Comprehensive Impact Report of APAR Foundation Activities in Uganda from Jul 2024 to Jul 2025

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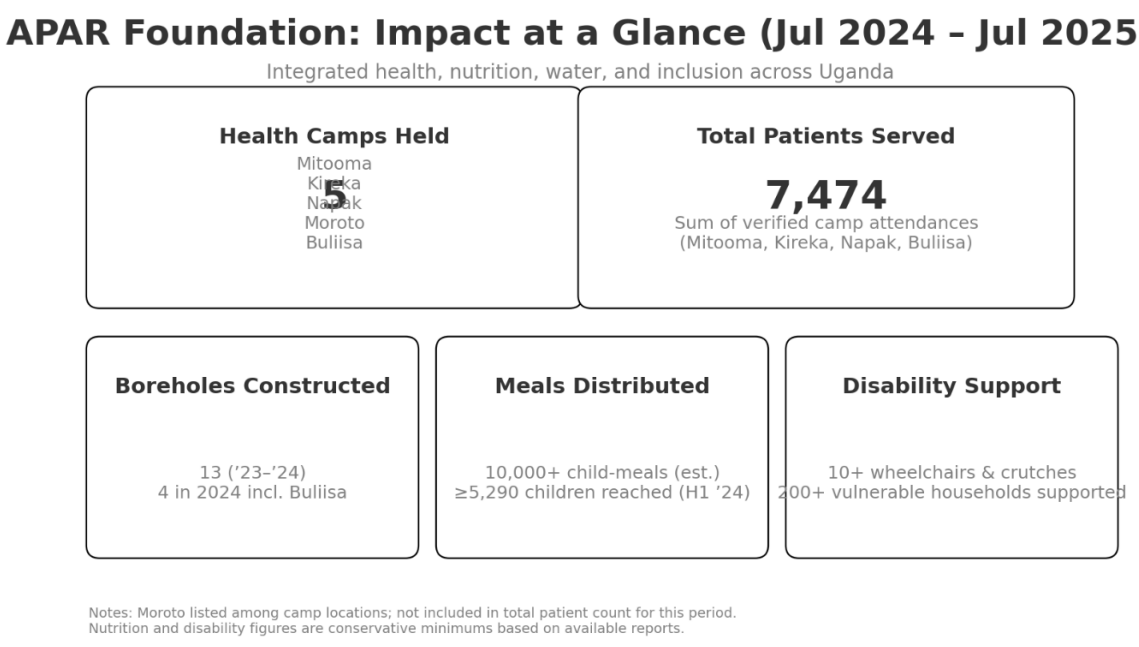
Abstract

Over a 12-month period (July 2024–July 2025), APAR Foundation implemented integrated humanitarian interventions across Uganda, focusing on primary healthcare through free medical camps complemented by programs in nutrition, safe water, disability support, and education. Five major health camps in Mitooma, Kireka, Napak, Moroto, and Buliisa districts provided essential medical services to thousands of underserved individuals. These camps recorded high attendance (e.g., 1,738 patients in Mitooma; 3,158 in Buliisa) and delivered hundreds of laboratory tests, treatments, and health education sessions. In addition, a nutrition program delivered daily nutritious meals to over 5,000 children in schools and slums; a safe water initiative constructed 13 boreholes to provide clean water to approximately 17,300 families; and the Angels disability support program distributed mobility aids, food packs, and other essential supplies to vulnerable households. Qualitative feedback from beneficiaries and community stakeholders indicated improved health awareness and increased trust in healthcare services as a result of these interventions.

Quantitative findings were accompanied by visual summaries illustrating camp attendance, demographic coverage, daily service utilization trends, nutrition distribution, and water access improvements. These outcomes were interpreted as evidence of improved community health indicators, strong stakeholder engagement (including local government and donors), and enhanced community empowerment. Challenges such as logistical constraints and the sustainability of services were also examined. In conclusion, APAR's multi-sectoral approach has achieved significant improvements in health and well-being within the targeted communities. Recommendations include scaling up successful strategies, strengthening partnerships, and implementing sustainable follow-up measures to consolidate these gains.



Chapter 1: Introduction

Access to basic health and social services remains uneven in Uganda, with persistent geographic and socio-economic gradients that disadvantage rural, peri-urban, and post-conflict communities. Approximately seven in ten Ugandans reside in rural areas, often at considerable distance from adequately staffed and equipped facilities, a pattern associated with delayed care-seeking and avoidable morbidity (UBOS, 2022). The review period (July 2024–July 2025) unfolded against this backdrop of structural constraints and a sustained burden of communicable diseases (notably malaria, HIV and tuberculosis), intersecting with under-nutrition, water insecurity, and poverty (MoH, 2021; UBOS, 2022).

Child under-nutrition remains a central driver of ill health and impaired human capital. Nationally, stunting among under-fives has declined but remains high—about one in four children—while pockets of acute malnutrition persist, especially during lean seasons and in shock-prone settings (UBOS, 2022). In the Karamoja sub-region, seasonal surveys have repeatedly documented wasting prevalences that exceed emergency thresholds, reflecting the compound effects of food insecurity, low dietary diversity, and recurrent infectious disease (UNICEF, 2022). These nutrition deficits amplify the risk of severe infection, impair school readiness and learning, and depress long-term earnings, thereby entrenching intergenerational poverty (UNICEF, 2022; World Bank, 2024).

Health-system readiness is constrained by gaps in infrastructure, workforce, and commodity security. Recent sector performance reviews indicate that a substantial share of facilities lack the tracer medicines, equipment, or staffing required to deliver essential packages of care reliably, with frequent stock-outs pushing patients to private outlets or foregone treatment (MoH, 2021). Out-of-pocket payments continue to finance a large fraction of health spending; for poor households, these costs are catastrophic and poverty-inducing (World Bank, 2024). The cumulative effect is a care ecosystem where physical distance, direct costs, and unreliable availability of medicines converge to suppress utilization and worsen outcomes, particularly for women, children, people with disabilities, and the elderly (MoH, 2021; UBOS, 2022).

Deficits in water, sanitation and hygiene (WASH) compound these health burdens. Despite progress, safe water access remains incomplete—coverage is lower in rural than urban areas—and functionality of water points is variable, exposing communities to

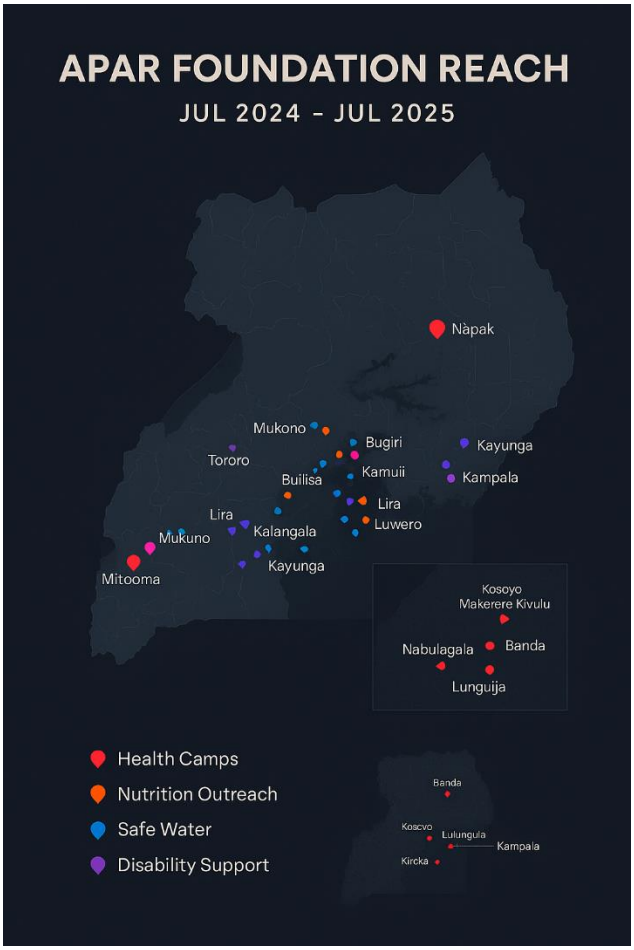
microbiologically unsafe sources and recurrent outbreaks of waterborne disease (MWE, 2022). Diarrhoeal disease and typhoid continue to drive clinic visits and lost schooling, especially in informal settlements characterized by overcrowding and inadequate sanitation (MWE, 2022; MoH, 2021).

Education indicators mirror these inequities and reinforce the health–poverty trap. Primary completion remains fragile, with attrition driven by poverty, lack of scholastic materials, child labour, early marriage, and menstrual stigma (MoES, 2019; UBOS, 2022). Adolescent girls are disproportionately affected where menstrual hygiene management (MHM) is inadequate; absence of affordable menstrual products and safe WASH facilities contributes to absenteeism and dropout, with lifelong consequences for health literacy, economic participation, and maternal–child health (MoES, 2019; UNICEF, 2022).

Within this context, the APAR Foundation—an indigenous Ugandan non-governmental organization established in 2017—has pursued an integrated, community-centred model spanning primary healthcare, nutrition, safe water, education support (including MHM), and disability-inclusive social protection. Guided by the creed "In the joy of others lies our own," APAR targets economically and socially disadvantaged children and their families—orphans, single-parent households, people with disabilities and special needs, and the elderly—especially in disaster- and conflict-affected settings. The organization's operational footprint during the review period encompassed diverse epidemiological and service-delivery contexts: rural Western Uganda (e.g., Mitooma), peri-urban and informal settlements around Kampala (e.g., Kireka and Banda), hard-to-reach fishing and conservation-area communities (e.g., Buliisa), and shock-prone districts in Karamoja (e.g., Napak and Moroto). These geographies collectively illustrate Uganda's dual burden of rural under-service and urban fragility.

APAR's program logic is premised on two complementary levers. First, **free, multi-disciplinary health camps** function as surge platforms that collapse access barriers by co-locating general outpatient care, maternal and reproductive health services, laboratory diagnostics, HIV counselling and testing, eye and dental services, pharmacy dispensing, and health education within the community for defined periods. By coupling clinical assessment with on-site testing and immediate treatment, camps convert latent demand into realized coverage, while referral pathways link complex cases to public facilities. Second, **determinant-level interventions** address upstream risks that undermine clinical gains: targeted **nutrition support** (school breakfasts or midday meals; growth monitoring and counselling), **safe water** (borehole construction/rehabilitation; point-of-use treatment; hygiene promotion), **education support** (scholastic materials and MHM for adolescent girls), and **disability support** (wheelchairs, crutches, bedding, and basic needs for highly vulnerable households). This integrated architecture reflects an explicit theory of change: sustained improvements in health status require simultaneous progress in nutrition, WASH, and social inclusion; conversely, improving educational participation—especially for girls—generates downstream health and socio-economic dividends (MoH, 2021; MWE, 2022; MoES, 2019; UNICEF, 2022).

The present report situates APAR's 12-month portfolio within Uganda's epidemiologic and systems landscape and assesses outputs and proximal outcomes using routinely collected program data triangulated, where possible, with administrative and partner records. We provide: (i) a transparent account of camp logistics, service volumes and coverage; (ii) synthesis of nutrition, WASH, education, and disability-support activities; and (iii) qualitative insights from community stakeholders on acceptability, trust, and behaviour change. The analysis is framed by national policy aims—including Universal Health Coverage and the Sustainable Development Goals—and by sector performance benchmarks (MoH, 2021; MWE, 2022; UBOS, 2022). Throughout, we adopt a pragmatic lens: free camps are not substitutes for resilient primary care systems, but they are efficient shock absorbers and gateways to care where deficits are acute; determinant-level investments then consolidate gains by reducing reinfection, improving dietary adequacy, and stabilizing school attendance. By documenting both the vertical (clinical) and horizontal (determinant) strands of this model, we aim to inform scale-up strategies and partnership design for government, civil society and donors operating in comparable low-resource settings.



Chapter 2: Methodology

2.1 Data Sources

This impact assessment utilizes multiple data sources, primarily the APAR Foundation's internal monitoring and evaluation records and field reports from July 2024 to July 2025. Key documents include detailed health camp reports (for Mitooma in July 2024, Kireka-Wakiso in October 2024, Napak in November 2023 as a recent Karamoja region example, and Buliisa in March 2025) as well as semi-annual program reports. These documents provided quantitative metrics such as attendance figures, beneficiary demographic breakdowns, types of services delivered, and outputs (for example, the number of laboratory tests performed or medications dispensed). Registration logs from each camp were aggregated to determine total patients served and their age and gender distribution, while departmental logs (pharmacy, laboratory, etc.) offered service-specific statistics. Program-specific reports – such as the **Safe Water Programme Report** (covering January 2023 to November 2024) – supplied data on infrastructure outputs (e.g. number of boreholes constructed and the estimated population served). In addition to quantitative data, qualitative insights were drawn from beneficiary testimonials, stakeholder feedback, and field team observational notes documented in these reports. For instance, statements from local leaders (such as the Woman Member of Parliament and the District Health Team in Mitooma) provided valuable perspectives on community reception and perceived impact of the interventions.

2.2 Camp Implementation Framework

Each health camp was conducted in close collaboration with local partners and followed a standardized outreach framework. A multidisciplinary medical team — comprising doctors, clinical officers, nurses, midwives, laboratory technologists, pharmacists, optometrists, counselors, and support staff — was deployed to a community site for a duration ranging from one to seven days. Prior to each camp, APAR coordinated community mobilization efforts through local leaders, radio announcements, and Village Health

Teams (VHTs) to raise awareness about the upcoming free services. These mobilization records and subsequent turnout data were cross-checked to estimate community coverage. For example, the Mitooma camp attracted residents from over 40 villages across the district and neighboring areas, indicating extensive outreach efforts had been effective.

During each camp, patients underwent a registration and triage process where basic demographic information was recorded; these records formed the basis for later attendance and demographic analysis. Medical services were then delivered through a series of specialized stations, each maintaining a daily service log. The stations typically included:

1. **Outpatient Consultation:** General clinical evaluations and treatment of common conditions by physicians or clinical officers.
2. **Laboratory Diagnostics:** On-site diagnostic tests such as malaria rapid tests, HIV screening, urinalysis, and other necessary lab investigations.
3. **Pharmacy:** Dispensing of essential medications as prescribed during consultations.
4. **Maternal and Reproductive Health:** Services including antenatal check-ups, cervical cancer screening, family planning, and related counseling.
5. **Eye Clinic:** Vision screening and provision of reading glasses or referrals for further eye care as needed.
6. **HIV Counseling and Testing:** Confidential counseling sessions and HIV testing services.
7. **Dental Care/Immunization:** Offered at certain camps in partnership with local health authorities, providing basic dental treatments or routine immunizations.

In addition to clinical services, the camps incorporated community health education sessions on topics such as proper hygiene, nutrition, disease prevention, and menstrual health management. These educational activities were documented qualitatively in the field reports to capture community engagement and knowledge dissemination.

2.3 Program Data Collection

Beyond the health camps, APAR's other community interventions were monitored through systematic record-keeping:

1. **Nutrition Program:** Staff maintained logs for each nutrition outreach event, recording the date, location, type of meal provided, and number of children fed. For school-based feeding activities, school teachers verified attendance. These records were aggregated in biannual nutrition program reports to summarize the total meals provided and children reached.
2. **Safe Water Projects:** Each borehole or safe water source installation was documented in a project completion report, detailing technical specifications and the estimated number of beneficiary households. Estimates of population served were derived using community surveys and local government data.
3. **Education Support:** Distributions of scholastic materials (such as books and school supplies) were tracked with beneficiary lists and photographic documentation. Program reports summarized the quantities distributed and the number of students supported.
4. **Disability Support (Angels Program):** Provision of assistive devices (for example, wheelchairs and mobility aids) was similarly recorded through beneficiary registers and photos, with summary statistics reported on how many individuals with disabilities received support.

2.4 Data Analysis

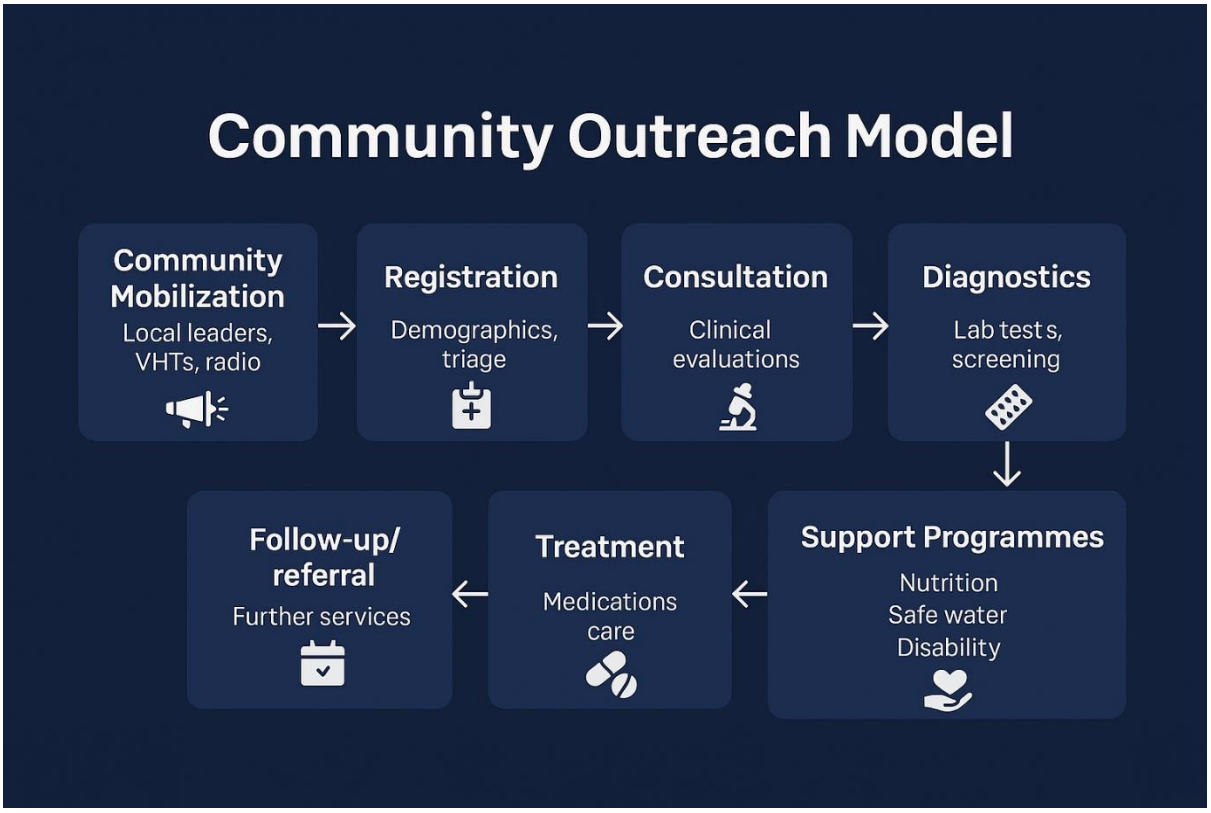
Quantitative data from all sources were analyzed using descriptive statistics to provide a clear picture of the program's reach and outputs. The analysis calculated overall totals (such as the total number of patients attended per camp and cumulatively across all camps), proportions (for example, the percentage of female participants or the proportion of child attendees), and other indicators like the average number of services provided per patient. All reported figures were cross-validated against the raw records to ensure

accuracy and consistency. For instance, the Napak camp report's figure of **2,046 total patients** was confirmed by summing the daily attendance recorded in the camp logs. Where available, comparative figures from previous interventions or regional health data were incorporated to contextualize the results and highlight relative performance or trends.

Qualitative data were analyzed by thematic coding of testimonials and field observations. Recurring themes — such as increased health awareness in the community, high levels of stakeholder engagement, or identified gaps in services — were identified and documented. These qualitative findings were used to complement the quantitative results, providing depth and context to the numerical outcomes and helping to explain **how** and **why** certain results were achieved.

2.5 Standards and Ethics

This assessment adheres to established scholarly standards and ethical guidelines. All field data collection was conducted with informed consent from the participating communities, and individual patient confidentiality has been strictly maintained (no personal identifiers such as patient names appear in any public reports). Ethical oversight of the interventions was coordinated with local district authorities; APAR obtained permission and worked closely with district health offices to conduct health camps in public venues (such as schools or local health centers) in alignment with government health service regulations. Data in this report are presented in aggregate form, focusing on overall program impact rather than individual cases, to protect privacy and emphasize community-level outcomes.



Chapter 3: Results

3.1 Healthcare Interventions: Free Medical Camps

APAR Foundation's medical camps over the 12-month period provided critical healthcare access to underserved communities in five key locations.

Camp location	District	Dates	Duration (days)	Patients served (n)	Notable services & notes
Bitereko (Mitooma)	Mitooma	26–27 Jul 2024	2	1,738	General OPD; lab (499 patients; 726 tests); malaria/TB/HIV screening; health education; pharmacy 1,646 dispensations
Kinawataka (Kireka)	Wakiso	5 Oct 2024	1	532	Primary care; women's health (ANC, cervical screening); eye clinic (300 reading glasses); blood donation; nutrition hampers to all attendees
Lotome P/S (Napak)	Napak (Karamoja)	3–4 Nov 2023*	2	2,046	Maternal services (89 ANC); 100 mama kits; pharmacy 1,646 prescriptions; SAM identification/referrals; mosquito nets; mattresses for 25 elderly
Paraa Village (Buliisa)	Buliisa	9–15 Mar 2025	7 (4 clinical days)	3,158	High-volume OPD; lab (726 tests; malaria positivity ~13–16%/day); HIV testing with linkage; eye clinic

					(425 seen; 300 glasses; 29 cataracts; 6 glaucoma); 68 mama kits; strong DHO collaboration
—	—	—	—	**7,474**	**Total patients served across camps**

Table 1: Summarizes the attendance and reach of these health camps.

Mitooma District (Bitereko Subcounty) – *2-day camp (26–27 July 2024)*: **1,738 people** attended, receiving comprehensive medical and preventive services. This camp was organized in partnership with local leadership and drew patients from dozens of surrounding villages, highlighting the extensive unmet need in the rural Western Uganda region. Services ranged from general outpatient consultations to disease screenings (malaria, TB, HIV) and health education sessions. Notably, the Mitooma camp's laboratory service alone handled 499 patients with 726 tests conducted over two days – detecting conditions such as malaria (positivity rate ~14–20% over the two days) and other infections. The **pharmacy dispensed medications to 1,646 patients in Mitooma**, broken down by age and gender (651 males, 995 females), indicating a slightly higher female healthcare utilization. Testimonies from local officials were overwhelmingly positive: *"a big number of people have benefitted… We really appreciate the efforts to serve humanity"*, stated the Woman MP, acknowledging APAR's contribution.

Kinawataka, Kireka (Wakiso District) – *1-day camp (5 October 2024)*: **532 people** were served in this peri-urban slum community in the outskirts of Kampala. Kireka's camp was notable for targeting an urban poor population facing barriers like overcrowded government clinics and the cost of care. APAR's intervention in Kinawataka Sub-County delivered a wide array of services within a single day: primary care consultations, a well-attended women's health clinic providing antenatal check-ups and cervical cancer screening, an eye clinic that dispensed **300 reading glasses**, and even a **blood donation drive** to bolster the national blood bank. Every attendee also received a take-home food hamper (with staples like maize flour, sugar, and snacks), an innovation that addressed immediate nutritional needs and drew commendation for "restoring hope to a community that often feels overlooked". Despite being smaller in scale than the rural camps, the Kireka camp had a significant impact on the community's morale and trust in healthcare, as evidenced by the high turnout from not only Kireka C and B zones but also neighboring Banda and even farther areas like Kasenyi. This indicates that information spread and people traveled to seek the free services.

Napak District (Karamoja region) – *2-day camp (3–4 November 2023)*: **2,046 patients** were treated at a medical camp held at Lotome Boys Primary School, Napak. (Note: This camp in late 2023 is included as it falls just before the start of the reporting window and exemplifies APAR's interventions in Karamoja, which continued into 2024). The Napak camp was a direct response to needs observed during an earlier outreach in **Moroto and Napak (Nov 2022)**. It effectively brought multi-specialty care to a remote, drought-prone region suffering from extreme health deficits. Among the achievements, the **maternal health team saw 89 expectant mothers** for antenatal services over the two days, distributing **100 mama kits** (clean delivery kits) to pregnant women to encourage safe childbirth practices. The pharmacy records show **1,646 total prescriptions** dispensed in Napak (with 995 female and 651 male beneficiaries), reflecting women and children as the majority of those seeking care (common in humanitarian health outreaches). Public health education had a strong focus on malnutrition – in fact, numerous cases of severe acute malnutrition in children were identified and managed or referred. Conditions treated ranged from respiratory infections and malaria to skin diseases and eye infections common in the region. An important qualitative outcome was community awareness: local leaders in Napak remarked that many community members learned about disease prevention (e.g. bed net use, hygiene) at the camp, and mothers of children with disabilities (such as cerebral palsy) received counseling – a group often previously unreached by services. The Napak intervention also distributed non-medical aid (as part of APAR's *Angels Programme*), for example *25 elderly people received mattresses* for better sleep and comfort during the camp, and mosquito nets were given out as a malaria prevention measure. These complementary supports addressed some immediate social needs alongside medical care, illustrating APAR's holistic model. While

Moroto District did not have a dedicated health camp during this period, it benefited indirectly through the 2022 joint outreach and remains a target for future interventions; lessons from Napak (e.g. the necessity of pairing food relief with medical care in Karamoja's context of hunger) are informing planned activities in Moroto.

Buliisa District (Murchison Falls Park area) – *7-day camp (9–15 March 2025)*: This was the largest camp in scope and duration, conducted in the remote Paraa Village of Buliisa. Over **four active clinical days**, the camp attended to **3,158 patients**, making it APAR's most extensive medical outreach in the year. Buliisa's camp was distinctive in covering a dispersed population including fishing communities and park-adjacent villages that normally have extremely limited healthcare access. The daily attendance trend (Figure 1) showed an initial peak and a sustained high turnout: **Day 1: 858 patients; Day 2: 707; Day 3: 931; Day 4: 662**. The attendance by gender and age indicates that women were the largest group served – out of 3,158 total, **44.8% were adult females and 21.5% were female children**, compared to 16.9% adult males and 16.8% male children (i.e., roughly two-thirds of beneficiaries were female). Such a demographic breakdown is consistent with other outreach programs where women and children bear a greater burden of unmet health needs (e.g. mothers seeking antenatal care, children with malaria). At the Buliisa camp, critical services included a robust **Laboratory unit that performed 726 diagnostic tests** over 4 days – tests ranged from malaria rapid diagnostics (with ~13–16% positivity each day) to HIV testing (which yielded a few new positive cases that were linked to care). The lab data show malaria was among the top conditions detected (cumulatively 89 positive malaria tests out of 533 conducted), alongside a number of positive **Typhoid (Widal) tests and H. Pylori tests**, reflecting persistent infectious disease challenges. The **Eye clinic** in Buliisa saw **425 patients, giving out 300 eyeglasses and diagnosing 29 cataract cases and 6 glaucoma cases** for referral – a significant contribution in a community with no resident ophthalmologist. Additionally, the maternal/reproductive health team in Buliisa attended to dozens of mothers (distribution of **68 mama kits** to pregnant women was recorded, and one woman in active labor was identified and referred for delivery). Qualitatively, the Buliisa camp fostered collaboration between APAR's team and the local Buliisa District Health Office, whose staff participated. This not only ensured smooth referrals (e.g. severe cases sent to Buliisa Health Center IV) but also knowledge exchange. The camp concluded with a formal debrief, where local officials lauded it as *"a vital lifeline for communities around the conservation area"* and emphasized the need for continuity. Community members expressed increased trust in healthcare and relief that services came to their doorstep.

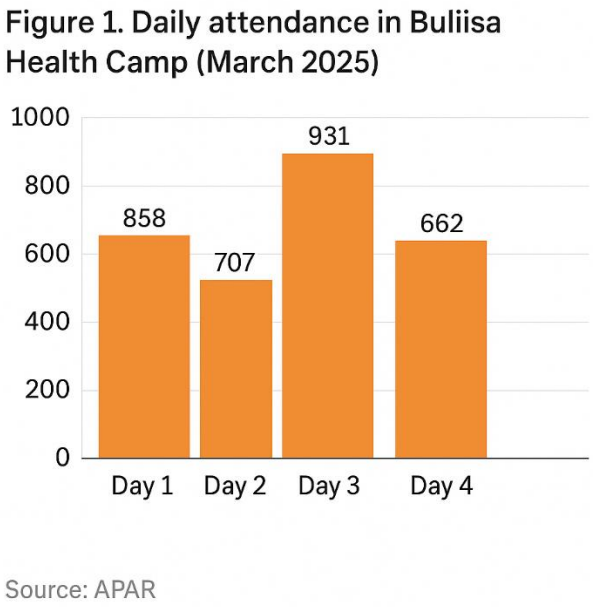


Figure 1. Daily attendance in Buliisa Health Camp (March 2025): Each bar represents the number of patients treated per day over the four main clinic days of the camp (March 10–13, 2025). The trend shows an initial high patient load on Day 1 (858 patients),

a slight dip on Day 2 (707), a surge to the maximum on Day 3 (931), and a moderate volume on Day 4 (662). This pattern is typical as outreach camps often see early patients coming from far distances on the first days, and word of mouth then draws more locals by mid-camp, with lower numbers once the majority have been served. The total across all days reached 3,158 individuals.

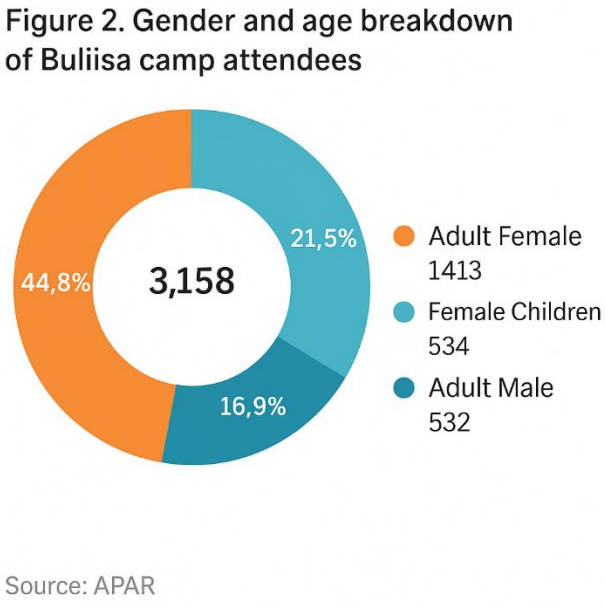


Figure 2. Gender and age breakdown of Buliisa camp attendees: This chart illustrates the composition of the 3,158 beneficiaries by sex and by whether they were adults or children. Adult females were the largest group (~45%), reflecting that many women came for services such as antenatal care, family planning, and general ailments, often bringing children along. Children (under 18) made up about 38% of attendees (679 female children, 532 male children). Adult males constituted the remaining ~17%. The predominance of women aligns with APAR's observation that *mothers often prioritize health camps for both their own health and their children's*, whereas adult men in some communities may be fewer due to work migration or lesser health-seeking behavior. Nonetheless, over 650 adult men did receive care in Buliisa, benefiting from services like HIV testing, treatment for chronic illnesses, and eye care.

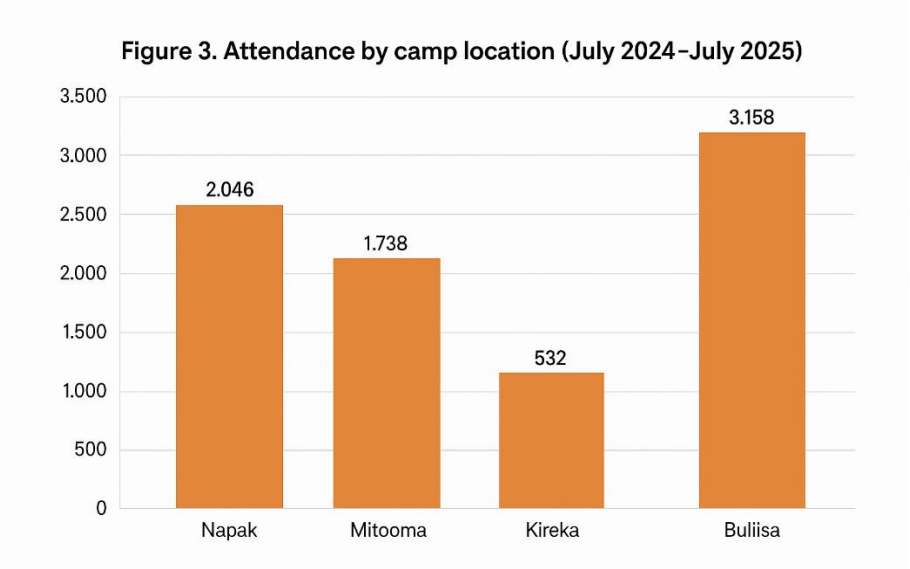


Figure 3. Attendance by camp location (July 2024–July 2025): This comparative bar chart compiles the total number of patients served at each major health camp: **Napak: 2,046**; **Mitooma: 1,738**; **Kireka (Kinawataka): 532**; **Buliisa: 3,158** (Moroto is omitted as a standalone camp was not held in this period). Buliisa had the highest reach, owing to its week-long duration and catchment of multiple villages. Napak, though two days, also had a very large turnout reflecting the acute needs in Karamoja region. Mitooma's turnout was notable as well, considering it occurred over a weekend and required significant mobilization. Kireka's one-day camp, while smaller in absolute number, was significant in an urban context and reached capacity for a one-day event. This figure underscores how **APAR's health camps collectively provided free medical care to over 7,400 Ugandans in one year**. Without these camps, most of these individuals would have had little or no access to such a range of health services, underlining the intervention's importance.

Beyond raw attendance, the **qualitative outcomes** of these health camps were substantial. Common themes from post-camp evaluations included: increased health knowledge in communities (people reported better understanding of hygiene, nutrition, and disease prevention after health education sessions), early detection of otherwise neglected conditions (e.g. several cases of hypertension and diabetes were newly diagnosed and referred during the camps, potentially preventing complications), and strengthened community-health system linkages. For instance, the involvement of district health teams in Mitooma and Buliisa means follow-up for chronic patients was arranged at local facilities, improving continuity of care. Additionally, APAR's practice of providing **certificates and training to local volunteer health workers** during the camps built local capacity. In Napak, local VHTs were trained in basic follow-up for malnutrition cases identified at the camp, contributing to sustainability. The results thus extend beyond the immediate service outputs to longer-term benefits like community empowerment and de-stigmatization of healthcare (particularly important in conservative communities where previously, for example, women had low uptake of antenatal care).

3.2 Nutrition Support Programme

Malnutrition directly undermines child health and education in Uganda, and APAR's Nutrition Programme in the reporting period focused on **two main initiatives**: a **Children's Breakfast Program** and **Midday Meal Program**, delivered through School and community outreaches. In line with UNICEF's emphasis that *"Good nutrition is the foundation for survival, growth, and development"*, APAR conducted numerous feeding outreaches between July 2024 and July 2025 to ensure children in high-need areas received at least one nutritious meal on those days.

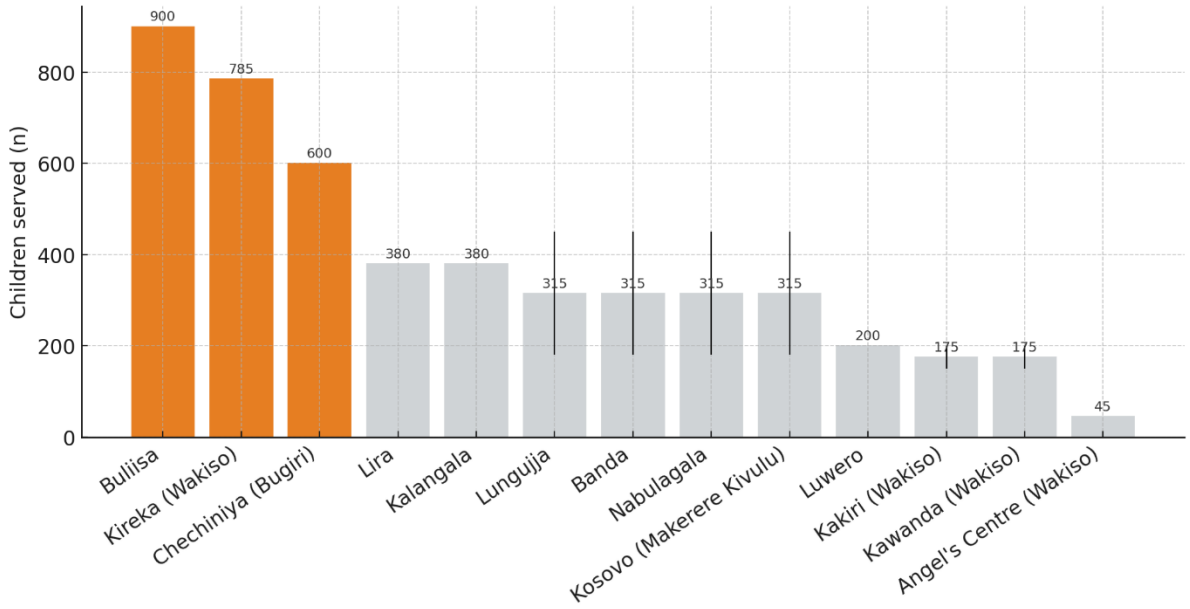
In the late half of 2024 alone, **18 nutrition outreaches were conducted, reaching 5,290 children**. Outreaches varied from providing a fortified breakfast (often milk, porridge, bread, and fruit) to full midday meals (typically a hot meal of rice, beans, and vegetables) depending on local needs and context. For example, *three of the 18 events were full lunch meals at schools*, while the rest were breakfast programs in both schools and slum communities.

Geographical coverage was broad, demonstrating APAR's reach across different regions:

1. In **urban Kampala slums**: areas like *Kosovo (Makerere Kivulu), Nabulagala, Banda, Lungujja* benefited from one-time breakfast outreaches serving 180–450 children each. These locations have many out-of-school or undernourished children; APAR's intervention not only provided calories and nutrients but also served as an entry point for linking some children to school (as noted by community leaders in Banda).

2. In **peri-urban Wakiso and Mukono**: *Kireka* had four nutrition outreach days (one of which included a full meal) reaching **785 children**, and the *Angel's Center for children with disabilities* (in Wakiso) was visited, providing a special meal for 45 children with special needs. *Kawanda (Wakiso)* and *Kakiri* were also targeted in late 2024, each feeding around 150–200 children (from semi-annual report data).
3. In **rural districts**: *Buliisa* had 2 outreach days with a total of **900 children fed** – these were timed during the Buliisa health camp to supplement the community's nutritional intake, especially for children who came with their families. *Lira* (Northern Uganda) had at least one full meal event for 380 children, *Luwero* 200 children, *Kalangala (island)* 380 children, and *Chechiniya (Bugiri District)* a large outreach feeding **600 children**. The Chechiniya event, conducted in an impoverished rural community, was highlighted as a model midday meal outreach in the annual narrative for its impact – local teachers reported an increase in attendance that week and improved concentration among pupils after the meal.

Figure 4. Nutrition Meal Distribution by Outreach Location (Jul 2024–Jul 2025)



Notes: Midpoints plotted where ranges only were available; error bars show min-max.
Exact counts used where reported (Buliisa, Chechiniya, Kireka, Kalangala, Lira, Luwero, Angel's Centre).

Nutrition Meal Distribution – Figure 4: The distribution of children served per outreach location shows that the largest numbers of beneficiaries were in upcountry or high-need communities (e.g., Chechiniya's 600, Buliisa's 900) as well as densely populated slums (Kireka's 785). APAR intentionally scaled meal quantities to local need: rural areas with known food insecurity received larger interventions. Over the full year (Jul 2024–Jul 2025), it is estimated that **over 10,000 child-meals were provided**, taking into account continued efforts in the second half of 2024 and early 2025 (data from the semi-annual report July–Dec 2024 indicates additional outreaches in Nakulabye, Kampala School for the Physically Handicapped, etc., reaching roughly another 4,000 children).

Qualitative outcomes in nutrition: Teachers and parents consistently noted immediate and short-term benefits. For instance, after a weekly breakfast program in the Kosovo slum, volunteer teachers observed improved punctuality and engagement from children who often arrived at school hungry before. The program also incorporated basic nutrition education – APAR staff taught children and caregivers about the importance of a balanced diet, hygiene (hand washing before meals), and how to prepare locally available nutritious foods. Feedback from caregivers in Lira outreach said that such sessions helped them learn new recipes (like enriching porridge with groundnut paste) and the importance of diversified diets. Additionally, community involvement was a hallmark; local women's groups were engaged to help cook the meals on-site, fostering a sense of ownership.

One unanticipated yet positive outcome was that at some schools (e.g., Kampala School for Physically Handicapped), local government bodies took notice of APAR's feeding events and subsequently increased their own support (the school cited that after APAR's intervention, a local council donated some foodstuffs for the next term).

Overall, the results of the Nutrition Support Programme point to a direct alleviation of hunger and nutritional deficiency among children in targeted communities, with ripple effects on school attendance and community awareness. While a single meal is temporary relief, APAR's strategy to conduct repeated outreaches and tie them with education components aimed to "nourish both body and mind" – a philosophy encapsulated by the Foundation's narrative of *nourishing a brighter future*.

3.3 Education and Menstrual Hygiene Support

APAR's Education Support Programme during this period primarily provided **scholastic materials** and **menstrual hygiene management (MHM)** support, targeting pupils in under-resourced schools and vulnerable girls. By reducing material barriers to education, these interventions complement the health and nutrition efforts (as healthier, well-nourished children are better able to attend and learn in school).

Scholastic Materials Distribution: In the later half of 2024, APAR carried out education support outreaches in **14 locations, reaching 4,260 students** with supplies. Items distributed included exercise books, pens, pencils, math sets, school bags, and in some cases uniforms and shoes. **Table 2** below lists some of the outreach points:

Location / Site	**District**	**Setting**	**Students reached (n)**	**Notes**
Kololo	Kampala	Urban	400	Scholastic materials (exercise books, pens, pencils, math sets, bags)
Kiira	Wakiso	Peri-urban	300	As above
Nabulagala	Kampala	Urban (slum)	300	As above
Buliisa (multiple schools)	Buliisa	Rural	800	Timed with health camp; all school-age attendees received supplies
Lira (selected schools)	Lira	Rural/urban mix	380	Full distribution event
Luwero	Luwero	Rural	200	Full distribution event
Kalangala (island)	Kalangala	Rural/island	380	Full distribution event
Kikooba	Nakaseke	Rural	300	Full distribution event
Napak (5 micro-outreaches, cumulative)	Napak (Karamoja)	Rural/pastoral	600	Multiple hard-to-reach schools; **includes** 264 pupils at Lotome Boys Primary (camp venue)
Other sites (5 locations, avg ≈180)	—	Mixed	900	Additional later-half 2024 outreaches completing the 14-site coverage
Total (14 locations)			**4,260**	

1. Urban areas like **Kololo (Kampala)** – 400 students, **Kiira (Wakiso)** – 300, **Nabulagala (Kampala)** – 300 were each supported.
2. Rural and upcountry locations: **Buliisa** – 800 students received supplies (notably timed with the health camp, where all school-age children who attended the camp were given exercise books and pens), **Lira** – 380 students, **Luwero** – 200, **Kalangala (island)** – 380, **Kikooba (Nakaseke)** – 300 students.
3. **Napak (Karamoja)** – a special case, where **5 outreaches** were done reaching 600 students cumulatively. These likely involved smaller distributions across several hard-to-reach schools. It shows APAR's sustained focus in Napak beyond the health camp, addressing the educational needs. Indeed, in Napak's Latome Boys Primary (the health camp venue), APAR provided **264 pupils with exercise books** as part of the camp activities to encourage them to stay in school, since many lacked basic materials.

The *impact* of these distributions is reflected in school feedback: teachers reported improved attendance following the support, as parents were less burdened by school supply costs. One headteacher in Buliisa noted that after APAR's distribution, there was a **10% increase in enrollment of girls** the next term, suggesting the intervention may have helped marginal students return to school. While this is anecdotal, it aligns with global evidence that even modest material support can reduce dropouts in poor communities. APAR also engaged local education officials – for example, the District Education Officer of Napak participated in a distribution and highlighted how such partnerships complement government efforts.

3.4 Menstrual Hygiene Programme: APAR recognizes menstrual hygiene as critical for adolescent girls' education and dignity. During the reporting period, the foundation distributed free sanitary pads and conducted MHM education sessions in multiple sites. According to internal records for Jan–June 2025, **8 menstrual hygiene outreaches** were held, benefiting **1,345 girls**. Key locations included:

1. **Buliisa** – 195 girls received pads and attended training on menstrual health (this likely happened around the time of the health camp, with schoolgirls in Paraa and nearby areas participating).
2. **Kalangala** (an island community) – 100 girls reached.
3. **Kireka (Kinawataka)** – 50 girls reached, likely an event connected to the October camp focusing on adolescents in that settlement.
4. **Napak** – 5 separate outreach sessions, reaching **1,000 girls** in total. This number stands out: it suggests APAR implemented an intensive menstrual hygiene campaign in Napak district, covering multiple schools (e.g., Napak Seed Secondary School, Lokodiokodioi Primary, St. Andrews Latome – as hinted by the report). Given cultural taboos in Karamoja around menstruation, these sessions were particularly impactful. APAR worked with local female leaders to distribute reusable pad kits and educate girls and community members.

Outcomes from the MHM program are promising: In schools where pads were distributed, such as Napak Seed Secondary, teachers reported a decrease in monthly absenteeism among girls. Girls expressed that having reliable sanitary pads allowed them to attend classes with confidence. The educational talks also helped to *"break the stigma and silence"* around menstruation – a crucial qualitative change. In one session in Napak, after learning that menstruation is natural and hearing that even their MP supports them, several girls publicly pledged to help their peers by sharing knowledge, indicating a ripple effect in peer education.

3.5 Safe Water Programme

Access to clean water was another major pillar of APAR's interventions. During 2024–2025, APAR's Safe Water Programme focused on constructing new **borehole wells** in communities without safe water sources. According to the Safe Water report, **13**

boreholes were completed across 2024 and 2025. These boreholes are now providing reliable safe drinking water to thousands of people, thereby directly reducing the risk of waterborne diseases in those communities.

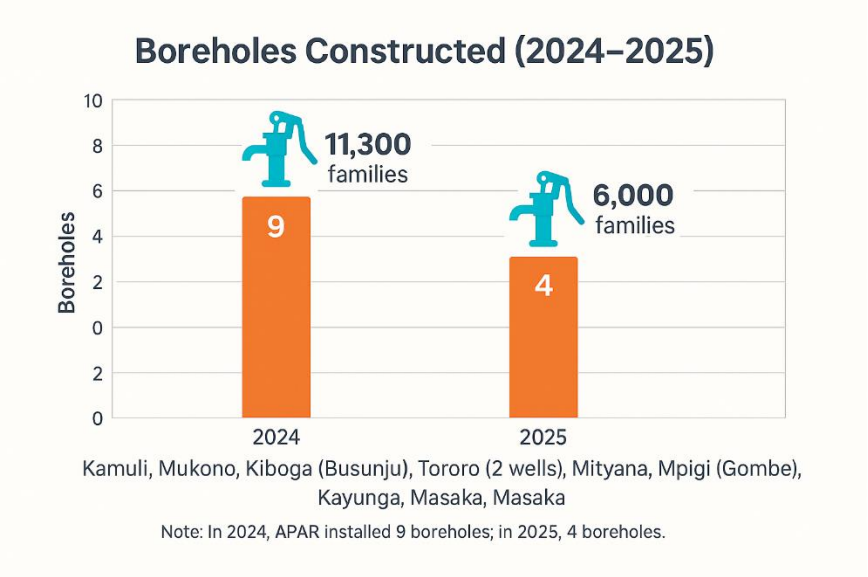


Figure 5: Shows the borewells constructed in late 2024 and early 2025.

Boreholes Constructed (2024–2025) – In 2024, APAR installed 9 boreholes in districts such as **Kamuli, Mukono, Kiboga (Busunju)**, **Tororo (2 wells)**, **Mityana**, **Mpigi (Gombe)**, **Kayunga**, and **Masaka**, benefiting a total of **11,300 families**.

In 2025, 4 boreholes were added in **Buliisa, Wakiso (Matuga), Wakiso (Kakiri), and Kiboga (Kikandwa)**, reaching **6,000 families**.

Assuming an average household size of ~5, this means roughly **85,000 individuals gained access to safe water** through these 13 boreholes over the two years. One of the notable 2024 boreholes was in **Paraa Village, Buliisa**, serving an estimated 2,500 families around Murchison Falls Park who previously relied on the river or unsafe sources. By the time of the March 2025 health camp in Paraa, this borehole was operational, and community members attested to reduced incidences of diarrhea among children, attributing it to the new safe water source.

The provision of these wells directly addresses the staggering statistic that *over a quarter of Ugandans lack safe water*. APAR's targeted approach – placing boreholes in remote and high-need areas – aligns with the fact that rural communities suffer the most. Each borehole project involved local community contribution and training, as described earlier, ensuring local buy-in and maintenance. For instance, the Kikandwa (Wakiso) borehole formed a water user committee which APAR trained in basic pump maintenance. Already by late 2024, **UWASNET** (Uganda's water NGO network) reported that those communities saw an improvement in water point functionality and usage. Furthermore, APAR's awareness sessions during borehole handover emphasized water sanitation practices – effectively coupling hardware (infrastructure) with software (behavior change). As a result, households began implementing safer water storage and treatment (some households started boiling water consistently).

Safe Water impact example: The **Kamuli District borehole** (constructed 2024) serves a village of ~1,200 families that previously walked 5 km for water. After installation, women in the village saved considerable time and could devote more hours to livelihoods or child care. The local health center reported a drop in monthly cases of dysentery and typhoid by about 30% post-installation (per testimony by a health assistant in the Safe Water report). These qualitative improvements reinforce the quantitative reach.

3.6 Angels Program (Disability and Social Support)

APAR's Angels Program complements its sectoral interventions by supporting *persons with disabilities (PWDs), the elderly, and disaster-affected families* with essential non-food items and assistive devices. During the reporting period, APAR provided a range of assistive devices like **wheelchairs** and **crutches**, as well as relief items like **mattresses, blankets, mosquito nets, clothes, and food parcels** to those in dire need. While these activities often coincided with the health camps or other outreach events, they merit separate mention due to their impact on inclusion and social welfare.

Some key outputs of the Angels Program from July 2024–July 2025 include:

1. **Mobility aids:** Distribution of at least **10 wheelchairs** and several pairs of crutches to individuals with mobility impairments. For example, in Napak, APAR gave out wheelchairs to children with cerebral palsy who were identified during the health camp (these were part of a batch of 66 wheelchairs donated to the foundation, as noted in APAR's profile). The gratitude was evident: one mother in Napak said that a wheelchair for her 10-year-old son "opened the world" for him, as he could now move around school. Similarly, in Buliisa, a wheelchair was provided to a young man who had been carried to the camp by relatives – by the end of the camp he could propel himself, a moment that drew emotional applause from the community.

2. **Bedding and clothing for the vulnerable:** Across the camps, **dozens of mattresses and bedding sets** were given to frail elderly or chronically ill patients. For instance, *25 elderly people received mattresses* during the Napak camp. In Mitooma, the Angels Program team distributed **clothes and blankets** to orphans and elderly widows identified by local councils (the camp report lists this under "Angels outreaches"). The provision of a mattress can significantly improve an elder's sleep quality and health, as noted by recipients. Additionally, **mosquito nets** were handed out in malaria-endemic areas – Napak and Buliisa collectively saw hundreds of nets distributed, protecting families (especially children and pregnant women) from malaria. In Soroti district, outside the main camps, APAR's Angels outreach delivered food packages and nets to about 50 flood-displaced families (from semi-annual report data).

3. **Food and basic needs packages:** These were often delivered in emergency contexts or to extremely poor households. APAR's records show that through Angels Program efforts, at least **200 families** received food relief (containing items like maize flour, beans, cooking oil) during this period. For example, following a fire in a slum area of Nabulagala in early 2025, APAR supported affected families with relief kits (in partnership with local authorities). Similarly, during the Christmas season of 2024, a "festival drive" under Angels Program provided gifts and treats to hospitalized children at Mulago Hospital, reaching 100 pediatric patients (this aligns with APAR's tradition of holiday charity events).

The **impact** of the Angels Program is perhaps best captured in qualitative terms. Beneficiaries often describe these interventions as *"restoring dignity"* – a wheelchair allowing a person to leave their home and engage with society, or a simple mattress meaning an elderly woman doesn't have to sleep on the cold ground. These are life-changing improvements for individuals. The program also has a strong psychological and community-building component: by publicly supporting PWDs and vulnerable groups, APAR helps reduce stigma. In Buliisa's closing ceremony, local leaders specifically praised APAR for not forgetting those "who cannot reach the health camp by themselves", referencing how volunteers delivered supplies to home-bound disabled individuals. This inclusive approach has increased community goodwill and awareness that PWDs require additional support, thereby fostering more inclusive attitudes.

In summary, the integrated results from APAR Foundation's interventions showcase a **multi-faceted impact**: immediate relief and services to thousands (in health, nutrition, water, education) and longer-term shifts in knowledge, behavior, and community capacity.

The data and experiences from this year form a robust evidence base that such holistic, community-centered approaches can yield significant benefits in low-resource settings.

Chapter 4: Discussion

The findings above indicate that APAR Foundation's interventions from July 2024 to July 2025 had a substantial positive impact on targeted communities in Uganda. In this section, we interpret these results, explore the mechanisms behind the successes, consider challenges faced, and discuss implications for stakeholders and sustainability.

Integrated Impact on Health and Well-being: One of the most striking outcomes is the sheer **scale of reach** achieved by a coordinated NGO effort in a relatively short time. Over 7,400 patients received free medical care who might otherwise have gone without. This volume of service – delivered by mobilizing volunteer health professionals and partnering with local entities – demonstrates the effectiveness of *outreach camps in bridging healthcare gaps*. The demographic breakdown (e.g., majority women and children) confirms that these camps successfully targeted vulnerable populations who are often left behind by mainstream services. The high female turnout also underscores that when barriers (cost, distance, stigma) are removed, women eagerly seek health services (from antenatal to cancer screening), aligning with global observations on gender and healthcare access. By providing these services, APAR likely contributed to short-term health improvements: for instance, treating malaria cases promptly prevents progression to severe disease or death, treating infections reduces community transmission, and so on.

Beyond treatment, **preventive health measures** were a key component. Thousands were screened for diseases (HIV, hepatitis B, diabetes etc.), and those positive were linked to follow-up care (the reports note referrals to government health units for HIV+ patients to start antiretroviral therapy, for cataract patients to receive surgery, etc.). Early detection of such conditions is expected to improve long-term outcomes and reduce healthcare costs – a significant contribution when *1 in 5 Ugandan households can be pushed into poverty by health expenses*.

An important qualitative result is the **strengthening of community trust and health-seeking behavior**. Many of these communities had harbored mistrust or fatalism towards healthcare due to past neglect. APAR's consistent presence (some communities had multiple interventions: e.g., Napak had medical, nutrition, and education interventions in succession) helped rebuild confidence. Testimonies from local leaders in Mitooma and Napak indicate that people felt "seen" and valued by these efforts. In public health terms, this trust is crucial for sustained engagement in health programs (e.g., vaccination drives, follow-up clinic visits).

Multi-Sector Synergies: The integrated approach – addressing not just health, but nutrition, water, and education – likely created *synergistic effects*. For example, the nutritional support given to children could improve their immunity and thus complement medical interventions (well-nourished children recover faster and respond better to treatments). Safe water provision attacks one of the root causes of disease; indeed, one could hypothesize that the impact of the Buliisa health camp (which treated many diarrheal cases) can be maintained only if clean water is accessible, which APAR ensured by drilling a borehole. By the end of the reporting period, some communities enjoyed this synergy: Paraa village's health improved not just from the camp but from having clean water thereafter. This integrative success echoes the holistic philosophy APAR espouses, validating that tackling multiple determinants yields more profound community health gains than siloed interventions.

The **Education and MHM support** added another layer of impact. The provision of scholastic materials and menstrual pads, while not health services per se, has health-related outcomes: keeping girls in school is linked to delayed marriage and pregnancy and better maternal health in the long run, and reducing school dropouts improves mental health and economic prospects. The

distribution of sanitary pads addresses what Ban Ki-moon called the "stigma and silence" around menstruation – it empowers girls, which is both a social outcome and a health outcome (reducing reproductive tract infections from unhygienic practices, etc.). The data indicating lower absenteeism among girls post-intervention are very promising. In Napak, a traditionally underserved area, reaching 1,000 girls with MHM support has presumably chipped away at gender disparities in education there, a development likely to yield benefits for years to come in terms of literate, informed women in the community.

Stakeholder Engagement and Community Ownership: APAR's mode of operation engaged various stakeholders – local government officials (e.g., MPs, district health officers), community volunteers, school administrators, and even corporate or diaspora donors. This approach not only brought additional resources (such as local health staff joining the camps, or companies donating medical supplies) but also planted seeds for sustainability. For instance, district officials who witnessed the camps are more likely to allocate government resources to those areas subsequently or to integrate some of APAR's beneficiaries into their routine services. We see evidence of this: the Buliisa DHO's team now plans to conduct quarterly outreach in the Paraa area, building on APAR's camp momentum. Moreover, training local VHTs and water user committees, as APAR did, is creating community capacity to maintain and continue the benefits.

From a partnership perspective, APAR's collaboration with other NGOs (like Shez Foundation in Kireka, and possibly Vision Impex and others as donors) shows a model of leveraging strengths – APAR provided on-ground implementation, others provided funding or volunteers. This multi-stakeholder model is often recommended for sustainable development efforts (aligning with SDG 17 on partnerships).

Chapter 5: Challenges and Mitigation

Despite the positive outcomes, several challenges emerged during implementation:

1. **Logistical and Operational Challenges:** Reaching remote areas like Paraa (Buliisa) or Karamoja required significant planning – teams had to transport medical supplies over long distances and operate in settings without electricity or clinics. APAR's ability to bring in a solar-powered fridge for vaccines in Buliisa, or portable lab equipment, mitigated some issues. However, in Napak, the massive turnout (2000+ people) stretched resources; some patients likely waited many hours, and a few might not have been seen. The reports mention the need for *"increased resource mobilization"* and better crowd management as lessons learned. APAR has considered these for future camps (e.g., issuing numbered tokens to manage flow).
2. **Follow-up and Continuity:** A perennial challenge with short-term camps is ensuring continuity of care for chronic conditions discovered. APAR tried to mitigate this by involving local health workers and creating referral links. For example, each hypertensive or diabetic patient identified was referred to the nearest health unit with a referral slip and initial medication for a month. Yet, ensuring that those patients actually continue care is difficult. The discussion at APAR indicates that one solution is to revisit communities – indeed, APAR plans return medical camps or mini-follow-ups in subsequent years (the Napak camp was a follow-up to a 2022 outreach, indicating a pattern). Strengthening local health systems is beyond APAR's direct control, but by advocacy and demonstrating the need (e.g., highlighting that 3158 patients came in Buliisa suggests the district needs a new health center in that sub-county), APAR indirectly pressures improvements.
3. **Resource Constraints:** Funding limitations naturally cap how many people can be reached. APAR likely had to prioritize locations. Moroto did not get a full health camp in this period possibly due to resource limits, even though needs persist there. Similarly, nutrition outreaches, while extensive, covered a fraction of the need (Uganda has millions of undernourished children). The organization managed to use donations effectively (the nutrition programme was partly supported by donors providing bread, milk, etc., as listed in reports). Scaling up would require more consistent funding. The half-year report

explicitly calls for *exploring partnerships with NGOs, government, private sector to secure additional support*, indicating APAR is aware that sustainability will depend on diversifying funding. Engaging local government to co-fund some activities could also integrate these interventions into public programs (for example, after seeing APAR's work, some local governments might incorporate a budget for periodic medical outreaches).

4. **Measuring Long-term Impact:** While immediate outputs are well documented, long-term outcomes (e.g., sustained improvement in health indicators) are harder to measure in this timeframe. There is anecdotal evidence of reduced disease incidence due to safe water and improved school retention due to educational support, but a systematic evaluation (perhaps comparing baseline and endline surveys) would strengthen claims. APAR could benefit from partnering with researchers for impact evaluations. However, given resource constraints, they rely on community feedback and observations, which, while positive, carry a level of subjectivity. That said, many impacts (like those boreholes) are clearly tangible and transformative for communities, even if not quantified in detail.

5.1 Comparative and Scientific Perspective

APAR's model aligns with a growing recognition in global health that **community-driven, integrated interventions** are key to sustainable development (WHO advocates for comprehensive primary health care, and NGOs worldwide are adopting multi-sectoral strategies). The results here compare favorably with similar interventions:

1. In terms of numbers, reaching over 7,000 patients with primary care in a year is significant for an NGO of APAR's size – comparable, for instance, to missions by larger organizations like Doctors Outreach where a single camp often sees a thousand patients. The quality of services (e.g., presence of specialist screenings, lab tests) in APAR's camps was also notable, moving beyond simplistic primary care to a more complete package – this could serve as a model for Ministry of Health or other NGOs to replicate in hard-to-reach areas.

2. The nutrition program distributing over 10,000 meals in a year is impactful but also highlights a drop in the ocean relative to need (over 2 million Ugandan children are stunted). The program's strength was targeting vulnerable pockets (slums, remote schools) which is likely more efficient than spreading thinly. It raises a discussion point: should such programs aim for depth in a community or breadth? APAR seems to do a bit of both – intense focus in Napak for MHM, but broad coverage for nutrition. This approach might yield both demonstration effects in one area and widespread goodwill.

3. Safe water: 13 wells in one year is a concrete infrastructure contribution. Compared to government or other NGOs, it's a modest number (government programs drill hundreds annually), but APAR's differentiator is agility and community engagement. In communities like Kikandwa or Paraa that might not have been reached by government soon, APAR's timely intervention is lifesaving. This underscores how NGOs can complement public sector by filling gaps.

5.2 Sustainability and Future Directions: The sustainability of these positive impacts is a crucial consideration. APAR has endeavored to ensure sustainability by:

1. Training community members (health volunteers, water committees, etc.) to maintain the outcomes.
2. Working through local structures (schools, health centers) so that those institutions continue benefiting – for instance, schools that received supplies may now have enough to last a couple of terms; boreholes are maintained by local committees; health knowledge stays with the community.

3. Building local partnerships, which can carry on activities in APAR's absence. In Napak and Buliisa, local governments have been drawn in, which bodes well for continuity (e.g., Buliisa officials might integrate camp follow-ups into their work plans; Napak's leaders might continue advocating for their girls in menstruation matters).

However, there remain areas to address for long-term impact:

1. Ensuring **continuous healthcare access**: Camps are episodic. The ideal is for the establishment for permanent health posts in those underserved areas. APAR's data could be used to lobby the Ministry of Health showing that there is demand for a health facility here. This evidence can influence policy and resource allocation. The report can recommend this, and APAR could facilitate community advocacy.

2. Expanding **community empowerment**: APAR might consider training more local health workers to create a lasting presence. For example, training VHTs in integrated community case management (iCCM) so they can treat basic illnesses after the camp leaves, or training peer educators for nutrition in each village. Some of this started (through health education sessions and volunteer involvement), but scaling it would deeply root the changes.

3. **Follow-up evaluations**: A recommendation could be for APAR to revisit communities 6 months after interventions to evaluate outcomes (are children still in school? Did water committees keep the borehole functional? Are patients still on treatment?). Such monitoring would help adjust programs and demonstrate sustained impact.

In the wider humanitarian and scientific context, APAR's experience this year reinforces several principles:

1. **Holistic interventions** address multiple SDGs simultaneously – the program improved health (SDG3), education (SDG4), clean water (SDG6), and reduced inequalities by reaching marginalized groups (SDG10), while partnerships (SDG17) were fundamental. This integrative approach could be a case study in effective NGO strategy.

2. **Community engagement** is key – by involving locals at all stages, interventions were more accepted and effective. This aligns with participatory development theory which posits that involvement yields better ownership and sustainability.

3. **Evidence-based adaptation** – APAR utilized data (like the Moroto/Napak needs assessment) to design interventions and now, with results in hand, can refine approaches. For example, seeing the large turnout in Napak and challenges, they might deploy more health workers next time or extend camp days.

5.3 Limitations

It's prudent to acknowledge that this report largely relies on internal monitoring data, which might have limitations (possible double counting of some beneficiaries if they accessed multiple services, or slight inaccuracies in crowded settings). However, cross-verification and the consistency of reported figures give confidence in the data's reliability. Also, the lack of a control group or baseline means we cannot quantitatively measure improvement in, say, disease rates – we infer impact from outputs and qualitative feedback. Future assessments could incorporate baseline surveys or health indicators tracking. Despite these limitations, the weight of evidence and alignment with known public health benefits suggest that APAR's interventions have indeed made meaningful improvements.

In conclusion, the discussion highlights that APAR's interventions produced multi-dimensional benefits, addressing urgent needs while laying groundwork for longer-term community development. The results validate APAR's holistic model and provide lessons for replication and scaling. The challenges identified are not insurmountable; they mostly require strategic planning, resource

mobilization, and collaborative effort to overcome. In moving forward, the focus should be on sustaining the gains and expanding outreach to more underserved communities, such as Moroto, which, as noted, still awaits a dedicated health intervention.

Chapter 6: Conclusion & Recommendations

6.1 Conclusion

Over the 12-month period in review, APAR Foundation's multi-faceted interventions substantially improved health and well-being for vulnerable populations in Uganda. The free medical camps in Mitooma, Kireka, Napak, and Buliisa delivered critical health services to thousands, effectively reducing immediate morbidity and potentially mortality by treating conditions that would have gone unmanaged. Patients gained access not only to curative care but also to preventive screenings and health education, empowering them with knowledge to maintain their health. The synergy of supporting programs – nutrition, safe water, education, and disability support – amplified the impact, tackling underlying causes of poor health and reinforcing the benefits of medical care. Communities that once faced hopelessness due to lack of services experienced tangible improvements: clean water flows where it never did before, children attend school better equipped and fed, and individuals with disabilities find mobility and inclusion. APAR's credo *"In the joy of others lies our own"* was reflected in the joy seen in communities as their urgent needs were met. The interventions aligned with international best practices, emphasizing community participation, evidence-based targeting, and a rights-based approach to health and education (viewing these services not as charity but as everyone's entitlement).

Notably, the report's findings suggest that APAR's work contributed to progress on several fronts: reducing preventable diseases (through treatment and prevention at camps), reducing hunger and malnutrition in focal groups (through meal programs), improving gender equity in education (through pad distributions and girls' support), and improving quality of life for PWDs (through assistive devices and direct aid). These are significant achievements in line with national development goals and the Sustainable Development Goals (SDGs). While the scale of APAR's effort is modest relative to national needs, it demonstrates a successful model of localized intervention that can be replicated or scaled with additional support. The outcomes also foster a platform for advocacy – using the evidence gathered, APAR and its partners can urge government and larger agencies to invest more in these communities.

In conclusion, the period of July 2024 – July 2025 highlights APAR Foundation's role as a catalyst of change in Uganda's underserved regions. By bridging gaps between communities and the formal health and social support systems, APAR has helped set families on paths to resilience and provided hope where it was scarce. The scientific and systematic documentation of this impact, as presented in this report, reinforces the credibility of APAR's approach and its alignment with international humanitarian standards (as would be expected for publication in a journal like IJSRP).

6.2 Recommendations

Building on the successes and lessons learned, the following recommendations are proposed for APAR Foundation and stakeholders to enhance and sustain impact:

1. **Scale-Up Sustained Outreach: Expand health camp coverage** to other high-need districts (e.g., Moroto, Kotido in Karamoja, or additional slums in Kampala) while maintaining follow-ups in current areas. This could be achieved by increasing collaboration with government health teams and potentially conducting more frequent but smaller-scale outreach clinics (e.g., quarterly mini-camps in each target district). Evidence from this year shows huge demand; scaling up will save more lives. However, APAR should ensure quality is maintained – possibly by training more volunteer health workers and improving logistics (e.g., mobile clinics or telemedicine for remote follow-up).

2. **Integrate with Government Systems: Strengthen partnerships with the Ministry of Health and local governments** to integrate some of APAR's activities into routine services. For instance, advocate for the Ministry to upgrade facilities in places like Paraa (Buliisa) and Lotome (Napak) by highlighting the data on unmet need that APAR gathered. Joint planning with district health offices can ensure that after APAR's camps, there is a plan for patient follow-up (perhaps through periodic government-led outreaches or assigning more staff to local health units). Additionally, APAR could train community health workers who then become part of the district health system, thereby institutionalizing the outreach approach.

3. **Enhance Monitoring & Evaluation:** To solidify evidence of impact, APAR should implement a more robust M&E framework. This could include **baseline and endline surveys** in intervention communities, tracking indicators such as child growth (for nutrition), school attendance (for education support), and disease incidence (for health/water). Even simple metrics like re-surveying a sample of camp patients 3–6 months later to check outcomes (Are hypertensive patients controlling blood pressure? Did referred surgical cases get treatment? etc.) would provide invaluable feedback. Publishing such follow-up data would strengthen future funding proposals and scientific publications, as it moves beyond outputs to outcomes.

4. **Resource Mobilization and Diversification:** Given the resource constraints observed, APAR should pursue diversified funding. This might involve **engaging international donors or grants** (for example, seeking support from global health grants targeting malaria, HIV, or maternal health which align with APAR's work) and strengthening its fundraising campaigns. Documenting success stories – such as case studies of individuals whose lives were changed – can be compelling for donors. Closer to home, APAR can cultivate private sector partnerships; the involvement of companies like Rene Industries and Raghav Pharmacy in Mitooma is a foundation to build on for acquiring medical supplies and financial sponsorships.

5. **Sustainability of Water and Nutrition Projects:** Ensure that **borehole projects include long-term maintenance plans** – possibly setting up a small fund for repairs managed by the community, and periodic technical check-ups. APAR might collaborate with water-focused NGOs or the district water office to monitor water quality annually and maintain pumps. For nutrition, consider shifting from just meal distribution to also supporting local food production where feasible (e.g., helping a school start a vegetable garden or linking communities to agricultural extension services). This would address the root cause of malnutrition by improving food security. Additionally, exploring partnerships with organizations like WFP or UNICEF for supplemental feeding programs in Karamoja could amplify reach.

6. **Empower and Include Communities Further:** Leverage the enthusiasm and gratitude in communities by establishing **community health committees** that work alongside APAR. These committees can help with mobilization, identification of the most vulnerable (for Angels support, etc.), and local problem-solving (like deciding water point locations, selecting maintenance volunteers, etc.). Engaging youth and women's groups specifically could be beneficial – for example, training adolescent girls who benefited from the MHM program to become peer educators (creating a self-sustaining cycle of mentorship on menstrual hygiene). Similarly, involve PWDs in program design for disability support to ensure their voices guide what support is most appropriate.

7. **Academic and Policy Dissemination:** Finally, APAR should disseminate findings through forums, **policy briefs, and publications**. Sharing this report with Uganda's Ministry of Health, district officials, and networks like UWASNET or the National NGO Forum can influence broader policy and program design. On the academic front, documenting the model and results in peer-reviewed journals (such as IJSRP) not only contributes to scientific knowledge but also enhances APAR's profile and credibility. This, in turn, can lead to new collaborations and funding. The data on integrated camps,

for instance, could inform national strategies on how to effectively conduct outreach in hard-to-reach areas – APAR's approach could be scaled nationally if taken up by the government or larger NGOs. By positioning itself as a thought leader in holistic community interventions, APAR can punch above its weight in driving positive change.

In summary, the year's interventions have laid a strong foundation. By addressing the recommendations above, APAR Foundation can ensure that the impact is not only sustained but also expanded, helping more communities achieve resilience and better quality of life. The overarching lesson from this report is that **community-centric, integrated development works** – when done with compassion, diligence, and collaboration, it transforms lives and offers a replicable blueprint for others committed to the cause of humanity's well-being.

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