning and Self-Care, Ministry of Health Uganda**

Dr. Roselline Achola is a Public Health Specialist currently serving as the Senior Technical Advisor for SRHR/Family Planning and Self-Care in the Ministry of Health, with a role in institutionalising self-care in the health system. This is through disease prevention and health promotion using the National Self-Care Guidelines, to support the advancement of primary health care for achieving Universal Health Coverage.

Dr. Achola served at various levels and locations with the United Nations Population Fund, where she offered technical guidance for the global programs on Reproductive health and commodity security.

In her leadership roles, Dr. Achola supports the formulation and implementation of policies, strategies, guidelines, and investment cases to harness domestic resources for health interventions. She also designs and implements

pilot projects like the CHEWs inserting implants in Uganda that generated evidence for scale-up.

She sits on several Global and local Health Technical Advisory Committees of experts that advance Global Public Health issues: High Impact Practices, Global Public Health Experts in Washington, Global SELF CARE working group, Donor partnerships, and Advisory Boards for research studies for evidence generation and a National Think Tank for SRH. She coordinates the FP2030 initiative in Uganda and leads the Uganda Self-Care Expert Group and is also an Honorary Lecturer with Makerere University School of Public Health.

Dr Roselline holds a PhD in Public Health from Makerere University





Jackie Katana

Founder & Executive Director, Faith for Family Health Initiative (3FHi)

Jackie Katana is a certified Project Management Professional, health expert and sexual and reproductive health advocate with more than 20 years of experience in public health programme design, implementation, management and policy. She is Founder and Executive Director of Faith for Family Health Initiative (3FHi) and previously served as Health Advisor at the Embassy of Ireland. She chairs Uganda's RMNCAH+N and Healthy Ageing Civil Society Organisation Platform for 2024-2028 and represents reproductive health civil society organisations on the Ministry of Health's Health Policy Advisory Committee. Her work spans civil-society leadership, policy engagement and partnerships for reproductive, maternal and community health.

Dr. Rachel Beyagira, MBChB, MMed (ENT), MPH

Acting Commissioner, Standards Compliance, Accreditation and Patient Protection, Ministry of Health Uganda

Dr. Rachel Beyagira is a Ugandan medical doctor, ENT specialist and public health professional serving as Acting Commissioner for Standards Compliance, Accreditation and Patient Protection at the Ministry of Health. She provides leadership in health standards, regulatory compliance, quality improvement, patient safety and patient protection. Her public service career has included serving as Assistant Commissioner for Adolescent and School Health and as a Ministry technical officer on viral hepatitis. She trained in medicine at Mbarara University of Science and Technology, completed a Master of Medicine in ENT at Makerere University and a Master of Public Health at the University of Sheffield. Her work focuses on people-centred health systems, service integration, disease prevention and quality of care.





Mr. John Wanyungu
Deputy Head, Division of Community
Health Services, Ministry of Health
Kenya

Mr. John Wanyungu is Deputy Head of the Division of Community Health Services at Kenya's Ministry of Health, where he leads Strategic Information and Community Health Services Delivery Digitization. Since 2021, he has spearheaded digital transformation of Kenya's Community Health Strategy, supporting more than 107,000 professionalised community health workers. He also co-chairs Community Health Units for Universal Health Coverage (CHU4UHC), a coalition coordinating investment, implementation and advocacy for stronger Primary Health Care. He holds a Master's degree in Community Health from the University of Liverpool and specialised postgraduate training in quality improvement and health systems management.

**Prof. Moses Galukande, MBChB, MMed,
Msc, PhD, FCG(ECSA) FACS****PROFESSOR MOSES GALUKANDE MBChB, MMed
(Surgery), MSc HPE, FCS-ECSA, FACS, Ph.D.**

Professor Moses Galukande is a distinguished Ugandan surgeon, academic, researcher and health systems leader with nearly three decades of experience in clinical practice, medical education, research and community health service delivery. He is Professor of Surgery at Makerere University College of Health Sciences, where he served as Chair of the Department of Surgery from 2016 to 2025. He is also Chancellor of Clarke International University and served as President of the Association of Surgeons of Uganda (ASOU) from 2024 to 2026. An accomplished clinician, Professor Galukande has performed over 30,000 surgical procedures, principally in breast surgery, gastrointestinal surgery and trauma. His contribution to public health extends beyond hospital walls. He has provided leadership for HIV prevention programmes involving approximately 60,000 medical male circumcisions with IMG-CCare network & IDI and served on World



Health Organization technical advisory groups as Co-Chair. A strong advocate for equitable access to essential surgery, he has been instrumental in organizing large-scale community surgical camps across Uganda. Notably, the Ankole surgical camp in 2024 delivered 2,418 operations, while the West Nile camp in 2025 delivered 2,236 operations, and most recently in Buganda region delivered 2797 operations demonstrating the potential of coordinated outreach to address unmet surgical needs in underserved communities. Professor Galukande is an internationally recognized researcher with 175 peer-reviewed scientific publications and over 6,500 citations. His research spans breast cancer, surgical access, trauma, patient safety and health systems. He has participated in international multi-country research collaborations, including landmark studies on breast cancer survival in sub-Saharan Africa. He is equally passionate about training the next generation of health professionals, having mentored numerous undergraduate, postgraduate and doctoral researchers. Beyond academia, he has authored over 300 newspaper articles promoting public understanding of health and disease prevention. His professional mission is anchored in a simple conviction: quality health care, including essential surgical services, must reach people where they live, not only where hospitals are located. Ladies and gentlemen, please join me in welcoming Professor Moses Galukande, who will speak on “Advancing Surgical Services in the Community as a Health Promotion and Disease Prevention Intervention.”



Dr. Robert Mutumba, MBChB, MPH
**Assistant Commissioner / Program Manager, STD/
AIDS Control Program, Ministry of Health Uganda**

Dr. Robert Mutumba is a public health specialist with more than 14 years of experience across RMNCAH, sexual and reproductive health, HIV/AIDS, malaria, tuberculosis, gender-based violence and mental health. He serves as Assistant Commissioner and Program Manager for the STD/AIDS Control Program at Uganda's Ministry of Health, leading national and subnational HIV/AIDS prevention and control interventions. Previously, he served as a Principal Medical Officer in the Reproductive and Child Health Department and chaired technical working groups in maternal and child health, family planning and SRH/HIV/GBV integration. He holds an MBChB and MPH and completed the Afya Bora Consortium Fellowship in Global Health Leadership and Management

Dr. Richard Mugahi
**Commissioner Health Service's in-charge of
Reproductive and Child Health**

Dr. Richard Mugahi is a Medical Doctor with specialization in Public Health.

He works at the Ministry of Health as the Commissioner Health Service's in-charge of Reproductive and

Child Health. He has 20 years of experience working at different levels of the Health Sector in Uganda. He has worked as a frontline clinician, and health care manager at both National and Subnational level. He has coordinated and implemented various safe motherhood interventions throughout the country. Noted achievements like coordinating national interventions to improve Skilled Birth Attendance at birth from 74% to 91%, which resulted in an overall 40% reduction of maternal mortality ratio. He is currently championing reforms to strengthen delivery of respectful quality Maternal and Newborn Care Services through the routine virtual (weekly)



engagements on Maternal and Perinatal Deaths Audits Surveillance and Response (MPDSR). He has authored and co-authored publications in respectful maternity care and Maternal, Family planning services, sexual reproductive health and Neonatal Quality of Care.

NATIONAL ORGANISING COMMITTEE

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Joy Nekesa	Intern
Melissa Lamar	Intern

BOOK OF ABSTRACTS

Integrated draft abstract section – **59 accepted abstracts: 32 oral presentations and 27 posters.** Abstracts are retained in programme order with their presentation codes, author details, affiliations and edited scientific content.

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Conference tracks

Track 1 11 abstracts

Strengthening Community Integrated Service Delivery through Community Health Workers

Track 2 7 abstracts

Leveraging Digital Transformation for Community Engagement and Systems

Track 3 21 abstracts

Promoting Community Systems for Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNACH)

Track 4 7 abstracts

Building Community Resilience for Health Security (Preparedness, Response and Recovery)

Track 5 13 abstracts

Advancing Social Behaviour Change for Health Promotion and Wellbeing

Programme at a glance

Session	Day and time	Track	Abstracts
Breakout Session 1	Day 1 · Wed 14 Oct 2:30 pm – 5:30 pm	Track 1	O1.1 – O1.6 (6)
Breakout Session 2	Day 1 · Wed 14 Oct 2:30 pm – 5:30 pm	Track 5	O2.1 – O2.7 (7)
Gallery Walk 1	Day 1 · Wed 14 Oct 8:00 am – 9:00 am	Tracks 1 & 5	P1.01 – P1.11 (11)
Breakout Session 3	Day 2 · Thu 15 Oct 11:30 am – 1:10 pm	Track 3	O3.1 – O3.5 (5)
Breakout Session 4	Day 2 · Thu 15 Oct 11:30 am – 1:10 pm	Track 4	O4.1 – O4.4 (4)
Gallery Walk 2	Day 2 · Thu 15 Oct 2:00 pm – 2:30 pm	Tracks 2, 3 & 4	P2.01 – P2.16 (16)
Breakout Session 5	Day 2 · Thu 15 Oct 3:00 pm – 5:00 pm	Track 3 (continued)	O5.1 – O5.6 (6)
Breakout Session 6	Day 2 · Thu 15 Oct 3:00 pm – 5:00 pm	Track 2	O6.1 – O6.4 (4)

PART A : ORAL PRESENTATIONS

Breakout Session 1

Track 1: Strengthening Community Integrated Service Delivery through Community Health Workers

Day 1 • Wednesday 14 October 2026 • 2:30 pm – 5:30 pm

- 01.1** **Community health workers test before they treat: Presumptive antimalarial treatment across community, public and private providers among febrile children in the 2024 to 2025 Uganda Malaria Indicator Survey**

Kaweesi Calvin Nantalaga

- 01.2** **Integrating eye health into Uganda's community health worker platform: Feasibility and early outcomes from a pilot in Kaliro District**

Anne Mary Agaba

- 01.3** **Taking TB screening to the streets: A mobile van model for active case finding in Kisenyi slums, Kampala**

Muwonge Robert

- 01.4** **Community treatment surpassing facility care: Evidence of last-mile disease prevention from a digitally-enabled community health model supporting Wakiso District, Uganda**

Moses Okech

- 01.5** **Strengthening community integrated service delivery: Lessons from expanding community-based contraceptive implant services using community health extension workers in Uganda**

Tumusiime K. Justine

- 01.6** **Institutionalising integrated community health workforces for dual burden disease prevention in rural Uganda**

Nuwamanya Babrah

Community health workers test before they treat: Presumptive antimalarial treatment across community, public and private providers among febrile children in the 2024 to 2025 Uganda Malaria Indicator Survey**Kaweesi Calvin Nantalaga**, Alice Nantege, Martha Nabirye

School of Medicine, Makerere University College of Health Sciences, Kampala, Uganda

Background

Uganda requires parasitological confirmation before antimalarial treatment, and village health teams (VHTs) are trained to test before treating under integrated community case management. Whether community structures uphold this standard nationally, relative to other providers, is unquantified.

Objectives

This study compared presumptive antimalarial treatment across community, public and private providers.

Methods

We analysed the children's recode of the 2024 to 2025 Uganda Malaria Indicator Survey. Among febrile children under five, presumptive treatment meant receiving an antimalarial with no blood taken. Providers were grouped as public, community health worker (CHW) or VHT, private formal, drug retail and informal. Survey-weighted modified Poisson regression estimated adjusted prevalence ratios (aPR) against the public sector, adjusting for child age, residence, maternal education and household wealth.

Results

Of 6,477 children, 2,080 (32.1%) had fever in the preceding two weeks. Presumptive treatment occurred in 22.0% of febrile children (95% confidence interval (CI) 19.6 to 24.4) and 32.6% of those treated. Blood was taken from 75.7% of children seen by CHWs or VHTs, 87.4% in the public sector, 65.0% in private formal facilities and 17.7% in drug retail. Presumptive treatment among CHW or VHT contacts was 7.7% and, after adjustment, did not differ from the public sector (aPR 1.54, 95% CI 0.62 to 3.86), although this imprecise estimate rests on 94 children. Presumptive treatment was 4.76 times higher in private formal facilities (95% CI 3.01 to 7.53) and 10.87 times higher in drug retail (95% CI 6.87 to 17.19). Neither residence nor wealth was associated with the outcome.

Conclusions and implications

CHWs delivered diagnostically appropriate malaria care indistinguishable from public facilities, subject to the imprecision noted. Presumptive treatment depends on where a child is taken rather than who the child is. This supports formally positioning community structures within primary health care and extending diagnostic supply, accreditation requirements and surveillance reporting to private providers.

Keywords: community health workers; village health teams; malaria case management; presumptive treatment; rapid diagnostic test

Integrating eye health into Uganda's community health worker platform: Feasibility and early outcomes from a pilot in Kaliro District

Anne Mary Agaba, Michael Bamulangeyo, Isaac Okiring, Jimmy Ochorin, Taylor Hendricks

Issue

Uganda's health system grapples with fragmented, disease-specific service delivery as the burden of non-communicable and vision-related conditions grows. Presbyopia and other causes of vision impairment remain under-addressed at community level, despite a village health team (VHT) platform capable of extending basic eye care alongside routine services.

Intervention

Between January 2025 and March 2026, the Clinton Health Access Initiative (CHAI), in partnership with the Ministry of Health (MoH) and EYelliance, developed a community eye health training package, including a community health worker (CHW) job aid, a facilitator's manual and eye health reporting tools aligned with the Health Management Information System (HMIS). Thirty trainers were equipped to cascade training to 200 VHTs across five sub-counties of Kaliro District. Equipped with screening kits and 16,200 pairs of reading glasses, VHTs integrated vision screening, dispensing of reading glasses for presbyopia (age 40+) and referral of eye health problems into their routine household and outreach visits.

Results

Over 5.5 months, VHTs screened 66,767 people. Presbyopia burden among screened adults aged 40+ was 50.8% (8,390 of 16,519 failed near-vision testing); 95.6% of these (8,021) received reading glasses, and 5,332 individuals were referred for eye care. VHT knowledge scores improved after training, and no eyeglasses were dispensed outside the 40+ eligibility criterion, indicating protocol adherence. VHTs provided vision screening and glasses alongside services such as immunisation, and reported data through routine documentation. Reading glasses were adopted into district supply chain processes.

Lessons learned

Integrating eye health into existing CHW workflows is feasible without a parallel delivery system, reaches underserved populations and can be scaled. District commitments to domestic financing through the Primary Health Care grant, and prioritised workforce recruitment, point to a pathway for institutionalising eye health within Uganda's community health system.

Taking TB screening to the streets: A mobile van model for active case finding in Kisenyi slums, Kampala

Muwonge Robert¹, Kasalirwe Teddy², Semei Christopher Mukama³, Ignatius Senteza³, Mary Nabukenya-Mudiope³

¹AIDS Information Centre, Uganda

²Uganda Cares Owino, Uganda

³Local Partner Health Services TB and Urban Health Activity, Uganda

Background

Tuberculosis (TB) remains underdiagnosed in urban informal settlements due to limited access to health services, transport barriers, stigma and competing livelihood demands. In Kisenyi slums, these factors contribute to delayed care-seeking, ongoing transmission and missed cases. Mobile van outreach offers an opportunity to bring TB screening closer to high-risk populations and improve early detection.

Objectives

To assess the yield of a mobile van-based active case-finding model for TB in Kisenyi slums.

Methods

A mobile van-based active case-finding intervention was conducted in high-risk hotspots, including markets, transport stages, taxi parks and densely populated residential areas. Four village health teams (VHTs) and five health workers screened individuals using Intensified Case Finding tools. Presumptive TB clients provided on-site sputum samples for GeneXpert testing. Health education and counselling were provided, and all diagnosed cases were linked to nearby facilities for treatment.

Results

Over four days, 1,240 individuals were screened; 410 (33.1%) were presumptive TB. Of these, 350 were tested, yielding 11 TB cases (including 3 bacteriologically confirmed), all of whom were linked to care on the same day. Positivity among those tested was 3.1%, with an overall yield of 0.9% and a number needed to screen (NNS) of 113. Additionally, 6 individuals tested HIV-positive and were linked to antiretroviral therapy (ART), including 2 pregnant women referred for antenatal care. Following negative TB results, 80 clients were initiated on TB preventive treatment (TPT).

Conclusions and implications

Mobile van outreach is an effective community-driven strategy for enhancing TB case detection in high-burden settings. Bringing services closer to communities reduces access barriers, increases screening uptake and improves linkage to care. Scaling up this model could significantly strengthen TB control in similar urban informal settlements.

Community treatment surpassing facility care: Evidence of last-mile disease prevention from a digitally-enabled community health model supporting Wakiso District, Uganda

Moses Okech, John Mwebaze, Evelyne Kusiima, Stella Kanyerere, Amy Kakiza Rwakihembo, Saul Mutimba

Living Goods Uganda

Background

Village health teams (VHTs) are the first point of contact for sick children under five at household level in Uganda, but have been constrained by limited commodities, inconsistent supervision and paper-based data. Living Goods supports the Ministry of Health and Wakiso District Local Government to strengthen community health services through the electronic Community Health Information System (eCHIS) and the DESC model (Digitising, Equipping, Supervising and Compensating).

Objectives

To examine whether DESC-supported, eCHIS-enabled community case management can shift under-five (U5) malaria treatment from facilities to the community, a measurable indicator of last-mile access.

Methods

A retrospective comparative analysis of routine facility (DHIS2/HMIS) and community (eCHIS) data was conducted in Wakiso District from January to December 2025. Monthly facility- and community-based U5 malaria treatment volumes were compared, as were U5 treatment rates between implementation sub-counties, where VHTs receive full DESC support (eCHIS, performance-based incentives, commodities, refresher training and supportive supervision), and control sub-counties without this support.

Results

Community treatment first exceeded facility treatment in March 2025 (community 4,139 vs. facility 3,392) and remained above it thereafter. Community volumes climbed from 2,113 in January to 11,732 in November (a 5.6-fold increase), while facility volumes stayed broadly stable (range 2,922–4,398). The community share of U5 malaria treatment rose from 35% to 77%, extending last-mile access rather than displacing facility care. In implementation sub-counties, the U5 malaria treatment rate rose from 14% in January to a peak of 56% in August, settling at 54% in December, whereas control sub-counties remained at 11–17%. This divergence began in March 2025, coinciding with the volume crossover.

Conclusions and implications

When VHTs are digitally equipped through eCHIS, stocked, supervised and compensated, community-based U5 malaria treatment can surpass facility-based treatment without reducing facility volumes. Scaling the eCHIS-enabled DESC model across additional districts offers a government-embedded pathway to closing the under-five access gap in Uganda.

Keywords: community case management; eCHIS; village health teams; under-five malaria; DESC model

Strengthening community integrated service delivery: Lessons from expanding community-based contraceptive implant services using community health extension workers in Uganda

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Issue

Community health extension workers (CHEWs) provide low-cost, high-impact health services where skilled professionals are limited. In Uganda, CHEWs can reduce barriers to family planning (FP) among rural and underserved women, such as long distances, transport costs, provider shortages and limited access to long-acting methods, by bringing contraceptive services closer to communities.

Intervention

PATH Uganda, the Ministry of Health and Makerere University School of Public Health implemented an 18-month CIFF-funded project in Kyotera, Namutumba and Lira districts and Lira City to assess the feasibility and acceptability of CHEW-delivered contraceptive implants. A six-day blended training covered FP counselling, client screening, infection prevention, implant insertion, side-effect management, referral and documentation. In total, 499 CHEWs were trained and mentored by 24 district trainers/mentors, and 158 facility-based nurses and midwives were mentored to strengthen CHEW supervision and community-facility linkages. Village health teams (VHTs) sensitised communities, while district teams strengthened FP commodity quantification, redistribution and emergency requisition. Data were captured in CHEW registers.

Results

From March to November 2025, CHEWs provided 10,673 Implanon NXT insertions, 5,785 DMPA-SC doses and other short-term FP methods, plus counselling and referrals, across the four districts and city. In Lira City, monthly implant insertions rose from 410 in March to 2,147 in July 2025, following intensified outreach, mentorship and support supervision, orientation of facility providers on long-acting FP, improved provider confidence and stable commodity availability. CHEWs referred clients needing services beyond their scope. VHT-led mobilisation strengthened community engagement and uptake, while commodity redistribution and emergency requisition helped mitigate stockouts. Uptake was highest among women aged 16–35 years.

Lessons learned

Integrating contraceptive implant services into CHEWs' roles demonstrated their potential to expand access to FP services. Strong linkage between CHEWs and VHTs, supervision by facility-based providers, functional referral systems, commodity availability and easy-to-use data systems are critical to sustaining CHEW-led integrated community health services in Uganda.

Institutionalising integrated community health workforces for dual burden disease prevention in rural Uganda**Nuwamanya Babrah****Background**

As Uganda faces a rising dual burden of communicable and non-communicable diseases (NCDs), reliance on fragmented health services strains rural facilities. Institutionalising the community health workforce offers a sustainable foundation for primary health care and national health security.

Objectives

To evaluate the impact of an integrated community health worker (CHW) service delivery model on mass screening, referral compliance and prevention outcomes for both malaria and hypertension.

Methods

A cluster-randomised study was conducted across 24 villages in Wakiso District over 12 months. Eighty village health teams (VHTs) were formally trained, equipped and financially incentivised to deliver integrated care. They conducted simultaneous community-level screening for malaria (using rapid diagnostic tests) and hypertension (using automated digital blood pressure monitors), alongside structured preventive counselling. Progress was tracked through digital health registries and facility referral logs.

Results

Integrated CHW deployment increased community-level malaria screening compliance from 45% to 88% and identified 340 previously undiagnosed hypertension cases. Referrals for confirmed malaria cases achieved a 96% same-day facility arrival rate. For hypertension, 74% of referred patients completed their initial facility evaluation within 14 days, and 62% maintained controlled blood pressure at the 6-month follow-up. Moving to an integrated model reduced the per-capita cost of community disease surveillance and prevention by 28% compared with vertical, single-disease programmes.

Conclusions and implications

Formally institutionalising and equipping a multi-skilled community health workforce significantly strengthens primary health care. Integrating communicable disease and NCD interventions at household level creates a resilient health security foundation capable of managing Uganda's evolving epidemiological landscape.

Breakout Session 2

Track 5: Advancing Social Behaviour Change for Health Promotion and Wellbeing

Day 1 • Wednesday 14 October 2026 • 2:30 pm – 5:30 pm

02.1 Messaging on what matters: A data-driven approach to prioritise high-impact beliefs for malaria vaccine uptake in Uganda

Ssanyu Kalibbala

02.2 Behavioural and social drivers of measles-rubella vaccine uptake among caregivers of children in Kyegegwa District, January-April 2026

Chrispus Musabe Bakunda

02.3 A secret for survival: Covert contraceptive use and the burden of male resistance to family planning in Kigezi

Ronald Arineitwe Kibonire

02.4 Malaria vaccine uptake among children under five years and associated factors in Kiryandongo District, Western Uganda: A community-based cross-sectional study

Hamdan Kivumbi

02.5 Uptake of the R21/Matrix-M malaria vaccine among children aged 6 to 18 months and associated factors in Apac District, Uganda

Angom Brenda

02.6 Community health workers as catalysts for social behaviour change: Improving household sanitation and health in 52 communities in Kamwenge

Daniel Oceng

02.7 Role of community health workers in delivering social behaviour change interventions for prevention of adolescent alcohol and substance abuse in Northern Uganda

Yiga Sharifuh

Messaging on what matters: A data-driven approach to prioritise high-impact beliefs for malaria vaccine uptake in Uganda**Ssanyu Kalibbala****Background**

Uganda launched the largest malaria vaccine introduction in April 2025. DMI's Better Health Project is a social and behaviour change communication (SBCC) intervention evaluating the uptake of public health interventions, including the malaria vaccine.

Objectives

To identify the beliefs most likely to influence malaria vaccine uptake, to inform messaging for a radio campaign in the West Nile, Northern and Eastern regions of Uganda.

Methods

Drawing on the Theory of Reasoned Action, a mixed-methods approach combined a baseline survey of female caregivers of children aged 7–14 weeks (n=766) with focus group discussions and key informant interviews with caregivers, community leaders and healthcare providers (n=44). Fifteen belief statements were assessed. Beliefs were selected on (1) “potential to gain”, the expected change in vaccination intention if everyone endorsed the belief; (2) feasibility of addressing them through mass media; and (3) alignment with qualitative insights.

Results

Approximately 80% of caregivers were certain of their intention to vaccinate their children against malaria. Four beliefs had the greatest potential to gain: “the malaria vaccine is still too new to know if it really works” and “children can still get malaria even after getting the vaccine, so it's not worth it” (14%), and “the malaria vaccine was not tested properly in Africa” and “if you miss one appointment for the malaria vaccine, it's not worth going back” (13%). Qualitative findings supported this prioritisation, highlighting uncertainty, mistrust and misconceptions about vaccine effectiveness and safety, and confusion about schedules, with some caregivers believing missed doses would not be provided.

Conclusions and implications

A structured, theory- and data-driven prioritisation approach focuses SBCC messages on the beliefs most likely to drive behaviour change. The findings informed the messaging strategy for a 1-year radio campaign to improve malaria vaccine uptake in Uganda, addressing safety concerns, increasing perceived risk of malaria and promoting completion of the four-dose schedule.

Behavioural and social drivers of measles-rubella vaccine uptake among caregivers of children in Kyegegwa District, January-April 2026

Chrispus Musabe Bakunda¹, Godfrey Tumwizere¹, Mariam Nambuya¹, Prossy Nakito¹, Wilber Arinaitwe¹, Elizabeth Nshabohurira¹, Allan Amandu¹, Regina Nanyunja¹, Lilian Aliyinka¹, Rodgers Kalanda¹, Richard Migisha¹, Benon Kwesiga¹, Daniel Kadobera³, Yasiini Nuwamanya², Alex Riolexus Ario¹

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²Uganda National Expanded Program on Immunization, Ministry of Health, Kampala, Uganda

³US Centers for Disease Control and Prevention, Kampala, Uganda

Background

Behavioural and social factors play a critical role in shaping caregivers' decisions regarding childhood immunisation.

Objectives

This study assessed behavioural and social drivers of measles-rubella (MR) vaccine uptake among caregivers of measles case-patients in Kyegegwa District.

Methods

We conducted a mixed-methods cross-sectional survey among caregivers of children aged 9-59 months in the most affected sub-counties of Kasule and Rwentuuha. We obtained a list of households with caregivers of case-children in the study area and systematically selected participants to reach the sample size. Caregivers were interviewed using a structured questionnaire based on the WHO Behavioural and Social Drivers of Vaccination framework. MR vaccine uptake (≥ 1 dose) was assessed, with predictors identified using multivariate logistic regression; qualitative data were analysed thematically.

Results

In total, 259 respondents participated (caregivers of 5 confirmed and 254 suspected cases). More than half of caregivers (53.7%) were aged 25-39 years. Overall, 82% reported that their children had received ≥ 1 dose of MR vaccine. MR vaccine uptake was associated with a health worker recommending vaccination of the child (adjusted odds ratio [aOR] 3.9; 95% confidence interval [CI]: 1.5-10.4) and perceived easy access to vaccination services (aOR 3.3; 95% CI: 1.1-9.8). Caregivers who reported personally taking their children for vaccination were also more likely to report MR vaccine uptake than those who did not (aOR 4.4; 95% CI: 1.6-12.3). Qualitative findings indicated that caregivers' trust in health workers, reminders from village health teams and convenient community outreach sessions were important enablers of vaccination. Some caregivers reported missed opportunities when they arrived late or vaccination services were no longer available.

Conclusions and implications

MR vaccine uptake is driven by caregiver agency, health worker recommendations and localised convenience. To close remaining immunity gaps, public health strategies must address systemic missed opportunities by offering flexible outreach hours and empowering community health teams with targeted tracking.

Keywords: measles-rubella vaccine; vaccine uptake; behavioural and social drivers; caregivers; routine immunisation

A secret for survival: Covert contraceptive use and the burden of male resistance to family planning in Kigezi**Ronald Arineitwe Kibonire**¹, David Ditaba Mphuthi², Muzafaru Twinomujuni³¹School of Nursing and Midwifery East Africa, Aga Khan University, Kampala, Uganda²Department of Health Studies, College of Human Sciences, University of South Africa, Pretoria, South Africa³Department of Life and Consumer Sciences, College of Agriculture and Environmental Sciences, University of South Africa, Pretoria, South Africa**Background**

Male opposition remains a well-documented barrier to contraceptive use in sub-Saharan Africa, yet the literature lacks a deep, context-specific understanding of the dynamics driving this resistance in critically high-burden settings. In the rural highlands of Uganda's Rubanda District, a region with a critically high maternal mortality rate, women's attempts to plan their families are often shrouded in secrecy because of spousal opposition.

Objectives

This study explored the lived experiences of women to understand the underlying drivers of male resistance to long-acting reversible contraceptives (LARCs) and the strategies women employ in response.

Methods

A qualitative study was conducted among women in Rubanda District, Kigezi region, Uganda. Data were collected through eight in-depth interviews and two focus group discussions comprising seven and nine women, respectively (n=24). Data were analysed thematically to identify the drivers of male resistance and women's coping strategies.

Results

Male resistance to family planning was not monolithic, but stemmed from a complex interplay of factors: deep-seated misinformation arising from men's exclusion from health education, socio-cultural norms equating masculinity with high fertility, and alcohol abuse leading to abdication of familial responsibilities. These barriers compelled women to adopt contraception covertly, placing them at risk of marital conflict and domestic violence. This secrecy reflected both the lack of husbands' engagement in health programmes and women's determination to safeguard their own health and secure the wellbeing of their children.

Conclusions and implications

Covert contraceptive use in Kigezi is a survival strategy born of the systemic exclusion of men from family planning education, rather than simple non-cooperation. Health promotion and community health worker strategies that actively engage men, challenge harmful masculinity norms and address alcohol-driven household neglect are urgently needed to shift family planning from a hidden, individual burden into an equitable, community-supported practice, strengthening community structures for reproductive health.

Malaria vaccine uptake among children under five years and associated factors in Kiryandongo District, Western Uganda: A community-based cross-sectional study**Hamdan Kivumbi**¹, Felix Bongomin^{2,3}, Buyinza Nicholas¹, Evas Atuhaire¹¹Department of Public Health and Nutrition, Faculty of Health Sciences, Victoria University, Kampala, Uganda²Department of Medical Microbiology and Immunology, Faculty of Medicine, Gulu University, Gulu, Uganda³Department of Internal Medicine, Gulu Regional Referral Hospital, Gulu, Uganda**Background**

Malaria remains the leading cause of morbidity and mortality among children under five in Uganda. The recent introduction of the R21/Matrix-M vaccine offers a new prevention tool, yet uptake and series completion remain a challenge.

Objectives

This study assessed malaria vaccine uptake among children under five years and associated factors in Kiryandongo District using the Behavioural and Social Drivers (BeSD) framework.

Methods

A quantitative community-based cross-sectional study was conducted in April–May 2026 using multi-stage sampling. A structured interviewer-administered questionnaire was completed by caregivers of children aged 6–59 months, and responses were verified against child health cards. Data were analysed in SPSS version 27; multivariable Poisson regression identified factors independently associated with uptake ($p < 0.05$).

Results

Of the 400 children analysed (response rate 400/422, 95%), mean age was 14.03 months ($SD=8.12$). Overall, 81.5% ($n=326$) had received at least one dose of the malaria vaccine; 81.3% ($n=325$), 60.5% ($n=242$), 35.8% ($n=143$) and 13.3% ($n=53$) had received doses 1–4 respectively. Independent predictors of higher uptake were strong caregiver intention ($aPR = 2.012$, 95% CI: 1.762–2.058; $p < 0.001$), health worker recommendation ($aPR = 1.119$, 95% CI: 1.005–1.245; $p = 0.041$), active family support ($aPR = 1.147$, 95% CI: 1.044–1.25; $p = 0.004$) and vaccine availability ($aPR = 2.338$, 95% CI: 1.433–3.816; $p < 0.001$).

Conclusions and implications

In Kiryandongo District, malaria vaccine uptake was high at initiation, with 8 in 10 children (81.5%) receiving at least one dose, but only about 1 in 8 (13.3%) completed the four-dose series. Vaccine availability, caregiver intention, health worker recommendation and spousal support were more strongly associated with uptake than socio-demographic factors. Ensuring steady vaccine supply, training health workers, engaging male partners and community leaders, and strengthening reminder systems could close this gap and reduce malaria deaths among children under five.

Keywords: malaria vaccine; vaccine uptake; BeSD framework; children under five; Kiryandongo

Uptake of the R21/Matrix-M malaria vaccine among children aged 6 to 18 months and associated factors in Apac District, Uganda**Angom Brenda**

Uganda Martyrs University, Uganda

Background

Uganda introduced the R21/Matrix-M malaria vaccine into routine immunisation on 2 April 2025, targeting 1.1 million children annually with a four-dose schedule across 107 high-burden districts, including Apac. No published evidence exists on early uptake, schedule completion or influencing factors at sub-national level.

Objectives

To determine R21 malaria vaccine uptake and associated factors among children aged 6 to 18 months in Apac District.

Methods

A community-based cross-sectional study was conducted in April–May 2026 in five wards of Agullu Division, Apac Municipality, enrolling 431 caregiver–child pairs through multi-stage cluster sampling. Interviewer-administered questionnaires (KoboCollect) were verified against child health cards where possible. Age-appropriate full uptake followed the Uganda National Expanded Programme on Immunisation (UNEPI) schedule: doses at 6, 7, 8 and 18 months. Multivariable modified Poisson regression ($P < 0.05$) used Stata version 17.

Results

Age-appropriate full uptake was 60.6% (261/431), partial uptake 37.4% and no uptake 2.1%. Uptake declined sharply by dose: Dose 1, 90.3%; Dose 2, 64.3%; Dose 3, 51.5%; Dose 4, 22.3%. Optimal uptake was associated with caregiver knowledge of the correct number of doses (adjusted prevalence ratio [aPR] = 1.64, 95% CI 1.16–2.34, $p = 0.006$), having two or more under-fives in the household (aPR = 1.16, 95% CI 1.01–1.33, $p = 0.045$) and ever experiencing vaccine unavailability at the facility (aPR = 0.64, 95% CI 0.51–0.79, $p < 0.001$).

Conclusions and implications

Six months into the rollout in Apac District, nine in ten eligible children have received the first dose, but only one in five children due for Dose 4 has received it. Knowledge of the dose schedule and supply chain reliability are the most modifiable determinants of completion. Strengthening supply forecasting and facility stock management, embedding R21 schedule counselling in antenatal care (ANC) and every immunisation contact, and using village health teams for defaulter tracing are likely to yield the largest gains.

Community health workers as catalysts for social behaviour change: Improving household sanitation and health in 52 communities in Kamwenge**Daniel Oceng**, Leonard Opeto

World Vision, Uganda

Issue

Poor sanitation and hygiene remain important determinants of preventable disease. Persistent open defecation shows that infrastructure alone cannot sustain behaviour change, and gaps in household sanitation in Uganda continue to enable disease transmission. Social and behaviour change (SBC) approaches that influence knowledge, motivation, social norms and households' ability to act are needed; community health workers (CHWs) and other community structures offer an important platform.

Intervention

Under its Kamwenge District water, sanitation and hygiene (WASH) programmes, World Vision Uganda implemented a one-year Market-Based Sanitation solution integrating SBC, community mobilisation and hygiene promotion across 52 communities/villages, targeting 4,899 households and approximately 24,495 people. CHWs worked alongside religious and cultural leaders, sanitation artisans and health assistants, using community barazas and household clusters to promote improved sanitation, address investment barriers and encourage collective action to end open defecation. Sanitation artisans linked households to locally available sanitation solutions, and CHWs used the Kobo Collect and mWater digital platforms to monitor progress.

Results

Within one year, 5,063 improved household latrines were constructed or upgraded, benefiting over 24,495 people across 52 communities/villages. In August 2026, the Ministry of Water and Environment verified 51 communities/villages as open defecation free (ODF), a 98.1% ODF pass rate among targeted communities. CHWs provided repeated household engagement, while community leaders and sanitation artisans reinforced social support and access to solutions.

Lessons learned

Community-led SBC, delivered through CHWs and strengthened by local structures, can meaningfully improve household sanitation. Combining mobilisation, behaviour change communication, hygiene promotion and Market-Based Sanitation addressed both behavioural and practical barriers to investment, positioning SBC not as a stand-alone communication activity but as a link between community motivation, collective action and household investment. Institutionalising CHW-led SBC within Uganda's primary health care and WASH systems, with supportive supervision, local sanitation markets and digital monitoring, could sustain sanitation behaviours and advance community health at scale.

Keywords: market-based sanitation; social and behaviour change (SBC); community mobilisation; hygiene promotion; open defecation free

Role of community health workers in delivering social behaviour change interventions for prevention of adolescent alcohol and substance abuse in Northern Uganda**Yiga Sharifuh**, Rita Bakesima

Department of Public Health, Faculty of Health Sciences, Lira University, Lira, Uganda

Background

Alcohol and substance abuse among adolescents is an emerging public health concern in Uganda, contributing to school dropout, violence, risky sexual behaviour, mental health disorders and vulnerability to disease. In Northern Uganda, widespread alcohol availability, peer pressure and inadequate parental supervision fuel substance use. Community health workers (CHWs) promote behaviour change through health education and mobilisation, but evidence on CHW-led interventions for adolescent substance abuse remains limited.

Objectives

This study assessed the prevalence and associated factors of adolescent alcohol and substance abuse in Northern Uganda, including participation in CHW-led interventions.

Methods

A community-based analytical cross-sectional mixed-methods study enrolled 250 adolescents aged 10–19 years in Northern Uganda. Data were collected through interviewer-administered structured questionnaires, and through focus group discussions and key informant interviews with CHWs, parents, teachers and local leaders. Data were analysed in STATA version 17 using descriptive statistics and multivariable logistic regression (adjusted odds ratios [AORs] with 95% confidence intervals [CIs]; $p < 0.05$ significant). Qualitative data were analysed thematically.

Results

The prevalence of alcohol and substance abuse was 34.8% (87/250). Peer influence (AOR=3.42; 95% CI: 1.86–6.28; $p < 0.001$), easy access to alcohol and psychoactive substances (AOR=2.87; 95% CI: 1.51–5.47; $p = 0.001$) and parental substance use (AOR=2.31; 95% CI: 1.22–4.37; $p = 0.010$) were independently associated with increased odds of substance abuse. Adolescents who had participated in CHW-led interventions, including peer education, community dialogues, household health education and school-based awareness campaigns, were significantly less likely to engage in substance abuse (AOR=0.41; 95% CI: 0.23–0.74; $p = 0.003$). Qualitative findings revealed improved awareness of substance-related harms, strengthened parent-adolescent communication and greater community accountability.

Conclusions and implications

CHW-led social behaviour change interventions are effective in addressing key drivers of adolescent alcohol and substance abuse. Strengthening CHW capacity and integrating evidence-based behavioural interventions into community health programmes can contribute significantly to adolescent wellbeing and community resilience. Scaling up CHW-led prevention initiatives should be prioritised in Uganda.

Keywords: community health workers; social behaviour change; alcohol abuse; substance use; adolescents

Breakout Session 3

Track 3: Promoting Community Systems for Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNACH)

Day 2 • Thursday 15 October 2026 • 11:30 am – 1:10 pm

03.1 **Taking health to the lake: Extending integrated health services to mobile and hard-to-reach populations through the MV Sigulu ferry clinic in Namayingo District, Uganda**

Paul Lwevola

03.2 **Strengthening adolescent maternal mental health through trained Mama and Papa Ambassadors: A community-based peer support model in rural Uganda**

Sandra Najjuko

03.3 **Community vulnerabilities and teenage pregnancy among adolescents in rural Eastern Uganda: Implications for strengthening RMNACH and primary health care systems**

Michael Akol

03.4 **Bridging geographic inequities in maternal health: G2PP antenatal care satellite model in hard-to-reach Malongo Subcounty, Mayuge District, Uganda**

Ndikolaki Fred

03.5 **Strengthening high-risk pregnancy antenatal care through access to ultrasound services at Kalisizo Hospital**

Brenda Bwenge

Taking health to the lake: Extending integrated health services to mobile and hard-to-reach populations through the MV Sigulu ferry clinic in Namayingo District, Uganda

Paul Lwevola¹, Richard Kagimu¹, Charles Balwanyi¹, Shiango Kenneth¹, Mathias Mangeni², Fred Semitala¹

¹Makerere University Joint AIDS Program, Kampala, Uganda

²Namayingo District Local Government, Uganda

Issue

Namayingo District in Eastern Uganda is 75% water-bound, encompassing 13 inhabited islands across Lake Victoria. Long travel distances, high transport costs and limited health infrastructure leave island and mobile populations critically underserved.

Intervention

The Makerere University Joint AIDS Program (MJAP), through the US Department of State-funded Local Partner Health Services-East Central (LPHS-EC) Activity, partnered with Namayingo District Local Government and the Ministry of Works and Transport to establish a clinic aboard the MV Sigulu, a ferry linking island communities. The vessel, which transports over 300 passengers per trip on regular mainland-island routes, was repurposed as a platform for integrated health service delivery. The ferry administration provided clinic space, traveller coordination and security; the district supplied commodities and health workers; and LPHS-EC facilitated service delivery through safari day allowances for health workers. Onboard staff delivered health promotion alongside integrated services; routine service data were analysed.

Results

Between August 2025 and March 2026, the clinic reached 22,487 travellers with health promotion messages on HIV prevention, tuberculosis (TB), antenatal care (ANC), malaria prevention, immunisation, outbreak awareness and health-seeking behaviours. A total of 1,074 travellers were screened for TB, identifying 238 presumptive cases and diagnosing eight individuals, all of whom were initiated on treatment. HIV self-testing was provided to 3,318 travellers, and 1,038 eligible individuals received HIV testing, resulting in nine new diagnoses, all linked to care. The clinic also distributed 6,155 condoms, provided family planning and ANC services to 28 and 22 travellers respectively, administered 1,573 vaccine doses, screened 10,510 travellers for fever, tested 3,521 using malaria rapid diagnostic tests (mRDTs), and diagnosed and treated 517 malaria cases.

Lessons learned

Integrating health promotion and essential primary healthcare services into routine transport systems is feasible, can overcome geographic barriers, improves service uptake and provides a sustainable platform for health promotion among underserved mobile and island populations.

Strengthening adolescent maternal mental health through trained Mama and Papa Ambassadors: A community-based peer support model in rural Uganda

Sandra Najjuko, Daniel Murokora, Martin Kasendwa, Richard Kimaka, Xavier Butayi

Babies and Mothers Alive Foundation, Uganda

Background

Mental health disorders are leading contributors to disease burden among adolescents, and pregnant adolescents are particularly vulnerable to depression, anxiety and psychosocial distress. In Uganda, limited access to mental health services at primary health care level calls for community-based approaches. Babies and Mothers Alive Foundation implemented a peer parenting support model in Rakai and Kyotera districts, using trained Mama and Papa Ambassadors to provide psychosocial support, facilitate peer support groups, conduct home follow-up and engage male partners in maternal care.

Objectives

This study evaluated the contribution of these community health workers to improving mental health among adolescent mothers.

Methods

A prospective descriptive cohort study followed 1,037 pregnant adolescents aged 15–19 years enrolled into 90 monthly peer parenting support groups from baseline to 12 months. Ambassadors mobilised mothers and partners, conducted follow-up visits, facilitated group sessions and promoted male involvement through invitation letters, reminder calls and household engagement. Mental health was assessed with the WHO Self-Reporting Questionnaire (SRQ-20) and perceived social support with the Multidimensional Scale of Perceived Social Support (MSPSS) at baseline, six and twelve months. Multivariable logistic regression identified factors associated with outcomes.

Results

Of male partners, 60% attended peer support sessions. Perceived social support increased from 69.3% at baseline to 89.8% at twelve months. Overall maternal mental wellbeing improved from 61.1% to 93.2%, a 32.1% improvement. Symptoms of depression, anxiety and somatic disorders each declined by approximately 15%. Male partner participation in peer support sessions (adjusted odds ratio [AOR]=0.108; 95% CI: 0.017–0.659), increased child support (AOR=0.062; 95% CI: 0.004–0.869) and maternal care (AOR=0.085; 95% CI: 0.014–0.449) were independently associated with reduced maternal mental health disorders.

Conclusions and implications

Institutionalising Mama and Papa Ambassadors strengthened adolescent maternal mental health through community-based psychosocial support and male engagement, offering a scalable primary health care model for reproductive, maternal, newborn, child and adolescent health (RMNCAH) programmes.

Keywords: adolescent maternal mental health; community health workers; Mama Ambassadors; Papa Ambassadors; primary health care

Community vulnerabilities and teenage pregnancy among adolescents in rural Eastern Uganda: Implications for strengthening RMNACH and primary health care systems**Michael Akol****Background**

Teenage pregnancy remains a major public health challenge in Uganda. Rural communities experience disproportionately high rates driven by poverty, early cohabitation, orphanhood, inadequate parental support and limited access to adolescent-friendly reproductive health services, reflecting weaknesses in community protection systems and primary healthcare delivery for adolescents.

Objectives

This study assessed the prevalence of teenage pregnancy and associated community-level vulnerabilities among adolescent girls in rural Eastern Uganda, and explored implications for strengthening community-based Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNACH) and primary healthcare systems.

Methods

A community-based cross-sectional study was conducted in April 2024 among 444 adolescent girls aged 13–19 years from 12 randomly selected villages in Atutur sub-county, Kumi district. Participants were recruited consecutively from households with support from village health teams (VHTs). Data were collected using researcher-administered structured questionnaires in Kobo Collect and analysed in SPSS version 27, using descriptive statistics and modified Poisson regression at a 95% confidence interval.

Results

The prevalence of teenage pregnancy was 29.7%, exceeding the national average of 25%. Adolescents cohabiting with male partners were three times more likely to have conceived than those staying with their parents (aPR=3.0, 95% CI: 2.23–4.10, $P<0.001$). Teenagers with both parents deceased were nearly twice as likely to have conceived as those whose parents were both alive (aPR=1.9, 95% CI: 1.15–3.31, $P=0.013$). Girls dissatisfied with the basic needs provided by their parents were over three times more likely to have conceived (aPR=3.3, 95% CI: 2.26–4.85, $P<0.001$).

Conclusions and implications

Teenage pregnancy in rural Uganda is driven by socioeconomic and community-level vulnerabilities that directly affect RMNACH outcomes. Institutionalised VHTs, adolescent-friendly reproductive health services, socioeconomic empowerment of adolescents and parents, school-community partnerships and targeted prevention of early marriage may substantially reduce teenage pregnancy. Integrating community-based adolescent health promotion and prevention into Uganda's primary healthcare framework is essential.

Keywords: teenage pregnancy; RMNACH; primary healthcare; community systems; village health teams

Bridging geographic inequities in maternal health: G2PP antenatal care satellite model in hard-to-reach Malongo Subcounty, Mayuge District, Uganda**Ndikolaki Fred**, Buyinza J., Ajidiru E., Basembeza A.**Issue**

Despite Uganda's policy commitment to universal maternal health services, geographic inequities in early antenatal care (ANC) persist in hard-to-reach rural communities. Malongo Sub-county has a population of 99,278 and an estimated 4,964 (5%) pregnancies annually, but only two public facilities, Malongo HCIII and Namoni HCII, provide maternal health services. First ANC visit (ANC1) attendance was low: 3,144 women in 2022 and 2,986 in 2023, only 60.2% coverage of estimated need. Long travel distances and difficult swamp terrain were major barriers.

Intervention

A Government-to-Private Partnership (G2PP) ANC satellite model was piloted in 2024 and 2025 at a purposively selected licensed private drug shop in Bumwena Parish (population approximately 41,000), a densely populated area furthest from public facilities. The operator received capacity building in basic maternal and child health services, focusing on ANC, referral and linkage. Malongo HCIII deployed a midwife weekly to provide comprehensive ANC at the site; laboratory specimens were tested at the facility and results given at follow-up visits. Data were captured with routine Health Management Information System (HMIS) tools and reported through the District Health Information Software 2 (DHIS2).

Results

Against an annual target of 4,964, ANC1 attendance increased from 2,986 in 2023 to 3,399 in 2024, raising coverage from 60.2% to 68.5%, an increase of 8.3 percentage points. Gains were sustained in 2025, with 3,396 ANC1 attendees and 68.4% coverage.

Lessons learned

The G2PP satellite model significantly improved ANC1 attendance in an underserved sub-county by bringing services closer through an existing private-sector platform, a feasible, low-cost and scalable strategy for hard-to-reach settings. Geographic proximity drives utilisation by reducing transport barriers and increasing early care-seeking. Licensed private drug shops integrated into formal health systems can extend the reach of public maternal health services. Regular midwife outreach, standardised DHIS2 reporting and integration with routine systems promote service quality, data visibility and programme sustainability.

Strengthening high-risk pregnancy antenatal care through access to ultrasound services at Kalisizo Hospital

William Mulindwa, **Brenda Bwenge**, Mariam Luyiga, Nathan Lubowa

Background

Uganda's maternal mortality ratio remains high at 189 per 100,000 live births, with over 60% of deaths occurring among mothers with high-risk pregnancies. Many of these deaths are preventable through quality antenatal care (ANC), a key entry point for early detection and management of complications. Although ANC attendance is high, delayed initiation, poor completion of recommended visits and limited access to obstetric ultrasound hinder early identification and management of complications. In 2023, Kalisizo Hospital identified only 17.8% of high-risk pregnancies among mothers attending ANC, with retention in special care at 8.3%.

Objectives

This quality improvement (QI) project aimed to strengthen identification, management and continuous ANC care for women with high-risk pregnancies through improved access to point-of-care ultrasound within a structured High-Risk Clinic (HRC).

Methods

A QI project to improve utilisation of ultrasound scanning was implemented at Kalisizo Hospital using an Identification, Retention and Response (IRR) framework. A weekly HRC led by a medical officer was established to provide integrated care for women with high-risk pregnancies. Key interventions included routine point-of-care obstetric ultrasound, a longitudinal high-risk pregnancy register, individualised appointment scheduling and active follow-up until delivery. Routine Health Management Information System (HMIS) data were used to monitor identification, retention, ultrasound utilisation and delivery outcomes over time. Postnatal interviews assessed factors influencing adherence to scheduled care.

Results

Over two years, identification of high-risk mothers increased to 71% (9,190/13,028), with 70% completing HRC care and 76% achieving positive delivery outcomes. Uptake of ≥ 2 ultrasound scans reached 97%, while retention improved to 85%. Adherence was mainly driven by ultrasound access (46%), individualised scheduling (28%) and follow-up (26%).

Conclusions and implications

Integrating ultrasound services within a structured, IRR-driven HRC significantly improved identification, retention and continuity of care for high-risk mothers, demonstrating a scalable model for improving maternal outcomes.

Breakout Session 4

Track 4: Building Community Resilience for Health Security (Preparedness, Response & Recovery)

Day 2 · Thursday 15 October 2026 · 11:30 am – 1:10 pm

04.1 Knowledge, attitudes and practices on mpox among pilgrims during the Martyrs' Day Commemoration in Namugongo Town Council, Uganda, June 2025

Martha Dorcas Nalweyiso

04.2 Strengthening community-led health facilities: A baseline assessment of allied health staffed health units serving key populations in Uganda

Kiyegga Andrew

04.3 Breaking silos: Strengthening community event-based surveillance through electronic Community Health Information System (eCHIS) integration in Wakiso District, Uganda

Moses Okech

04.4 Building community resilience for health security

Mubarak Alhassan

Knowledge, attitudes and practices on mpox among pilgrims during the Martyrs' Day Commemoration in Namugongo Town Council, Uganda, June 2025

Martha Dorcas Nalweyiso¹, Justine Wobusobozi¹, Richard Migisha¹, Benon Kwesiga¹, Daniel Kabobera², Bernard Lubwama³, Emmanuel Obuya³, Alex Riolexus Ario¹

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³Ministry of Health, Kampala, Uganda

Background

Uganda reported 4,880 mpox cases and 44 deaths across 120 districts by May 2025, with Kampala District in the central region accounting for more than half of the cases. Mass gatherings, such as the Martyrs' Day Commemoration on June 3, pose heightened transmission risks.

Objectives

We assessed knowledge, attitudes and practices (KAP) on mpox and associated factors among pilgrims during the commemoration.

Methods

We conducted a cross-sectional study among pilgrims from 29 May–3 June 2025. Using systematic sampling, every tenth pilgrim entering any of the 14 shrine entry points was enrolled. Data were collected using a structured electronic questionnaire. Knowledge focused on mpox causes, attitudes on responsibility and practices on preventive behaviours. Using a modified Bloom's cut-off, scores $\geq 60\%$ were considered adequate knowledge, positive attitudes and good practices. Associated factors were assessed using modified Poisson regression with robust standard errors.

Results

We enrolled 1,438 pilgrims, of whom 834 (58%) were male and 659 (46%) were from the central region; mean age was 34 years (standard deviation 15). A total of 1,222 (85%) had adequate knowledge, 1,200 (84%) positive attitudes and 470 (27%) good practices. Adequate knowledge was associated with secondary education or higher (adjusted prevalence ratio [aPR]=1.14, 95% confidence interval [CI]: 1.11–1.15), age >25 years (aPR=1.08, 95% CI: 1.03–1.11) and being male (aPR=1.05, 95% CI: 1.01–1.08). Positive attitudes were associated with secondary education or higher (aPR=1.14, 95% CI: 1.00–1.29) and younger age of 25–44 years (aPR=1.06, 95% CI: 1.00–1.11).

Conclusions and implications

Pilgrims demonstrated adequate knowledge and positive attitudes towards mpox, particularly younger and more educated individuals. We recommend targeted health education for less educated and older pilgrims, and translation of information, education and communication (IEC) materials into simple local languages to ensure comprehensive understanding of mpox.

Keywords: mpox; pilgrims; knowledge; attitudes; practices

Strengthening community-led health facilities: A baseline assessment of allied health staffed health units serving key populations in Uganda

Kiyegga Andrew, Mutunga Godfrey

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Background

Disruptions in global HIV financing triggered a 30% closure rate among key population sites in Uganda, a 62.5% drop in HIV testing access and a 94% spike in antiretroviral treatment discontinuations. These shocks exposed the fragility of community-led health facilities expanding beyond HIV programming into outpatient, mental health and reproductive healthcare.

Objectives

This assessment evaluated the operational readiness, workforce conditions and institutional resilience of 13 community-led health facilities serving key populations, identifying priorities for strengthening them.

Methods

A mixed-methods assessment, combining facility assessments and semi-structured interviews with administrators and clinicians, was conducted in 2026 across 13 purposively selected community-led health facilities, including health units and drop-in centres, in Central and Western Uganda, with informed consent and de-identified data. A Healthcare Systems Strength framework assessed diagnostics, staffing, service integration, infrastructure and regulatory readiness, analysed descriptively.

Results

One facility reached Highly Operationalised status, 4 Strong Community Integrated, 5 Functional Community, 1 Transitional and 1 Outreach Linked, with 1 not fully assessed. Clinical officers were the primary prescribing cadre in 7 of 13 facilities, working alongside nurses and allied health professionals, often understaffed with limited professional development. None of the assessed facilities independently initiated antiretroviral therapy or operated established psychiatric care systems. Reporting and financing remained predominantly HIV-centred despite facilities increasingly delivering chronic, sexual and reproductive healthcare. Twelve of 13 facilities depended on donor financing, and 4 reported interruptions tied to unpaid rent and inconsistent outreach annexes. Facilities expressed openness to national standards through peer learning.

Conclusions and implications

Community-led health facilities carry a scope of care outgrowing the reporting, financing and regulatory systems around them. Strengthening them requires formal recognition, national health system integration, diversified local financing, continuous professional development and reduced professional isolation through coordinated peer learning, to protect healthcare access and resilience against shocks.

Breaking silos: Strengthening community event-based surveillance through electronic Community Health Information System (eCHIS) integration in Wakiso District, Uganda

Arinda Arthur, **Moses Okech**, Richard Muhumuza, Priscillah Balirwa, Saul Mutimba, Amy Kakiza Rwakihembo, Stella Kanyerere

Living Goods Uganda, Uganda

Background

Community-level surveillance in low-resource settings is often fragmented across parallel reporting channels. In Uganda, community event-based surveillance (CEBS) has been integrated into the electronic Community Health Information System (eCHIS) to strengthen detection by village health teams (VHTs), complementing the 6767 SMS platform and the Integrated Disease Surveillance and Response (IDSR) system.

Objectives

This study examined whether integrating CEBS into eCHIS produces sustained, structured community reporting of priority syndromes aligned with IDSR and the 7-1-7 detection-notification-response framework.

Methods

A mixed-methods implementation evaluation ran in Wakiso District from December 2025 to June 2026, with 326 active VHTs reporting six syndromic signal categories through eCHIS. Community health extension workers (CHEWs) verified reports and escalated them to district teams, with signals routed to DHIS2 and national dashboards for triage by emergency operations centres. Five indicators were tracked monthly, with qualitative assessment of usability and adoption.

Results

VHTs submitted 1,407 CEBS reports, of which 422 (30.0%) were verified as signals. After a launch surge in December 2025 (197 signals from 457 reports; 43.1%), monthly reporting stabilised at 128–178 reports (January–May 2026) and peaked at 220 reports and 66 signals in June. The detection rate rose monotonically from 19.6% in January to 30.0% in June, a 53% relative gain. Signals (n; villages; %) comprised animal bites (68; 51; 27.3%), fever with bleeding (65; 45; 26.1%), unexplained rash (40; 33; 16.1%), sudden or unexplained death (37; 27; 14.9%), other threats (26; 23; 10.4%) and abnormal changes in drinking water (13; 12; 5.2%).

Conclusions and implications

Integrating CEBS into eCHIS created a sustained, government-aligned community detection platform: reporting stabilised, detection improved as VHTs and CHEWs gained fluency, and signals mapped onto IDSR priority syndromes, reducing fragmentation under the 7-1-7 framework. Closing residual gaps in time-to-escalation documentation, feedback to VHTs and verification is critical; the Wakiso experience offers a foundation for national CEBS scale-up.

Keywords: community event-based surveillance; CEBS; eCHIS; village health teams; IDSR

Building community resilience for health security**Mubarak Alhassan**

School of Nursing Sciences, Kampala International University W-C, Uganda

Background

Prolonged banditry and insurgency in north-western Nigeria have disrupted healthcare access, damaged health infrastructure, displaced populations and increased psychosocial distress. Community health nurses (CHNs) can strengthen preparedness, response, continuity of care and recovery. This study evaluated a CHN-led Community-Based Primary Health Intervention (CBPHI) to strengthen community resilience and health security.

Objectives

To assess healthcare barriers and vulnerabilities; determine psychosocial burden and resilience; implement and evaluate a CHN-led intervention; and identify factors influencing sustainability and scale-up.

Methods

A concurrent mixed-methods design was used. A quasi-experimental pre-test/post-test study with a control group involved 780 households across six local government areas (LGAs) in Zamfara and Sokoto States. Validated instruments assessed trauma, resilience, social support, self-efficacy and healthcare access barriers. Twelve focus group discussions and 25 in-depth interviews complemented the quantitative findings. The 12-week CBPHI included risk identification, health education, preparedness, community-based services, psychosocial support, referrals, engagement and recovery activities.

Results

At baseline, 73.4% of households reported inability to access healthcare. Key barriers were insecurity (89.2%), physical inaccessibility (78.6%) and damaged infrastructure (61.3%). Post-traumatic stress disorder (PTSD), depression and anxiety affected 61.8%, 54.2% and 48.7%, respectively. Intervention communities showed significantly greater improvements than controls in healthcare utilisation (43.1% vs. 11.2%), PTSD symptoms, resilience (+17.3 vs. +2.8) and social support (+3.2 vs. +0.6; $p < 0.001$). Community trust, culturally responsive care, local leadership, gender-sensitive approaches and CHN leadership enhanced effectiveness.

Conclusions and implications

CHN-led community interventions can strengthen health security by integrating preparedness, emergency response, psychosocial support and recovery. Investment is recommended in CHN capacity, community preparedness, safety, resilient primary healthcare infrastructure, referral systems and locally led recovery.

Keywords: community resilience; health security; community health nursing; preparedness; emergency response

Breakout Session 5

Track 3 (continued): Promoting Community Systems for RMNACH

Day 2 · Thursday 15 October 2026 · 3:00 pm – 5:00 pm

- 05.1** **Community health extension workers as a bridge between facility and home: Strengthening continuity of care for small and sick newborns through the Hospital-to-Home model in Uganda**

Mbabazi Nives

- 05.2** **Mobile cervical cancer prevention outreaches: Partnering with local communities to increase HPV and cervical cancer awareness and advocacy in Midwestern Uganda**

Shamim Namagembe

- 05.3** **Utilisation of family planning methods among teenage mothers in Lira District: Prevalence and associated factors**

Julius Kayizzi

- 05.4** **Strengthening community-based maternal healthcare through mobile health technologies: Experiences of midwives and community health workers in rural Western Uganda**

Atuhairwe Harriet

- 05.5** **Harnessing community theatre to shift sociocultural norms on teenage pregnancy: A desk review of evidence from sub-Saharan Africa**

Katiisa Christopher

- 05.6** **Health facility–community linkages for postpartum follow-up of women with adverse pregnancy outcomes: A feasibility study in Mayuge District, Uganda**

Julius Ssemambo

Community health extension workers as a bridge between facility and home: Strengthening continuity of care for small and sick newborns through the Hospital-to-Home model in Uganda**Mbabazi Nives**¹, Sandra Najjuko², Kintu Emax¹, Daniel Murokora², Martin Kasendwa²¹Kyotera District Local Government, Kyotera, Uganda²Babies and Mothers Alive Foundation, Uganda**Issue**

Small and sick newborns remain vulnerable after discharge from newborn care units (NCUs), where weak facility-community linkages interrupt follow-up and delay referral of complications. Community health extension workers (CHEWs) can bridge this gap by linking households with the health system.

Intervention

Babies and Mothers Alive Foundation, with the Ministry of Health, Adara Group and Kyotera District Local Government, integrated CHEWs into the Hospital-to-Home (H2H) model. Between July 2025 and June 2026, high-risk newborns discharged from Kalisizo Hospital and Kakuuto HC IV were enrolled and followed for six months. Thirteen CHEWs were trained as H2H trainers of trainers (ToTs) to mentor CHEWs and village health teams (VHTs), and the Chief CHEW coordinated follow-up. CHEWs made home visits with newborn-care kits and standardised tools to assess growth, development, danger signs, breastfeeding, nutrition and kangaroo mother care, counsel caregivers and facilitate referrals. Quarterly mentorship meetings reinforced competencies.

Results

CHEWs enrolled 146 newborns (48 Schedule A and 98 Schedule B). Of these, 102 (70%) were actively followed, 36 relocated and eight died; 81 (79.4%) of those actively followed received regular home visits through six months. CHEWs conducted 551 home visits, reaching 540 household members. Conditions included prematurity, birth asphyxia, low birthweight, neonatal sepsis, jaundice and breastfeeding difficulties. CHEW ToTs trained and mentored 109 community health workers (102 VHTs and seven CHEWs) across 11 parishes.

Lessons learned

CHEWs bridged NCUs, VHTs and households by coordinating follow-up, mentoring frontline workers and supporting early referral of complications. The ToT approach demonstrated potential for cascade mentorship within existing community structures. Relocation, weak referral mechanisms and traditional beliefs affected continuity and outcomes. H2H competencies should be built into the CHEW platform, with standard follow-up protocols, functional referral and feedback, Health Management Information System (HMIS) integration, home-care tools and routine mentorship. Scaling CHEW-led mentorship of VHTs could sustainably extend quality newborn care into households.

Keywords: community health extension workers; small and sick newborns; continuity of care; Hospital-to-Home; community health systems

Mobile cervical cancer prevention outreaches: Partnering with local communities to increase HPV and cervical cancer awareness and advocacy in Midwestern Uganda**Shamim Namagembe****Issue**

Uganda has one of the highest age-standardised rates of cervical cancer (CC): incidence of 54.8 per 100,000 and mortality of 25 per 100,000 women, well above the global estimates of 13.1 and 6.8 respectively. Despite this burden, only 10% of Ugandan women have ever been screened, and only 4.8% in rural areas. This inequity is particularly concerning because rural women have a higher prevalence of high-risk human papillomavirus (HPV) infection (18% compared with 11% in urban areas). Consequently, 80% of cases present to health facilities at advanced stages. Effective primary and secondary prevention demands not only adequate resources but also community acceptance, informed demand and active participation in vaccination and screening programmes.

Intervention

A community-based project was implemented in three districts of Bunyoro region to enable rural women to access sustainable cervical cancer services in their localities. Project data on community outreach, community education and screening from March 2024 to July 2026 were analysed.

Results

Between 2024 and 2026, the Uganda Rural Development and Training Programme (URDT) conducted 83 community outreaches, working with 242 VHTs, 51 religious leaders and a 96-member CC prevention task force. Of all people who attended CC health education sessions, 29,296 (72.91%) were reached through outreaches. All 45 radio programmes on 3 community radios and the audio towers were conducted with community members. Of all women screened, 8,955 (57.44%) were identified through community outreaches, as were 669 (52.76%) of the pre-cancers treated.

Lessons learned

Working with community structures is effective and feasible in rural settings. Harnessing the authority and trust of local leaders, VHTs and community radios increases uptake and active community participation, and enables a rapid response to stigma, myths and misconceptions, encouraging open conversations about HPV and cervical cancer prevention.

Utilisation of family planning methods among teenage mothers in Lira District: Prevalence and associated factors

Julius Kayizzi, Ritah Bakesiima

Faculty of Public Health, Lira University, Uganda

Background

Adolescent motherhood remains a pressing public health and social challenge.

Objectives

This study investigated the prevalence and determinants of family planning use among teenage mothers in Lira District, Northern Uganda.

Methods

A cross-sectional study used descriptive and analytical techniques. A sample size of 402 teenage mothers was estimated using the Kish-Leslie formula. Participants were selected by systematic random sampling from health centre III and IV records in Amach, Agweng and Bar sub-counties. Data were entered and analysed in SPSS version 20.

Results

Mean age was 18.09 years (standard deviation [SD] = 2.26); 182 (52.9%) were aged 16–17 years, 264 (76.7%) were single and 133 (38.7%) were Anglican. All were either Lango (226, 65.7%) or Acholi; 174 (50.6%) had no formal education and 122 (35.5%) were casual labourers. The prevalence of family planning use was 27%; implants were the most common method (34.4%), and private clinics (34.4%) and pharmacies (34.4%) the most common sources. Family planning use was less likely among those who were aged 15–16 years at first delivery (adjusted odds ratio [aOR] = 0.291; 95% confidence interval [CI]: 0.095–0.890; $p = 0.030$), did not attend antenatal care (aOR = 0.189; 95% CI: 0.096–0.369; $p < 0.001$), had no plans to return to school (aOR = 0.192; 95% CI: 0.095–0.385; $p < 0.001$), had an unintended first pregnancy (aOR = 0.371; 0.156–0.884; $p = 0.025$) or did not experience forced sex (aOR = 0.138; 95% CI: 0.045–0.426; $p = 0.001$).

Conclusions and implications

This study found a low prevalence of family planning use, underscoring that awareness alone is insufficient to translate into contraceptive use among adolescent mothers in this setting. We recommend prioritising early adolescents, promoting school re-entry and retention, addressing partner influence and gender power dynamics, and integrating sexual and gender-based violence screening and support within reproductive health services.

Keywords: contraception; teenage mothers; adolescent health; Lira District

Strengthening community-based maternal healthcare through mobile health technologies: Experiences of midwives and community health workers in rural Western Uganda

Atuhairwe Harriet, Rita Florence Matte

Faculty of Nursing and Midwifery, Lira University, Uganda

Background

Digital health innovations are increasingly recognised as critical enablers of primary health care (PHC) and community health system strengthening in low-resource settings. In Uganda, mobile health (mHealth) technologies have been introduced to improve maternal healthcare delivery, particularly in rural communities where access to skilled care is constrained by geographical, infrastructural and socioeconomic barriers. Despite growing investment, evidence on the experiences of frontline providers implementing mHealth interventions remains limited.

Objectives

This study explored the experiences of midwives and community health workers (CHWs) using mHealth technologies to support maternal healthcare services in rural Masindi District, Western Uganda.

Methods

A qualitative descriptive study was conducted in Bikonzi Sub-county, Masindi District. Sixteen participants, comprising 12 CHWs and 4 midwives, were purposively selected based on their experience using mHealth-supported maternal healthcare interventions. Data were collected through in-depth interviews and analysed using inductive thematic analysis.

Results

Participants consistently described mHealth as a critical enabler of maternal healthcare delivery. Three major benefits emerged: enhanced communication and continuity of care, expanded access to healthcare services, and improved maternal health outcomes through timely referrals, appointment reminders and emergency response. mHealth strengthened trust between providers and pregnant women, improved antenatal care attendance, and facilitated management of high-risk pregnancies and gender-based violence cases. However, implementation was constrained by unreliable electricity, poor internet and network connectivity, limited digital infrastructure, insufficient technical capacity and socio-cultural barriers. Continuous training, availability of digital devices, technical support and community engagement were identified as key facilitators of successful implementation.

Conclusions and implications

mHealth technologies have substantial potential to strengthen community health systems and improve maternal healthcare delivery in rural Uganda. Integrating mHealth within PHC platforms can enhance access, responsiveness and continuity of maternal care. Investments in digital infrastructure, workforce capacity strengthening and sustainable implementation support are essential to optimise the contribution of mHealth to maternal health and health security in underserved communities.

Keywords: mobile health; community health workers; midwives; maternal health; primary health care

Harnessing community theatre to shift sociocultural norms on teenage pregnancy: A desk review of evidence from sub-Saharan Africa**Katiisa Christopher**

Speedbird Advisory

Background

Teenage pregnancy remains high in sub-Saharan Africa, driven not by a lack of health information but by deep-rooted sociocultural norms, including patriarchy, transactional sex and intergenerational silence on adolescent sexuality. Clinic-based interventions have had limited reach; community theatre is a promising participatory tool for norm transformation, but evidence on its mechanisms and contextual effectiveness is fragmented.

Objectives

To synthesise evidence on the effectiveness, facilitators and barriers of community theatre interventions targeting teenage pregnancy norms in sub-Saharan Africa, and draw lessons for Uganda.

Methods

A systematic desk review covered peer-reviewed literature (2010–2026) and grey literature (NGO reports, Ministry of Health evaluations). PubMed, Scopus and African Journals Online (AJOL) were searched. In total, 28 studies and programme reports were included. Data on intervention design, community engagement, behavioural outcomes and normative shifts were extracted using a standardised framework, and barriers and enablers were synthesised thematically.

Results

Three primary mechanisms of norm change were identified: (1) modelling alternative behaviours, such as adolescents refusing early marriage or negotiating condom use; (2) creating public “safe spaces” for intergenerational dialogue, especially between parents and adolescents; and (3) engaging gatekeepers (religious leaders, elders) as active participants rather than audiences. However, effectiveness depended on (a) sustained performances (≥6 monthly sessions) rather than one-off events; (b) integration with functional referral pathways to adolescent-friendly health services; and (c) careful navigation of cultural taboos to avoid backlash. Programmes that failed to involve male guardians showed minimal impact on delaying first pregnancy.

Conclusions and implications

Community theatre is a low-cost, high-engagement strategy for reshaping harmful norms around adolescent sexuality, but not a standalone solution; success depends on repeated exposure, multi-stakeholder co-creation and strong links to health systems. Ugandan District Health Teams should integrate community theatre into annual health promotion workplans, monitoring norm shifts (community scorecards) and service uptake (routine Health Management Information System data on adolescent antenatal bookings).

Health facility–community linkages for postpartum follow-up of women with adverse pregnancy outcomes: A feasibility study in Mayuge District, Uganda

Julius Ssemambo, Alice Nassanga, Adella Ainembabazi, Christopher Baleke

Mayuge Institute for Global Health Sciences Research and Innovation (MIHRI), Uganda

Background

Women with hypertensive disorders of pregnancy (HDP) or adverse birth outcomes remain at increased risk of poor maternal and cardiovascular health after delivery, yet postpartum follow-up is often limited after facility discharge. Routine maternal health records can identify women requiring monitoring, but evidence on linking facility records with community follow-up is limited.

Objectives

(1) To assess the feasibility of tracing women using telephone contacts in routine maternal health records; (2) to assess the availability and completeness of post-delivery maternal health records; and (3) to explore the role of community health workers (CHWs) in tracing, verification and postpartum follow-up.

Methods

We conducted a feasibility study among 51 women identified from routine maternal health records in Mayuge District. Women were traced using telephone contacts, supplemented by CHW support and household visits. Identity and residence were verified and available maternal records reviewed. Historical blood pressure and weight were extracted, and current measurements obtained using a digital blood pressure monitor and weighing scale. Tracing success, record availability, completeness and operational challenges were assessed descriptively.

Results

All 51 women contacted were successfully reached at home. Most mothers (96%) retained their antenatal and child immunisation cards, whereas laboratory results and other facility-based records were generally unavailable. Of these, 24 (47.1%) had antenatal cards documenting blood pressure and weight across multiple visits, while 27 (52.9%) had incomplete cards with missing measurements or undocumented visits. Home-kept records enabled comparison of previous and current blood pressure and weight. CHWs guided the team to homes, traced mothers with outdated contacts, verified identity and residence, and supported access to records.

Conclusions and implications

Facility–community linkage is feasible for postpartum follow-up. Integrating CHWs into routine maternal health systems could strengthen continuity of care and postpartum monitoring.

Breakout Session 6

Track 2: Leveraging Digital Transformation for Community Engagement and Systems

Day 2 • Thursday 15 October 2026 • 3:00 pm – 5:00 pm

06.1 From paper to pixel: Leveraging real-time digital surveillance to optimise the TB care continuum and health security in Kiruhura District

Muganzi Richard Rukakaza

06.2 User experiences and factors associated with electronic Community Health Information System (eCHIS) use among village health teams in Wakiso District, Uganda

Agatha Tukamuhebwa

06.3 Using generative AI on WhatsApp to link Ugandans to family planning information and services

Nakazzi Gracie

06.4 Utilising QR codes to improve reporting of HIV self-testing results and linkage to care during the Nyege Nyege Music Festival

Geofrey Kasumba

From paper to pixel: Leveraging real-time digital surveillance to optimise the TB care continuum and health security in Kiruhura District**Muganzi Richard Rukakaza**¹, Kanya David Ivan¹, Nakyanzi Rita²¹Kiruhura District Health Office, Kiruhura, Uganda²LPHS-JCRC, Uganda**Issue**

Effective tuberculosis (TB) control relies on timely and actionable data. In Kiruhura District, delayed paper-based and WhatsApp reporting historically obscured critical bottlenecks across the TB care continuum, hindering rapid response and compromising local health security.

Intervention

The district implemented a locally driven digital transformation, shifting from retrospective reporting to proactive, real-time data management. A comprehensive TB Surveillance Dashboard (kiruhuratbmonitor.org) was developed and deployed across the district. It translates epidemiological data into actionable tools, including a facility-specific Red Flag alert system benchmarking local performance against defined targets, External Quality Assurance monitoring, automated quality improvement (QI) tracking, treatment monitoring, household-level contact tracing registries and real-time laboratory hub linkages.

Results

Longitudinal data (June–August 2026) demonstrated rapid improvements. Digitised community tracing achieved a 96.6% contact screening rate and 10.7% positivity yield, alongside 100% TB preventive treatment (TPT) initiation. The Red Flag module isolated diagnostic bottlenecks, while real-time peripheral facility access to testing hubs, including results downloads and automated monitoring of sample rejections and machine errors, reduced maximum GeneXpert turnaround time (TAT) from 50 to under 7 days. Precision mentorship guided by automated alerts tripled GeneXpert positivity yield from 4.1% to 12.1%. Linking patients to named community directly observed therapy (DOT) supporters ensured 100% DOT adherence, zero loss to follow-up and a 100% evaluated treatment success rate. To sustain impact and reduce administrative burden, a built-in concept generator automates periodic performance reporting.

Lessons learned

Equipping frontline health workers, facility managers and district health teams with end-to-end data visualisation and indicator red-flagging enables targeted support supervision and optimises the entire TB management cascade. Digitised community health systems, soon expanding to include AI-driven hotspot geo-mapping, provide the accountability required to build resilient primary health care and enhance local health security.

User experiences and factors associated with electronic Community Health Information System (eCHIS) use among village health teams in Wakiso District, Uganda

Agatha Tukamuhebwa, Chrispus Mayora, Saul Kamukama

Makerere University School of Public Health, Kampala, Uganda

Background

Digital health systems are increasingly integrated into community health programmes to strengthen service delivery and management. In Uganda, the electronic Community Health Information System (eCHIS) supports village health teams (VHTs) to document and report community health services. However, variations in eCHIS use persist.

Objectives

To explore user experiences and assess factors associated with eCHIS use among VHTs in Wakiso District.

Methods

A cross-sectional mixed-methods study was conducted among VHTs in Wakiso District between March and June 2026. Quantitative data were collected from 322 VHTs using a structured questionnaire administered through KoBoCollect. Optimal eCHIS use was defined as submission of at least 20 eCHIS activities during the seven days preceding the survey, the criterion implementing partners use to monitor VHT performance and inform incentive payments. Descriptive and bivariate analyses were followed by modified Poisson regression with robust standard errors. Qualitative data from 14 in-depth interviews and 7 key informant interviews were analysed thematically.

Results

Overall, 95% of VHTs had submitted at least one eCHIS activity during the previous seven days, but only 45.3% achieved optimal use. Optimal use was significantly associated with extensive prior digital experience (aPR = 1.65; 95% CI: 1.25–2.17), age 40 years and above (aPR = 1.70; 95% CI: 1.15–2.51) and female sex (aPR = 1.98; 95% CI: 1.20–3.27). VHTs generally perceived eCHIS as useful and easy to use. However, qualitative findings revealed challenges with unstable internet connectivity, unreliable electricity, device problems including theft and damage, system downtime and synchronisation failures. Participants also reported increased documentation workload and the need for refresher training and technical support.

Conclusions and implications

Despite generally positive experiences with eCHIS, fewer than half of VHTs achieved optimal use. Addressing barriers related to digital skills, technical support, system and infrastructure reliability, and documentation workload could improve eCHIS use and strengthen digital community health service delivery in Uganda.

Keywords: eCHIS; village health teams; user experience; health information systems; digital health

Using generative AI on WhatsApp to link Ugandans to family planning information and services

Nakazzi Gracie, Denis Ssemugabi, Stephen G. Alege, Peter Buyungo, Lillian Sekabembe

Issue

Despite near-universal awareness of contraception in Uganda, misconceptions, fear of side effects and infertility, stigma and limited access to confidential information continue to constrain informed family planning (FP) decisions. Digital technologies, especially WhatsApp, are shaping how individuals seek health information. We explored whether generative artificial intelligence (AI) embedded in WhatsApp, a platform people already use, could provide trusted, personalised FP information while shortening the pathway from information-seeking to service access.

Intervention

Nurse Lina, developed by Population Services International Uganda with United Nations Population Fund (UNFPA) support through the EMPOWER-Private Sector project, is a WhatsApp-based generative AI assistant providing Ministry of Health-aligned information on contraceptive methods, eligibility, side effects, and myths and misconceptions. It enables conversational, context-responsive interaction and integrates a facility geo-locator to connect users to nearby FP services. Safety was embedded through approved content boundaries, harmful-content screening, continuous monitoring, human oversight and escalation pathways. It is accessible via WhatsApp (0700542322) or a QR code promoted through information, education and communication (IEC) materials, mass media and social media.

Results

Between January and August 2026, Nurse Lina engaged 3,810 unique users. Women comprised 74.3% and men 25.3%; 77% were aged 18–34 years. Users primarily sought information on FP methods (38.1%), side effects/bleeding (17.2%) and eligibility (8.9%). In all, 11% used the geo-locator, demonstrating movement beyond information towards potential service access.

Lessons learned

Generative AI can create a private, non-judgemental entry point for sensitive FP conversations at scale. However, impact depends on trusted content, robust safeguards, human oversight, user-centred design and integration with health services. This shows how AI can transform WhatsApp from a communication channel into a digital bridge from questions to care: a scalable model for FP and other stigma-sensitive priorities that government, non-governmental organisations (NGOs) and digital health implementers can adapt to expand information access and strengthen service delivery.

Utilising QR codes to improve reporting of HIV self-testing results and linkage to care during the Nyege Nyege Music Festival

Geofrey Kasumba, Marika Straka, Paul Lwevola, Achilles Kiyimba, Happy Walusaka

Makerere University Joint AIDS Program (MJAP) – Local Partner Health Services East Central Activity, Uganda

Issue

HIV self-testing (HIVST) is an important strategy for expanding access to HIV testing, particularly among key and priority populations facing stigma, discrimination and barriers to facility-based testing. A major challenge remains obtaining self-test results and ensuring timely linkage to confirmatory testing and treatment for individuals with reactive results.

Intervention

During the 2025 Nyege Nyege Music Festival in Jinja, Uganda, the Makerere University Joint AIDS Program (MJAP) piloted Quick Response (QR) codes integrated with Google Forms for real-time reporting of self-test results. In a peer-led HIV prevention campaign across the festival grounds, peer educators, identifiable by branded reflective jackets carrying the message “Ask Me About HIV/AIDS”, distributed HIV self-test kits alongside QR codes linked to the reporting platform. Participants were encouraged to scan the code and confidentially submit their results. Individuals reporting reactive results were contacted confidentially and linked to the nearest health facilities for confirmatory testing and HIV care.

Results

In total, 115 HIV self-test kits were distributed. Forty-six participants submitted results via the QR code platform (45.5% reporting rate). Of these, 14 had reactive results and were successfully followed up and linked to appropriate health facilities for confirmatory testing and treatment, based on their reported locations. Bulk SMS reminders containing the reporting link were subsequently sent to the remaining 55 participants who had not submitted their results, to encourage reporting and facilitate follow-up.

Lessons learned

QR code technology is a feasible and innovative digital approach for improving follow-up of HIV self-testing in high-mobility settings such as music festivals, enabling confidential reporting and timely linkage to care for participants with reactive results. However, limited access to smartphones and internet connectivity reduced reporting rates. Future interventions should integrate multiple digital and offline follow-up strategies, including SMS-based reporting and peer navigator support, to maximise HIVST result reporting and strengthen linkage to care in similar settings.

PART B — POSTER PRESENTATIONS

Gallery Walk 1

Tracks 1 & 5

Day 1 • Wednesday 14 October 2026 • 8:00 am – 9:00 am

- P1.01** **Strengthening community-based alcohol use disorder screening through lay health worker task-sharing in rural Uganda: A COM-B-informed study** Joyce Namwase
- P1.02** **Factors associated with the utilisation of community health worker services among households in Kampala Capital City, Central Uganda: A community-based cross-sectional study** Patrick Madrama Lulu
- P1.03** **Strengthening community-integrated primary health care through competency-based training and field practicum of community health extension workers in Uganda** Heta Norah Nabirye
- P1.04** **Prevalence, socio-demographic factors and experiences of gender-based violence among adults with non-communicable diseases in Kyamulibwa, Kalungu District** Mukasa Sulaiman
- P1.05** **Prevalence and factors associated with malaria in households following scale-up of integrated community case management of malaria in Kiruhura District, western Uganda, 2025** George Oryongatum
- P1.06** **Healthcare-seeking behaviour among caregivers of children with suspected measles in Kyegegwa District, January-April 2026** Elizabeth Nshabohurira
- P1.07** **Closing the gap: Community health workers drive active tuberculosis case finding at Rakai Health Sciences Program ART clinic through community-based surveillance in Kyotera District, Uganda** Kimera Simon Peter
- P1.08** **Knowledge, attitudes and preventive practices towards hepatitis B infection among residents of Laroo Division, Gulu City: Implications for social behaviour change interventions** Ali Moses
- P1.09** **Determinants of condom use among sexually active young women aged 15–24 years in Uganda** Wamboko Allan David
- P1.10** **What shapes the quality of life among older persons living with HIV? A multidimensional assessment from TASO clinics in Uganda** Christine Atuhairwe
- P1.11** **Finding the missing TB cases through community eyes: An HIV client-led referral approach at Olilim Health Centre III, Otuke District** Koli Sarah

Strengthening community-based alcohol use disorder screening through lay health worker task-sharing in rural Uganda: A COM-B-informed study

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Background

Alcohol use disorder (AUD) contributes substantially to preventable morbidity and social harm, yet screening and early intervention remain limited in rural, resource-constrained settings. Task-sharing with lay health workers (LHWs) may extend these services within communities, but depends on LHWs' capability, opportunity and motivation to screen and refer.

Objectives

This study explored factors influencing LHW readiness to screen and refer people with AUD in rural Uganda, to inform the development of a community-based task-sharing approach.

Methods

We conducted a qualitative study in rural south-western Uganda involving 18 in-depth interviews with LHWs and three key informant interviews with healthcare providers. Interviews explored knowledge and skills, access to resources and facilities, community relationships, motivation, referral experiences and gender-related barriers. Data were analysed thematically using a combined deductive and inductive approach guided by the Capability, Opportunity, Motivation and Behaviour (COM-B) framework.

Results

Eight themes were identified across the COM-B domains. Under Capability, LHWs described gaps in comprehensive AUD knowledge and communication skills, and physical limitations affecting linkage to care. Opportunity was shaped by connections with health facilities, strong social proximity and community trust, and the availability of appropriate structures and tools. Motivation was supported by perceived positive outcomes of helping community members and community appreciation, but undermined by unsuccessful referral outcomes and limited incentives. Gender-related barriers, including stigma and verbal abuse, particularly affected female LHWs. Although LHWs recognised some features of problematic alcohol use, they lacked standardised screening tools and structured referral and feedback mechanisms.

Conclusions and implications

LHWs have community relationships and motivation that could support AUD screening and referral, but their contribution is constrained by gaps in capability and health-system support. The findings informed a community-based task-sharing approach incorporating structured training, standardised AUD screening and strengthened referral pathways, showing how formative implementation research can guide integration of alcohol-related services into primary health care in rural Uganda.

Keywords: lay health workers; alcohol use disorder; task-sharing; primary health care; community health

Factors associated with the utilisation of community health worker services among households in Kampala Capital City, Central Uganda: A community-based cross-sectional study

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Background

Community health workers (CHWs) play an important role in improving health outcomes, particularly where access to formal healthcare is limited. Village health teams (VHTs) in Uganda link communities with the formal health system, yet their services remain underutilised.

Objectives

To determine the level of CHW service utilisation and assess the individual and organisational factors influencing utilisation among households in Kisugu, Kampala.

Methods

A community-based descriptive cross-sectional study was conducted among households in Kisugu, Makindye Division, Kampala Capital City. A sample of 350 respondents was determined using the Kish and Leslie formula, and multistage sampling was used to select households, with one eligible adult respondent per household. Data on socio-demographic, individual, behavioural, socioeconomic, cultural and organisational factors were analysed using STATA version 19.0. Descriptive statistics and chi-square tests were performed, and prevalence ratios (PRs) with 95% confidence intervals (CIs) were reported.

Results

Among 350 respondents, 27.4% (n=96) had utilised CHW services, while 72.6% (n=254) had never utilised them. Utilisation was higher among divorced respondents (PR=3.11; 95% CI: 1.53–6.29) and those in the middle wealth category (PR=1.83; 95% CI: 1.08–3.09). Lack of awareness of CHW services (PR=0.48; 95% CI: 0.26–0.88) and preference for self-medication (PR=0.52; 95% CI: 0.29–0.95) were associated with lower utilisation. Rejecting the belief that traditional medicine is better was associated with higher utilisation (PR=1.77; 95% CI: 1.01–3.10), while high wealth was associated with lower utilisation (PR=0.18; 95% CI: 0.05–0.63).

Conclusions and implications

CHW service utilisation was low. Awareness, socioeconomic status, health-seeking behaviour and cultural beliefs influenced utilisation. Strengthening community awareness of CHW roles and services, and addressing harmful health-seeking practices such as self-medication, may improve utilisation and strengthen community-based primary healthcare delivery.

Keywords: community health workers; service utilisation; health-seeking behaviour; health services accessibility; urban health

Strengthening community-integrated primary health care through competency-based training and field practicum of community health extension workers in Uganda**Heta Norah Nabirye****Background**

Uganda's transition towards stronger community-based primary health care places community health extension workers (CHEWs) at the interface between households and the formal health system. The national CHEW programme is expanding, with 5,616 CHEWs trained and a national target of 21,432 by 2029. Effective community-level delivery depends on appropriate competencies, supportive supervision, functional referral systems and health-system integration.

Objectives

This implementation experience assessed the contribution of competency-based training and field practicum in preparing CHEWs for community-integrated primary health care delivery.

Methods

An implementation-focused assessment was conducted among 106 CHEW trainees in Iganga District (47 females, 44.3%; 59 males, 55.7%). Training combined classroom-based competency-based learning with a supervised field practicum covering health promotion, disease prevention, community engagement, household assessment, identification of danger signs, referral and linkage to health facilities, and community health information activities. Effectiveness was assessed using pre- and post-training knowledge tests, competency assessments, and attendance and completion records; practicum performance was assessed through supervisor assessments and trainee field reports.

Results

Of the 106 trainees enrolled, 99% completed classroom-based training. Mean knowledge scores increased from 45% pre-training to 84% post-training, a 39-percentage-point improvement. All trainees completed the supervised field practicum, conducting 4,120 household visits and 2,013 community health sessions and making 490 referrals to health facilities. Competency assessments showed that 99% attained the required competency level, and supervisor assessments showed 90% satisfactory performance in key areas. Challenges included absenteeism, logistical constraints and delays in facilitation, highlighting the need for continued mentorship and supportive supervision.

Conclusions and implications

Competency-based CHEW training combined with a structured field practicum can strengthen the transition from classroom learning to practical community-level primary health care delivery. Sustained mentorship, supportive supervision, adequate tools, functional referral pathways and accountability mechanisms are essential for maintaining competencies and ensuring consistent delivery of integrated community health services.

Keywords: community health extension workers; competency-based training; field practicum; primary health care; Uganda

Prevalence, socio-demographic factors and experiences of gender-based violence among adults with non-communicable diseases in Kyamulibwa, Kalungu District**Mukasa Sulaiman****Background**

In rural Uganda, the intersection of gender-based violence (GBV) and non-communicable diseases (NCDs) remains underexplored, despite an increasing NCD burden, structural inequities and individual vulnerabilities. National and local policies rarely integrate GBV as an adverse outcome into chronic NCD care.

Objectives

To investigate the prevalence, lived experiences and correlates of GBV among adults with NCDs in Kyamulibwa Sub-County, Kalungu District, within the General Population Cohort Study.

Methods

A mixed-methods cross-sectional design, guided by the Intersectionality Framework, combined quantitative surveys of GBV prevalence and associated socio-demographic and NCD-related factors with qualitative interviews on survivors' experiences, vulnerabilities and coping mechanisms. Ethical clearance: Uganda Martyrs University, MRC/UVRI and LSHTM Uganda Research Unit, and UVRI Research and Ethics Committee.

Results

Among 215 adults with NCDs, the survey-weighted prevalence of any GBV was 43.7% (95% CI: 39.7–53.5%). Emotional neglect (46.5%) and economic control (41.4%) were most frequent, then physical violence (23.7%) and sexual coercion (18.1%). Women experienced more physical violence than men (28.2% vs 13.6%, $p=0.006$). 12.6% experienced ≥ 3 GBV types and 5.8% all four. Independent risk factors included psychosis (aPR 1.82), epilepsy (aPR 1.54), high economic vulnerability (aPR 2.31), NCD stigma (aPR 1.63), female sex (aPR 1.31), income $<250,000$ UGX (aPR 1.47) and functional dependence (aPR 1.49); younger age (18–35 years) was protective (aPR 0.55). Women with psychosis had the highest predicted GBV probability (65.1%), with a 34.3 percentage-point sex gap. GBV was associated with poor medication adherence (aOR 2.14), suboptimal treatment status (aOR 2.47), irregular clinic attendance (aOR 1.89), higher PHQ-9 scores (median 9.0 vs 4.0) and lower WHOQOL-BREF psychological health scores (28.4 vs 40.2%). Qualitative findings showed a bi-directional relationship between NCDs and GBV, including an abuser-caregiver paradox affecting safety planning.

Conclusions and implications

The findings support integrating GBV screening into NCD care, equitable health policies, and survivor-centred, trauma-informed chronic disease management in resource-constrained rural settings.

Keywords: gender-based violence; NCDs in rural Uganda; General Population Cohort; Kyamulibwa

Prevalence and factors associated with malaria in households following scale-up of integrated community case management of malaria in Kiruhura District, western Uganda, 2025**George Oryongatum**¹, Eric Ssegujja², Ivan Kanya³¹Sanga Health Centre III, Kiruhura District, Uganda²Makerere University School of Public Health, Uganda³District Health Office, Kiruhura District, Uganda**Background**

Malaria remains a major public health challenge in sub-Saharan Africa, with a disproportionate burden in rural Uganda. Despite national adoption of integrated community case management (ICCM), implemented through village health teams (VHTs) to improve early diagnosis and treatment, several districts continue to report a high malaria burden.

Objectives

This study assessed malaria prevalence and examined household-level factors associated with malaria risk following scale-up of ICCM in Kiruhura District, western Uganda.

Methods

A mixed-methods cross-sectional study was conducted among 327 households registered under ICCM between September 2022 and August 2023. Quantitative data were collected using structured questionnaires; bivariate and multivariable logistic regression identified factors independently associated with malaria, reported as odds ratios with 95% confidence intervals (CIs). Qualitative data were collected through key informant interviews and focus group discussions with 15 purposively selected stakeholders and analysed thematically to explore experiences of ICCM implementation.

Results

A total of 327 households were surveyed, a response rate of 98.4%. Most households were rural, with a mean household size of seven. Overall, 410 malaria episodes were reported, corresponding to a prevalence of 26.7% among residents of ICCM-supported households, while 10.1% of households experienced at least one malaria episode during the reference period. Children under five years accounted for 74.8% of reported cases. In multivariable analysis, vegetation near households was associated with increased malaria risk (adjusted odds ratio [AOR] = 1.17; 95% CI: 1.02–1.34). Conversely, use of long-lasting insecticide-treated nets (LLINs) (AOR = 0.66; 95% CI: 0.48–0.91) and seeking care from public health facilities (AOR = 0.74; 95% CI: 0.66–0.83) were independently protective.

Conclusions and implications

Malaria remains highly prevalent in ICCM-supported households in Kiruhura District. Efforts to reduce the household malaria burden could focus on strengthening the supply chain for ICCM commodities, improving VHT support and motivation, and enhancing community education on effective prevention practices, such as proper use of LLINs.

Healthcare-seeking behaviour among caregivers of children with suspected measles in Kyegegwa District, January–April 2026

Elizabeth Nshabohurira¹, Godfrey Tumwizere¹, Regina Nanyunja¹, Mariam Nambuya¹, Allan Amandu¹, Rodgers Kalanda¹, Lillian Aliyinka¹, Prossy Nakito¹, Chrispus Musabe Bakunda¹, Wilber Arineitwe¹, Richard Migisha¹, Benon Kwesiga¹, Daniel Kadobera³, Yasiini Nuwamanya², Alex Riolexus Ario¹

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Background

Delayed care-seeking for suspected measles may increase the risk of complications and continued community transmission. A measles outbreak was confirmed in Kyegegwa District on 20 March 2026.

Objectives

To assess healthcare-seeking behaviour and identify factors associated with delayed formal healthcare-seeking among caregivers of children with suspected measles.

Methods

We conducted a mixed-methods cross-sectional study among 85 caregivers of children with suspected measles identified during active case search in the two most affected sub-counties of Kyegegwa District. Quantitative data were collected using structured questionnaires; qualitative data through interviews with four community caregivers and two village health team (VHT) members. Delayed formal healthcare-seeking was defined as seeking care at a health facility >48 hours after rash onset. We used logistic regression to identify factors associated with delay and analysed qualitative data thematically.

Results

Among 85 caregivers, 53 (62.4%) delayed seeking formal healthcare. Only 24 (28%) first sought care at a health facility. The remaining caregivers first used home remedies (36%), traditional healers or herbs (18%), medicines from drug shops or private clinics (11%), did nothing (45%), or consulted a VHT (2%). Caregivers knowledgeable about measles had higher odds of delayed care-seeking (adjusted odds ratio (aOR)=5.28; 95% confidence interval (CI): 1.63–17.16), as did those requiring ≥60 minutes to reach a health facility (aOR=4.93; 95% CI: 1.50–16.12). Qualitative findings identified home treatment, herbal remedies, advice from relatives, transport costs, medicine stock-outs and long waiting times as contributors to delays.

Conclusions and implications

Delayed formal healthcare-seeking was common among caregivers of children with suspected measles. Strengthening community referral processes, addressing misconceptions about measles treatment and improving timely access to affordable health services may support earlier care-seeking and contribute to measles prevention and control.

Keywords: measles; healthcare-seeking behaviour; caregivers; delayed healthcare seeking; Uganda

Closing the gap: Community health workers drive active tuberculosis case finding at Rakai Health Sciences Program ART clinic through community-based surveillance in Kyotera District, Uganda

Kimera Simon Peter, Mulungi Hamida, Alex Ssemakalu

Background

Tuberculosis (TB) remains a major challenge in rural communities, where geographic distance, transport costs and stigma can delay access to diagnostic services. Conventional facility-based screening may therefore miss people with TB who remain in the community.

Objectives

This study evaluated a proactive community health worker (CHW)-led, community-based surveillance approach to strengthen active TB case finding and linkage to diagnostic services at the Rakai Health Sciences Program antiretroviral therapy (ART) clinic in Kyotera District, Uganda.

Methods

From January to December 2025, eight CHWs were trained and deployed across four sub-counties to conduct TB symptom screening, contact tracing, referral and case tracking during routine household visits. CHWs used a standardised symptom checklist integrated into the Intensified TB Case Finding (ICF) form to identify people with presumptive TB. The TB focal person transported sputum by motorcycle to the clinic for GeneXpert testing, and referral vouchers gave access to chest radiography. CHWs tracked referrals and outcomes in paper registers.

Results

A total of 1,210 community members were screened, of whom 494 (40.8%) had presumptive TB. Of these, 32 pulmonary TB cases were confirmed, a diagnostic yield of 6.5% among people with presumptive TB. Of the cases, 16 (50%) were diagnosed by GeneXpert (bacteriologically confirmed) and the same number by chest X-ray. Screening during routine CHW household visits identified cases beyond the reach of facility-based services.

Conclusions and implications

A CHW-led, community-based TB surveillance model provided a practical, resource-efficient approach to strengthening active TB case finding in Kyotera District. Standardised screening, referral vouchers, decentralised specimen transport and CHW-led follow-up created a functional link between households and diagnostic services. Its low cost, use of existing community structures and independence from digital infrastructure suit resource-constrained settings. Scaling up could widen active case finding, reduce diagnostic delays and help close the gap between people with TB in the community and diagnostic services.

P1.08

Poster · Gallery Walk 1 · Track 5

Day 1 · Wed 14 Oct · 8:00 am – 9:00 am · Ref HPDP2026-037

Knowledge, attitudes and preventive practices towards hepatitis B infection among residents of Laroo Division, Gulu City: Implications for social behaviour change interventions**Ali Moses**¹, Arthur Nseko²¹Faculty of Medicine, Gulu University, Uganda²Department of Public Health, Gulu University, Uganda**Background**

Hepatitis B virus (HBV) infection remains a major public health challenge and contributes substantially to morbidity and mortality in sub-Saharan Africa. Uganda has an estimated HBV prevalence of approximately 6%, with Northern Uganda one of the most affected regions. Despite safe and effective vaccines, uptake and completion of the recommended vaccination schedule remain suboptimal. Understanding community knowledge, attitudes and preventive practices is essential for designing effective social and behaviour change interventions.

Objectives

This study assessed knowledge, attitudes and preventive practices towards HBV infection among residents of Laroo Division, Gulu City.

Methods

A community-based descriptive cross-sectional study was conducted between May and July 2025 among 270 residents selected through systematic random sampling. Data were collected using structured questionnaires and analysed with descriptive statistics in SPSS version 25.

Results

Most respondents had positive attitudes towards HBV prevention: 74% agreed that individuals should undergo HBV testing and 63.3% expressed confidence in HBV vaccination. Although 56% reported receiving at least one vaccine dose, only 25.7% had completed the recommended three-dose schedule. Over 65% reported previous exposure to blood or body fluids through accidental injuries or close contact, indicating persistent risk of infection. Awareness of HBV prevention measures did not consistently translate into recommended preventive behaviours.

Conclusions and implications

While awareness and attitudes towards HBV prevention were generally favourable, important gaps remain in preventive practices, particularly completion of the vaccination schedule. Strengthening community-led health education, risk communication and social behaviour change interventions may improve vaccine uptake and reduce HBV transmission in Northern Uganda. Community health workers should be leveraged to promote sustained behaviour change and increase access to HBV prevention services.

Keywords: hepatitis B; health promotion; social behaviour change; vaccination; community engagement

Determinants of condom use among sexually active young women aged 15–24 years in Uganda

Wamboko Allan David

Background

Despite high HIV risk and teenage pregnancy rates among young women in Uganda, condom use remains low. Understanding its determinants is critical for designing effective interventions.

Objectives

This study assessed factors associated with condom use among sexually active young women aged 15–24 years in Uganda.

Methods

This cross-sectional study analysed data from 4,849 sexually active young women aged 15–24 years in the 2016 Uganda Demographic and Health Survey (UDHS), which used multistage sampling. Bivariate analysis (chi-square tests) and multivariate logistic regression identified factors associated with condom use at last sexual intercourse. Variables included age, marital status, education, wealth, residence, religion and HIV knowledge.

Results

Overall condom use at last sex was very low (16.8%), despite 88.8% of respondents knowing that consistent condom use reduces HIV risk. Bivariate analysis showed significant associations with age, residence, marital status, education, wealth and HIV knowledge ($p < 0.05$). In logistic regression controlling for all variables, only marital status, education, HIV knowledge and age 24 remained significant predictors. Married young women had 88.5% lower odds ($OR = 0.115$) and cohabiting women 91.3% lower odds ($OR = 0.087$) of condom use than never-in-union women. Secondary education ($OR = 7.70$) and higher education ($OR = 8.18$) strongly predicted condom use. Knowledge that condoms prevent HIV increased the odds by 70.8% ($OR = 1.708$). Age 24 was associated with 49.4% lower odds ($OR = 0.506$) than age 15, even after adjustment. Religion, wealth, residence and other age groups were not significant in the final model.

Conclusions and implications

Condom use among sexually active young women in Uganda is critically low, particularly among married or cohabiting women, those with low education and women aged 24. Interventions should target these high-risk subgroups, address relationship dynamics that reduce condom use within unions, and bridge the knowledge–practice gap through empowerment and education programmes.

Keywords: condom use; young women; determinants

What shapes the quality of life among older persons living with HIV? A multidimensional assessment from TASO clinics in Uganda**Christine Atuhairwe**, Hillary Muhanguzi, Titus Ochieng**Background**

The Quality-of-Life (QoL) Composite Index provides a multidimensional, person-centred measure integrating functioning, symptom burden, general health perception, psychological and social well-being, and living environment. It is critical for assessing successful ageing with HIV. However, evidence on its determinants among older persons living with HIV (OPLHIV) in Uganda remains limited.

Objectives

To estimate the QoL Composite Index and identify its determinants among OPLHIV receiving care from The AIDS Support Organisation (TASO) clinics in Uganda.

Methods

A cross-sectional study was conducted among OPLHIV aged ≥ 50 years attending TASO clinics across Uganda. The primary outcome was the QoL Composite Index (range: 0–1), derived from a validated multidimensional instrument. Data were collected through face-to-face interviews. Multivariable associations were assessed using beta regression with a log link, while random forest regression identified variables shaping QoL.

Results

Among 439 participants, the median QoL Composite Index was 0.51 (IQR: 0.41–0.61). After model regularisation, two socioeconomic factors were independently associated with higher QoL: tertiary/university education ($\beta=0.226$, 95% CI: 0.105–0.346; $p<0.001$) and employment ($\beta=0.078$, 95% CI: 0.018–0.138; $p=0.011$). The presence of a non-communicable disease was strongly associated with lower QoL. HIV-specific indicators, including age, duration of HIV infection, viral load and antiretroviral therapy (ART) adherence, were not independently associated with the composite measure.

Conclusions and implications

The QoL Composite Index elucidates the multidimensional nature of well-being among older Ugandans living with HIV. Quality of life was shaped predominantly by socioeconomic conditions and multimorbidity rather than HIV-specific clinical markers. Improving well-being in later life with HIV requires care models that extend beyond viral suppression to address socioeconomic security and integrated geriatric health needs.

Keywords: quality of life; older persons

Finding the missing TB cases through community eyes: An HIV client-led referral approach at Olilim Health Centre III, Otuke District**Koli Sarah****Issue**

Tuberculosis (TB) remains a major public health challenge and a leading cause of morbidity and mortality worldwide. Despite ongoing TB screening, health education, contact tracing and integrated TB/HIV services, Olilim Health Centre III registered persistently low TB case identification between October 2024 and March 2025. Many individuals with TB symptoms remained undetected within communities due to limited health-seeking behaviour, stigma, long distances to health facilities and inadequate community surveillance.

Intervention

A facility–community linkage intervention was implemented through the HIV clinic between March 2025 and August 2025, using HIV clients as community informants to identify people with presumptive TB in their villages. During routine clinic visits, clients were sensitised on common TB symptoms, including persistent cough, fever, night sweats, weight loss and general ill health, and encouraged to identify neighbours, relatives or village members with these symptoms and report them to health workers. Clients then guided health workers to the homes of identified individuals for TB screening and evaluation. Presumptive TB cases were investigated according to national TB diagnostic guidelines, and confirmed cases were enrolled into treatment.

Results

The intervention enhanced active community TB case finding by extending surveillance beyond the health facility. A total of 100 HIV clients were oriented, 382 community members were referred and 378 were screened and presumed to have TB. Between April 2025 and August 2025, 57 clients were diagnosed with TB, compared with only 30 TB cases identified between October 2024 and March 2025.

Lessons learned

Engaging HIV clients as community informants is a feasible, low-cost and innovative strategy for improving TB case detection in underserved settings. The intervention leveraged existing HIV care structures to identify missed TB cases and strengthened community ownership of disease prevention. Integrating patient-led community surveillance into routine TB/HIV services may contribute significantly to closing the TB detection gap and advancing efforts towards TB elimination.

Gallery Walk 2

Tracks 2, 3 & 4

Day 2 · Thursday 15 October 2026 · 2:00 pm – 2:30 pm

- P2.01** **Enhancing utilisation of the electronic Integrated Request and Result Dispatch System for Ebola virus disease sample management in Yumbe Health Region, Uganda** Patrick Pithua
- P2.02** **Effect of family-oriented dialogues on the uptake of postpartum family planning methods among adolescent mothers in Rakai District** Ahumuza Shannon
- P2.03** **Strengthening safe motherhood through digital ANC tracking (FamilyConnect)** Mpiirweh JB Ruka
- P2.04** **Peer-led group antenatal care: Expanding access to maternal services for pregnant adolescents and young women in Tororo through community-led models** Nathan Okiror
- P2.05** **A CHW-led, digitally integrated community kangaroo mother care model: Evidence for positioning community structures as the foundation of newborn survival in Uganda** Niwenyesiga Bridget
- P2.06** **Strengthening active case finding, referral and linkage through care groups and village health teams to improve nutrition outcomes in Adjumani refugee settlements, Uganda** Gerald Nuwagira
- P2.07** **Improving community uptake of maternal and child health services through supported community mobilisation and attitudinal change: A case of Atangwata HC III, Otuke District** Ariko Annet
- P2.08** **Perceived effects of a digital viral load request system on data quality, sample rejection and turnaround time in Kampala** Mugabekazi Winnie
- P2.09** **Beyond physical access: Confidentiality and perceived quality of youth-friendly health services at Kawaala Health Centre, Kampala** Melanie Justice Komakech
- P2.10** **The impact of climate change on reproductive, maternal and newborn health (RMNH) in a changing climate: A case study of Mayuge District, Uganda** Igeme Thomas
- P2.11** **Factors associated with recurrent malaria episodes among children under five (6–59 months) at Kayunga Regional Referral Hospital, Central Uganda** Derick Modi
- P2.12** **From vulnerability to resilience: Youth-led community systems strengthening to improve reproductive, maternal and adolescent health outcomes among adolescent girls and young women in Kampala's informal settlements, Uganda** Nabukeera Doreen

- P2.13 The Champions Tracking System: A Ministry-led interoperable digital pipeline for tracking training and competency of frontline maternal health providers**
Joshua Kalule
- P2.14 Timeliness of measles outbreak detection, notification and early response in Uganda: A 7-1-7 target assessment, January–December 2025** Sharon Namasambi
- P2.15 A scoping review of the most effective interventions for curbing antimicrobial resistance in adults and children over the last decade** Tuhaise Maria Thereza Ledochowska
- P2.16 Cross-border medical tourism and healthcare-seeking behaviour among Bundibugyo Ebola virus disease cases during the Uganda outbreak, May to June 2026** Mariam Nambuya

Enhancing utilisation of the electronic Integrated Request and Result Dispatch System for Ebola virus disease sample management in Yumbe Health Region, Uganda

Patrick Pithua^{1,2}, Samuel Gidudu¹, Michael Eilu², Sarah Namuyanja², Sarah Acayo³, Susan Nabadda⁴, Mary Naluguza⁵, Jonathan Ntale⁵, Thomas Nsibambi⁵, Daniel Kadobera⁵, Sheila Okoth⁵, Alex Riolexus Ario¹

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Issue

During the Ebola virus disease (EVD) response in Uganda, the Ministry of Health promoted the Integrated Request and Result Dispatch System (IRRDS), a national electronic platform for laboratory test requests and result reporting intended to replace paper-based processes. Despite its availability, none of the five districts in Yumbe health region were using IRRDS for EVD sample management at the start of the response, limiting timely electronic submission of laboratory requests and dissemination of results.

Intervention

In June 2026, we implemented a rapid quality improvement initiative to increase the use of IRRDS for EVD sample management across the region. We assessed baseline IRRDS utilisation and identified barriers to uptake among district surveillance and laboratory teams. Interventions included stakeholder engagement, training of healthcare workers, provision of internet data bundles, interoperability between IRRDS and the Uganda Virus Research Institute (UVRI) Arua laboratory information management system, and on-site technical mentorship. Progress was monitored as the proportion of suspected EVD samples submitted through IRRDS.

Results

At baseline, IRRDS utilisation for EVD sample management was 0% across all five districts of Adjumani, Koboko, Moyo, Obongi and Yumbe. Following the interventions, the proportion of suspected samples submitted through IRRDS increased to 100% in all five districts within three weeks.

Lessons learned

The rapid quality improvement initiative achieved complete adoption of IRRDS for EVD sample management across Yumbe health region within three weeks. Targeted stakeholder engagement, training, system integration and technical support can rapidly accelerate the uptake of electronic laboratory information systems during public health emergency responses.

Keywords: rapid quality improvement; Ebola virus disease; IRRDS; laboratory information systems; electronic laboratory requests

Effect of family-oriented dialogues on the uptake of postpartum family planning methods among adolescent mothers in Rakai District**Ahumuza Shannon**, Aloysius Kiberu, Daniel Murokora, Kasendwa Martin**Background**

Adolescent pregnancy remains a major public health challenge in sub-Saharan Africa, driven by high unmet need for contraception, low uptake of postpartum family planning (PpFP) and high rates of rapid repeat pregnancy. Strengthening primary health care and health security for this population requires institutionalising the community health workforce, including community health workers and family dialogue facilitators, as a frontline channel for reaching adolescent mothers with family planning information and services.

Objectives

This study evaluated the effect of a community-based, family-oriented dialogue intervention, delivered through the community health workforce, on PpFP uptake among adolescent mothers in Rakai District, Uganda, and assessed whether uptake varied by level of intervention exposure.

Methods

We conducted a retrospective single-cohort pre-post study using secondary data from a community-based family dialogue intervention implemented in two sub-counties of Rakai District, with baseline (2020) and endline (2024) surveys among adolescent mothers. PpFP uptake was compared over time using McNemar's test, and factors associated with uptake were assessed using Poisson mixed-effects regression.

Results

The median age of adolescent mothers was 18 years (IQR: 18–19); most had primary education (154/240, 64.2%) and were married (184/240, 76.7%). The median number of dialogue sessions attended was 3 (IQR: 2–5). PpFP uptake increased from 14.2% at baseline to 64.6% at endline ($p < 0.001$). In multivariable analysis, time (aRR = 7.77; 95% CI: 3.72–16.20) and number of sessions attended (aRR = 1.18; 95% CI: 1.00–1.33) were associated with PpFP uptake.

Conclusions and implications

The family-focused dialogue intervention significantly increased postpartum family planning adoption among adolescent mothers, and greater attendance at dialogue sessions was associated with higher adoption. This highlights the importance of integrating community health workers and family-inclusive dialogues into primary health care to improve reproductive, maternal, newborn, adolescent and child health and to enhance health security.

Strengthening safe motherhood through digital ANC tracking (FamilyConnect)Donald Kagulire, Stella Nalubowa, **Mpiirweh JB Ruka****Issue**

Maternal and neonatal mortality remain persistently high in Uganda, especially in underserved districts such as Kasese and Kabarole. The Mama Rescue Project's Result Area One aims to sensitise and support 40,000 expectant mothers to complete at least four antenatal care (ANC) visits.

Intervention

The project introduced FamilyConnect, a mobile health solution that enables health workers and village health teams (VHTs) to identify, register and track pregnant women throughout their ANC journey. It automates gestation-based appointment reminders and delivers culturally adapted SMS messages, bridging gaps in information, accessibility and continuity of care. Aligned with the goal of improving access to maternal health services for expectant mothers and informal workers in the Rwenzori region, FamilyConnect operates through a community-led model integrated with the public health system. VHTs conduct household mapping and recruit pregnant women, whose gestational age is confirmed by midwives. The platform then sends lifecycle-based reminders and educational messages, while Health Information Assistants update attendance to track ANC adherence.

Results

To date, 26,093 women have been registered on FamilyConnect in Kasese and Kabarole. Of these, 17,639 (67.6%) have completed at least four ANC visits, a significant increase from the baseline of 43.9%. Real-time data also enable monitoring of progress towards Result One and inform corrective action.

Lessons learned

Integrating FamilyConnect into routine maternal health services is contributing directly to Result One of the Mama Rescue Project, improving ANC attendance, reducing missed appointments and empowering communities with timely, actionable health information. Digital health solutions embedded within existing health systems and community structures can significantly enhance maternal health service utilisation. The approach offers a replicable, scalable model for other low-resource settings seeking to improve safe motherhood outcomes through multisectoral collaboration and accountability.

Peer-led group antenatal care: Expanding access to maternal services for pregnant adolescents and young women in Tororo through community-led models

Nathan Okiror, Jane Nakawesi, Yusuf Namanya, Richard Juuko Kyakuwa, Alex Mugume, Freda Akello, Connie Bwire, Abdulaziz Wambewo, Patricia Nahirya Ntegge, Denise Birungi, Dithan Kiragga

Issue

Adolescent girls and young women (AGYW) face disproportionate barriers to antenatal care (ANC), including stigma, low autonomy, late pregnancy disclosure, transport challenges and weak social support. In rural Tororo, these barriers contribute to delayed ANC enrolment and poor continuity of maternal services.

Intervention

A peer-led group antenatal care (G-ANC) model was implemented across supported health facilities in Tororo District to improve early ANC uptake and retention among pregnant AGYW through community-based peer support. Pregnant AGYW were identified through routine community outreach, village health teams and facility-based screening, then linked into structured peer cohorts facilitated by trained adolescent peer mothers. The model integrated health education, psychosocial support, appointment reminders and peer accompaniment for routine ANC visits. Performance was monitored using routine district ANC service data from April 2025 to March 2026, focusing on first ANC attendance (ANC1) and completion of the fourth ANC visit (ANC4).

Results

Over the reporting period, 15,366 pregnant AGYW were reached with first ANC services against an annual target of 12,112, translating to 114% cumulative achievement. Quarterly ANC1 performance remained above target for three consecutive quarters (129%, 117% and 114%), indicating sustained demand generation and successful linkage to care. Retention improved, with 9,570 AGYW completing at least four ANC visits, representing 79% cumulative ANC4 coverage, notable in a population historically characterised by poor follow-up. The peer-led approach strengthened continuity by reducing missed appointments, improving disclosure and fostering trust through adolescent-centred support groups.

Lessons learned

Peer-led group antenatal care is an effective community-driven strategy for extending maternal health services to marginalised pregnant adolescents and young women. In Tororo, the model increased early ANC enrolment and improved continuity of care by addressing structural and social barriers through peer engagement. Scaling community-led ANC models offers a practical way to reach underserved young mothers and strengthen equitable maternal health outcomes in high-burden settings.

P2.05

Poster · Gallery Walk 2 · Track 3

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-197

A CHW-led, digitally integrated community kangaroo mother care model: Evidence for positioning community structures as the foundation of newborn survival in UgandaPauline Picho Keronyai, **Niwenyesiga Bridget**, Apiny Jean Marion**Issue**

Globally, an estimated 15 million babies are born preterm annually, and preterm birth accounts for more than one in five deaths among children under five. Neonatal mortality remains a significant challenge in Uganda. Community kangaroo mother care (KMC) is a low-cost, evidence-based intervention that significantly improves survival and neurodevelopmental outcomes for preterm and low-birthweight infants. Many small and vulnerable neonates (SVNs) are discharged before reaching optimal weight, making community-based continuation of KMC critical.

Intervention

Nama Health Impact layered a community KMC module onto its existing platform of professionalised community health workers (CHWs) who are Skilled, Salaried, Supplied and Supervised (the “4S Model”) in Mukono, Buikwe, Pakwach and Kayunga Districts, aiming to reduce neonatal mortality through timely danger-sign identification and emergency referral. Each discharged SVN is referred to a village-based CHW who coaches skin-to-skin care and breastfeeding, tracks weight, nutrition, immunisation, water, sanitation and hygiene (WASH), maternal mental health and family planning on the CommCare Connect digital platform, and refers danger signs back to the facility. At least five structured home visits are made per SVN, supported by digital weighing scales, pulse oximeters and locally made kangaroo wraps.

Results

An external evaluation of 605 enrolled SVNs found 94% showing improved weight gain, at a cost of \$10–15 per baby per 28-day cycle versus ~\$100/day for facility-based neonatal intensive care. The neonatal mortality rate was 6.9 per 1,000 births, well below Uganda’s national average of 21/1,000. Enrolment has since grown to 716 SVNs year-to-date, with early-stage expansion underway in Pakwach and Kayunga districts.

Lessons learned

Embedding KMC within an existing, government-linked CHW platform delivers low-cost, high-impact newborn survival outcomes at community level. Professionalised community structures can be positioned as the foundation of primary health care and health security, offering a scalable, evidence-based pathway towards integration into Uganda’s national CHW service package.

P2.06

Poster · Gallery Walk 2 · Track 3

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-068

Strengthening active case finding, referral and linkage through care groups and village health teams to improve nutrition outcomes in Adjumani refugee settlements, Uganda**Gerald Nuwagira**, Henry Turinawe, Royas Nayebare, Brian Hirya

Lutheran World Federation, Department of World Services, Uganda

Issue

Early identification and timely treatment of acute malnutrition are critical to the survival and nutrition of children under five years. In humanitarian settings, community structures bridge households and health facilities. This programme assessed the contribution of Care Group Volunteers (CGVs) and Village Health Teams (VHTs) to active case finding, referral and linkage of malnourished children to Community-Based Management of Acute Malnutrition (CMAM) services in refugee and host communities of Adjumani.

Intervention

Community structures, including Care Groups, VHTs and Father Support Groups, were strengthened through continuous mentorship, supportive supervision and refresher training on nutrition screening, referral pathways and maternal and child nutrition. Volunteers conducted household visits, family mid-upper arm circumference screening, nutrition education and referral to health facilities, and supported treatment adherence and follow-up. A programme review used routine monitoring data from January to May 2026.

Results

The strengthened community platform contributed to improved identification and linkage of malnourished children to treatment, reflected in consistently high CMAM performance. Cure rates remained above Sphere standards in four of the five reporting months, reaching 94.1%, 88.4%, 93.0% and 92.0%, while death rates remained at 0% throughout. Defaulter rates remained below the acceptable threshold in four months despite one period of increased defaulting linked to refugee mobility and disease outbreaks. Average length of stay progressively reduced from 73.1 to 55.7 days, suggesting improved treatment adherence and earlier recovery.

Lessons learned

Continuous mentorship of health workers, CGVs and VHTs, with strengthened coordination among district authorities, partners and community structures, enhanced referral completion, follow-up and continuity of care. Community platforms integrating CGVs and VHTs can substantially strengthen case finding, referral and linkage for acute malnutrition in humanitarian settings. Investing in volunteer capacity, supportive supervision and integrated referral systems has potential to improve nutrition outcomes and strengthen reproductive, maternal, newborn, adolescent and child health service delivery.

Keywords: care groups; Village Health Teams; active case finding; referral; CMAM

P2.07

Poster · Gallery Walk 2 · Track 3

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-077

Improving community uptake of maternal and child health services through supported community mobilisation and attitudinal change: A case of Atangwata HC III, Otuke District

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Issue

Atangwata Health Centre (HC) III in Ogor Sub-county, in the remote district of Otuke, serves a catchment population of 18,476. Due to poor access, in FY 2023/2024 the facility registered coverages of 53% for BCG, 65% for DPT1, 52% for DPT3 and 49% for measles vaccines, below the target of >90% for children under 5. Dropout rates of 21% for DPT1-DPT3 and 26% for DPT1-measles exceeded the acceptable <10%, placing the facility in Category 4 for Reaching Every District/Reaching Every Child (RED/REC). Maternal services stood at 79 for first antenatal care (ANC1) coverage, 31% for first-trimester attendance, 36 for ANC4 coverage, 38 for institutional delivery and 50% for postnatal care (PNC) timing. Continued community mobilisation was needed to promote use of integrated maternal and child health services.

Intervention

In FY 2024/2025, CUAMM, funded by the ELMA Foundation and supported by the district, trained 25 village health teams (VHTs) and 25 peer mothers on key family care practices, motivated them with job aids, T-shirts and bags, and supported line listing, mapping and linking defaulters back to care to boost existing Ministry of Health services. Integrated community sensitisation and mobilisation drives and outreaches were extended to communities with defaulters, and joint quarterly VHT/peer and facility performance review meetings were held.

Results

In FY 2024/2025, child health coverage improved to 85% for BCG, 100% for DPT1, 115% for DPT3 and 131% for measles vaccines, and dropout rates fell to -9% for DPT1-DPT3 and -24% for DPT1-measles, moving the facility to Category 2 for RED/REC. Maternal service uptake changed to 70 for ANC1 coverage, 58 for first-trimester attendance, 55 for ANC4 coverage, 70 for institutional delivery and 142% for PNC timing.

Lessons learned

Community health workers play a critical role in improving access to and utilisation of maternal and child health services.

Perceived effects of a digital viral load request system on data quality, sample rejection and turnaround time in Kampala**Mugabekazi Winnie****Background**

Digital transformation offers an important opportunity to strengthen health systems and improve the efficiency and responsiveness of HIV services. However, paper-based viral load (VL) request processes can contribute to incomplete documentation, errors, specimen rejection and delays in receiving results.

Objectives

This study explored healthcare workers' perceptions of the effects of a digital VL request system on data quality, sample rejection and turnaround time at the Makerere Joint AIDS Program (MJAP) ISS Clinic in Kampala, Uganda.

Methods

A qualitative descriptive study was conducted among 20 purposively selected healthcare workers involved in HIV care and VL-related processes, including laboratory personnel, records assistants, data clerks, clinicians, medical doctors and pharmacists. Data were collected through in-depth and key informant interviews and analysed thematically using NVivo 12. Triangulation across professional cadres enhanced the credibility of the findings.

Results

Three major themes emerged: improved data quality, reduced sample rejection and shortened turnaround time. Participants reported that automated patient identification, mandatory fields and real-time validation reduced transcription errors and improved completeness of VL documentation. Standardised electronic forms and barcode-based specimen tracking were perceived to reduce sample rejection, with participants reporting a decline from approximately 8% to less than 3%. Digital transmission of results also reduced workflow bottlenecks: participants reported that VL results previously taking approximately 21 days were received in less than 10 days. Faster availability of results enabled more timely clinical decisions, particularly for patients with unsuppressed viral loads.

Conclusions and implications

Digital VL request systems can strengthen health-system responsiveness by improving information quality, reducing avoidable laboratory inefficiencies and accelerating access to results. Integrating digital innovations into routine HIV services, supported by continuous user training, reliable infrastructure and supportive supervision, can contribute to more efficient and responsive health systems in Uganda.

Keywords: digital transformation; health systems; HIV; viral load; data quality

P2.09

Poster · Gallery Walk 2 · Track 3

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-213

Beyond physical access: Confidentiality and perceived quality of youth-friendly health services at Kawaala Health Centre, Kampala**Melanie Justice Komakech**

Open World Foundation

Background

Access to health services does not necessarily translate into quality care for young people. Efforts to improve youth-friendly services often emphasise availability and physical access, while less attention may be given to how young people experience care, particularly privacy, confidentiality and provider interaction.

Objectives

This study assessed factors associated with young people's perception of the quality of health services at Kawaala Health Centre, Kampala, to identify priorities for strengthening adolescent-responsive health services.

Methods

A cross-sectional study was conducted among 35 young clients at Kawaala Health Centre. A structured questionnaire covered socio-demographic characteristics, access to services, treatment by health workers, privacy and confidentiality, and overall perceived quality. Descriptive statistics summarised participants' characteristics and experiences; chi-square tests assessed associations with perceived quality, and binary logistic regression identified independent predictors.

Results

Overall, 82.8% of respondents rated service quality positively (51.4% good, 31.4% very good), while 17.1% rated it fair. Access-related factors, including ease of reaching the facility, waiting time and affordability, were not significantly associated with perceived quality. Being carefully listened to by health workers was associated with positive perceptions, while confidence in confidentiality was the only factor that remained independently associated with perceived quality after adjustment. Respondents without confidence in confidentiality were less likely to report positive perceptions (AOR=0.06, 95% CI: 0.004–0.927).

Conclusions and implications

Physical access alone may not guarantee positive experiences of youth-friendly services; trust, particularly confidence in confidentiality, is an important dimension of perceived quality. Health facilities should strengthen confidentiality practices and ensure private consultation environments for young clients. The Ministry of Health and facility managers should integrate respectful communication, active listening and confidentiality into routine health worker training and supervision, and establish routine feedback mechanisms that allow young clients to report concerns and contribute to service improvements.

The impact of climate change on reproductive, maternal and newborn health (RMNH) in a changing climate: A case study of Mayuge District, Uganda

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Background

Increasing evidence shows that climate variability, including floods, droughts and rising temperatures, negatively affects health systems, livelihoods, and maternal and newborn health outcomes, particularly in vulnerable rural populations.

Objectives

This study examined the impact of climate change on reproductive, maternal and newborn health (RMNH) in a changing climate context, using Mayuge District, Uganda, as a case study.

Methods

A cross-sectional mixed-methods design was employed involving 130 respondents, of whom 120 completed and returned valid questionnaires. The study targeted pregnant women, mothers with children under five years and health professionals (nurses, midwives and clinical officers). Data were collected using structured questionnaires, key informant interviews and document review. Quantitative data were analysed using SPSS, and qualitative data thematically.

Results

Most respondents were engaged in climate-sensitive livelihoods: peasant farming (45.8%), small-scale businesses (20.8%) and fishing (16.7%), while health workers accounted for 16.7%. The dominance of subsistence farming indicates high vulnerability to climate variability, as irregular rainfall, droughts and flooding directly reduce agricultural productivity, household income and food security. The study established a strong positive relationship between climate change and poor RMNH outcomes ($r = 0.71$; $R^2 = 0.62$). Climate change affects RMNH through direct pathways, such as heat stress during pregnancy and limited access to health facilities during extreme weather events, and indirect pathways, including food insecurity, maternal malnutrition, increased disease burden, and disrupted access to maternal and newborn health services due to damaged infrastructure and transport systems.

Conclusions and implications

Climate change significantly undermines RMNH outcomes in Mayuge District by increasing socio-economic vulnerability and limiting access to essential health services. The study recommends strengthening climate-resilient health systems, improving access to maternal healthcare, and enhancing community-based adaptation strategies to mitigate climate-related health risks.

Keywords: climate change; reproductive health; maternal health; newborn health; RMNH

P2.11

Poster · Gallery Walk 2 · Track 3

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-024

Factors associated with recurrent malaria episodes among children under five (6–59 months) at Kayunga Regional Referral Hospital, Central Uganda**Derick Modi****Background**

Malaria remains a substantial global challenge and a major cause of mortality and morbidity in many developing nations. Children aged 6–59 months in low- and middle-income countries such as Uganda are the most affected.

Objectives

This study aimed to determine the prevalence of, and factors associated with, recurrent malaria episodes among children aged 6–59 months at Kayunga Regional Referral Hospital.

Methods

A cross-sectional study was conducted among caregivers of children aged 6–59 months at Kayunga Regional Referral Hospital in central Uganda. Data were collected from 250 consecutively sampled caregivers using a researcher-administered questionnaire and analysed at univariate, bivariate and multivariate levels.

Results

A total of 250 participants took part, a response rate of 98.45%. The prevalence of recurrent malaria episodes was 84% (210). Factors significantly associated with recurrent malaria were living in houses that were annually sprayed (aOR 8.93, 95% CI 2.11–37.81), living in houses that were not sprayed (aOR 3.80, 95% CI 1.27–9.41, $p = 0.017$), treatment with quinine for the previous infection (aOR 0.28, 95% CI 0.12–0.65), and residing in a house whose windows were closed at 7–8 pm (aOR 8.31, 95% CI 2.21–10.27).

Conclusions and implications

Household prevention practices, malaria treatment history and housing conditions were significantly associated with recurrent malaria, highlighting the need to strengthen malaria control interventions. Malaria prevention programmes should consider biannual indoor residual spraying in high-transmission areas using insecticides to which vectors are susceptible.

P2.12

Poster · Gallery Walk 2 · Track 3

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-032

From vulnerability to resilience: Youth-led community systems strengthening to improve reproductive, maternal and adolescent health outcomes among adolescent girls and young women in Kampala's informal settlements, Uganda**Nabukeera Doreen**

Movement of Women Living with HIV/AIDS, Uganda

Issue

Approximately 25% of girls aged 15–19 in Uganda have begun childbearing, and adolescent pregnancies contribute substantially to maternal and newborn morbidity and mortality. Maternal mortality stands at 189 per 100,000 live births and neonatal mortality at 22 per 1,000 live births. Adolescent girls and young women (AGYW) in informal settlements face additional barriers: poverty, limited access to sexual and reproductive health services, gender-based violence (GBV), HIV vulnerability, stigma and weak referral systems.

Intervention

Between January and December 2025, youth advocates and peer supporters in Busabala and surrounding informal settlements of Kampala led a community intervention to improve AGYW access to reproductive, maternal, newborn, adolescent and child health (RMNACH) services. Activities included community dialogues, household visits, peer mentorship, health education, GBV screening and referral, HIV prevention messaging and linkage to maternal health services. Village health teams, health facilities, community leaders and young mothers were engaged to strengthen referral pathways. Monitoring and follow-up records were reviewed.

Results

In total, 180 AGYW were followed up through outreach and peer support. Sixty-seven were linked to sexual and reproductive health services, and 42 pregnant adolescents were supported to attend antenatal care and complete recommended visits. Twenty-three GBV survivors were identified and referred for health, psychosocial and protection services. Community dialogues on adolescent health, HIV prevention, maternal care and gender equality reached over 400 community members. Increased health-seeking behaviour, improved service uptake, strengthened referral linkages and reduced stigma towards adolescent mothers and young women living with HIV were reported.

Lessons learned

Youth advocates' involvement enhanced trust, acceptance and community ownership. Integrating youth advocates, peer supporters and community health workers into RMNACH programming enhances service uptake, strengthens referrals and addresses social barriers to care. Institutionalising and investing in community-driven approaches is essential to end preventable maternal and newborn deaths and ensure equitable access to care for young people in Uganda.

Keywords: RMNACH; adolescent health; maternal health; community systems; youth leadership

The Champions Tracking System: A Ministry-led interoperable digital pipeline for tracking training and competency of frontline maternal health providers

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Issue

Postpartum haemorrhage (PPH) remains a leading direct cause of maternal death in Uganda; outcomes depend on the competence of the provider attending the birth. Routine systems record maternal outcomes (EAFYA and electronic registers reporting into the District Health Information Software 2, DHIS2) and deployment (the integrated Human Resources Information System, iHRIS), but not whether a provider was trained, last assessed or how she performed. Under the UNFPA Safe Birth Africa (SBA) Project, Low Dose High Frequency PPH training runs across 30 health facilities, with more than 150 providers trained. Manual marking takes about one day, fails when training runs concurrently and leaves no record once a project closes.

Intervention

The Champions Tracking System is a Ministry of Health-led training data pipeline, built with implementing-partner support on Ministry-managed infrastructure for implementation over six months across the 30 SBA-supported facilities. Components are: registration under a phone-number-derived unique identifier capturing the national human-resource identifier; unified digital instruments (tests, Objective Structured Clinical Examination checklists, practice records) on self-hosted ODK Central; automated marking returning scored results on submission; an interoperability layer exchanging competency indicators with DHIS2 and matching records to iHRIS; and a dashboard driving recognition, monthly reporting and digital certification. It builds on providers' existing ODK or Kobo Collect use; usability tracking allows in-period revision of instruments. Rollout follows a Month 1 readiness assessment and a Month 2 pilot; code, credentials and administrator training transfer to the Ministry in Month 6.

Lessons learned

The system addresses a gap in Uganda's health information architecture: absent training and competency data on the primary health care workforce. Placing these indicators beside service-delivery and human-resource data is intended to make capacity-building returns measurable; Ministry hosting and handover retain the capability afterwards. Results will be reported after implementation. The generic design makes it adaptable to community health worker training programmes.

Timeliness of measles outbreak detection, notification and early response in Uganda: A 7-1-7 target assessment, January–December 2025

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Background

Timely detection and response are critical determinants of outbreak control. The 7-1-7 framework provides a standardised benchmark for assessing outbreak response performance and identifying bottlenecks and enablers of timely response. In 2025, Uganda recorded 66 confirmed measles outbreaks.

Objectives

We evaluated 7-1-7 timeliness across Uganda's 2025 measles outbreaks to inform response improvements.

Methods

We evaluated 46 laboratory-confirmed measles outbreaks in 2025 with complete 7-1-7 timeliness data. Timeline data were abstracted from National Rapid Response Team reports and verified through structured interviews with District Health Teams. Emergence was defined as the date the outbreak threshold was first met, detection as the date the surveillance system first recognised the outbreak, and notification as the date it was reported to public health authorities. Time from emergence to detection, detection to notification, and notification to completion of seven early response actions was summarised using medians and interquartile ranges (IQR). Qualitative data from 186 key informant interviews were analysed thematically across the three 7-1-7 domains.

Results

Performance was suboptimal across all 7-1-7 benchmarks. Median detection time was 16 days (IQR 8–31), notification 1 day (0–5) and completion of early response actions 34 days (22–49). Eight (17%), 27 (59%) and two (4%) outbreaks met detection, notification and response targets, respectively; none achieved full compliance. Enablers included strengthened triage and screening for febrile rash illness at health facilities, rapid mobile phone-based reporting (WhatsApp), and coordinated district response structures, including trained Rapid Response Teams and functional district task forces. Bottlenecks included low clinical suspicion, weak community-based surveillance, delayed laboratory confirmation, and logistical constraints such as vaccine shortages, weak cold-chain capacity and transport limitations.

Conclusions and implications

Measles outbreak response timeliness in Uganda is substantially below 7-1-7 targets because of systemic weaknesses across surveillance and response systems. Strengthening community-based surveillance, improving diagnostic turnaround and institutionalising routine 7-1-7 monitoring could improve response timeliness during outbreaks.

Keywords: measles; 7-1-7 framework; outbreak response timeliness; disease surveillance; Uganda

A scoping review of the most effective interventions for curbing antimicrobial resistance in adults and children over the last decade

Tuhaise Maria Thereza Ledochowska

Background

Antimicrobial resistance (AMR) is an escalating global health threat, contributing to over 1 million deaths annually and projected to cause 50 million deaths per year by 2050. Misuse of broad-spectrum antibiotics during the COVID-19 pandemic accelerated this crisis. While significant research exists on AMR interventions in adults, an integrated, comparative synthesis of the most effective adult and paediatric interventions over the last decade is absent.

Objectives

This scoping review mapped and evaluated the most effective interventions implemented to curb AMR in adult and paediatric populations over the past decade (2015-2025), seeking to identify structural knowledge gaps between age groups.

Methods

Guided by the PRISMA extension for scoping reviews (PRISMA-ScR), PubMed, Google Scholar, Scopus and Web of Science were searched using Boolean operators. English-language primary studies, systematic reviews and clinical guidelines on AMR prevention in human populations published from 2015 to 2025 were eligible. Extracted data were charted by intervention, mechanism, population, outcome and translational barrier.

Results

A total of 20 studies were synthesised, revealing a stark structural divide between age cohorts. Adult-focused research is dominated by biological, genetic and material innovations, including phage therapy. Paediatric interventions are almost entirely limited to antimicrobial and diagnostic stewardship programmes that optimise existing, older drugs.

Conclusions and implications

A profound translational and equity gap divides global AMR strategies. Adult care pioneers highly precise biomolecular tools, but these are stalled by a lack of standardised clinical trials and regulatory protocols. Paediatric care is excluded from this biotechnology wave because of ethical restrictions on drug trials and unpredictable childhood pharmacokinetics. The findings highlight the urgent need for tailored, resource-appropriate interventions and standardised metrics for children, and can inform policy, clinical guidelines and research to reduce the burden of AMR across all age groups.

Keywords: antimicrobial resistance; children; adults; effective interventions; prevention

P2.16

Poster · Gallery Walk 2 · Track 4

Day 2 · Thu 15 Oct · 2:00 pm – 2:30 pm · Ref HPDP2026-144

Cross-border medical tourism and healthcare-seeking behaviour among Bundibugyo Ebola virus disease cases during the Uganda outbreak, May to June 2026**Mariam Nambuya****Background**

Ebola virus disease (EVD) outbreaks in the Uganda–Democratic Republic of Congo (DRC) border region have consistently shown complex patterns of population mobility that influence transmission dynamics, case detection and outbreak control. Districts along this highly porous border have historically experienced frequent cross-border movement. In such settings, healthcare-seeking behaviour is not confined within national boundaries: individuals often cross borders in search of perceived higher-quality, more accessible or culturally acceptable healthcare, leading to medical tourism.

Objectives

This study examined the lived experiences, decision-making processes and factors influencing decisions to seek care in Uganda among Bundibugyo EVD cases.

Methods

We conducted a qualitative exploratory study using case investigation narratives from patients and their caretakers (n=18). Narratives recorded in other languages were transcribed verbatim and translated into English. Data were analysed using thematic analysis following Braun and Clarke's six-step approach, with systematic coding of text segments related to healthcare-seeking behaviour and cross-border movement. Codes were refined into overarching themes, including pathways to care, determinants of cross-border healthcare seeking, delays and health system influences.

Results

Six interrelated themes emerged. Participants described Uganda as a preferred destination for perceived higher-quality healthcare, with families and social networks facilitating transportation, referrals and access to health facilities. Patients frequently moved through multiple health facilities as illness progressed, and initial symptoms were often managed as common illnesses before Ebola was suspected. These repeated movements and prolonged interactions with family members, health workers, transporters and other patients created multiple opportunities for exposure before diagnosis and isolation.

Conclusions and implications

Cross-border medical tourism, family-mediated healthcare decisions, fragmented care pathways and delayed Ebola recognition were interconnected processes that created multiple opportunities for transmission before isolation and contact tracing were initiated. We recommend incorporating cross-border surveillance and health-seeking pathways into epidemic preparedness and response.

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THANK YOU

Dear Delegates,

Thank you for participating in and supporting the 4th Health Promotion and Disease Prevention Conference.

Your contribution to the exchange of evidence, experience and practical solutions is central to strengthening community structures for Primary Health Care and health security.

We look forward to seeing you at the next edition.

Thank you.

OUR PARTNERS



Thank you

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