The Ugandan Journey to Integrating Community Health into Health Systems- A Case Study

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Acknowledgments

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Contents

Acronym List

CFI	Certificate of Financial Implication
CHEW	Community Health Extension Worker
CHSS	Community Health System Strengthening
HMIS	Health Management Information System
HUMC	Health Unit Management Committee
ICCM	Integrated Community Case Management
LG	Local Government
MOFPED	Ministry of Finance, Planning and Economic Development
NACHLII	National Community Health Learning and Improvement Initiative
MOH	Ministry of Health
NCCC	National CHEW Coordination Committee
NCHCC	National Community Health Coordination Committee
PHC	Primary Health Care
TBA	Traditional Birth Attendants
UHC	Universal Healthcare
USG	United States Government
VHT	Village Health Team
WHO	World Health Organization

Introduction

Health worker shortages plague Uganda's primary health care (PHC) system. There are currently only 0.4 health providers—physicians, nurses, and midwives—serving every 1,000 Ugandans.[1] This is well below the World Health Organization (WHO) recommendation of, at minimum, 2.5 health providers for every 1,000 people. In addition, 70% of medical doctors and 40% of nurses and midwives are based in urban areas, serving only 12% of the population.[2] Uganda needs a strong community-based health workforce to compensate for shortages and misdistribution of health providers.[3] Lack of access to health services, especially among rural populations, compromises the health and well-being of Ugandans and contributes to the fact that 75% of the disease burden in Uganda is attributed to preventable diseases.[4]

A strong community health system is key in delivering high quality and equitable health services, particularly to vulnerable and rural communities. In 2001, recognizing that the majority of disease burden is preventable diseases, Uganda's Ministry of Health (MoH) prioritized a community-based approach to primary health care through the use of Village Health Teams (VHTs) to deliver basic health services and education. In 2014, after nearly 15 years of implementation, the MoH conducted a VHT assessment to look at the success and challenges of the VHT program. The assessment showed several gaps and challenges which included a lack of a common, regularly monitored framework to guide VHT engagement and inform learning; weak linkages with the health facility and district health teams. In response to the assessment's findings, the MoH developed the Community Health Extension Workers (CHEWs) strategy to strengthen the health workforce, linkages between the community and the health system, and disease prevention efforts within the community. While the Ugandan government ultimately did not endorse the CHEW policy and strategy, the collaborative effort between the Government of Uganda, Implementing Partners and donors, has led to the development of several new and evolving initiatives that have led to a growing opportunity for a stronger community health system and new models of care to better coordinate services and support vulnerable populations.

There is now an active national conversation about Community Health Workers (CHEW and VHT) and a broader focus on the Community Health System. Further, with a strong commitment to community health, the MoH has been working with partners and is now looking at costing analysis of different community health models, which will inform revisions to the policy.

This case study will explore the Ugandan government's evolving journey to developing new policies to improve the community health system and community-based workforce as a key contribution to primary health care and to achieving universal health coverage.

VHT Spotlight: Olive's story

Olive, an energetic and jolly woman, lives in Nsango, a small village in Eastern Uganda's Mayuge district with her husband and five children. At forty-two years old, Olive has served her community as part of its VHT for over ten years, mobilizing members for health activities, promoting health to prevent disease, treating simple illnesses at home, and connecting families to the health system.[1] Although she is proud of the role she has played, she speaks of the need for compensation, greater recognition of her role on the VHT, and more opportunities for training and collaboration to improve her effectiveness. Olive said:

"I would like government to recognize the work of us, the VHTs and other community health workers by being compensated for the time spent while mobilizing and sensitizing communities for health services. I am involved in routine immunization activities, treatment of children below five years, make home visits to follow up with clients, conduct health education and write monthly reports, this takes too much time...If government can also help us get refresher trainings, and attend meetings, we can be able to meet with other VHTs, share challenges and discuss solutions."

It is an exciting time for Olive and other VHT workers. The Ugandan MoH is working hard to strengthen the community health system nationally through policies and initiative such as the Community Health Extension Worker (CHEW) program, Community Health Roadmap and the National Community Health Learning and Improvement Initiative (NACHLI). While it may take time, these policies have the opportunity to make sweeping changes to its community health system that will have immense impact on tackling preventable diseases.

National Policies, Systems and Implementation of Strategies for Community Health System

Overview of the Community Health System in Uganda[5]

Uganda's health system is decentralized, empowering local governments (LGs) to plan strategically, build partnerships and coalitions, and establish contextualized accountability measures for health service delivery. The primary health care (PHC) system is composed of two main levels: health facility structures that provide a platform for focused curative and rehabilitative services and the community system for health promotion and disease prevention. The health system supports districts, sub-districts, sub-counties, parishes, and villages to implement and manage community health services. Each district has a health department and a district health team, which has the mandate to plan and implement health services.

While LGs and district health offices have the authority to make key decisions in both human resource management and policy implementation, in many districts, they lack the resources for implementation, resulting in weakened local leadership and an inability to be effective.

Challenges to the Community Health System in Uganda

- PHC accounts for 70% of health sector disbursements, but three quarters of this is spent on wages, leaving major funding gaps at the level of care and community level for activities[1].
- Lack of coordination among government and NGO managed community health efforts.
- Lack of resources for implementation, means that promising pilots are not scaled.
- The decentralized health system makes it challenging to effectively translate national policies into high quality programming at district levels.
- Community health policy is developed in a siloed fashion- focused on specific cadres, disease areas with insufficient costing or integration into the health care system
- The community level is poorly defined, fragmented, under-resourced and overstretched to effectively improve health outcomes.
- Community health does not have single management structure

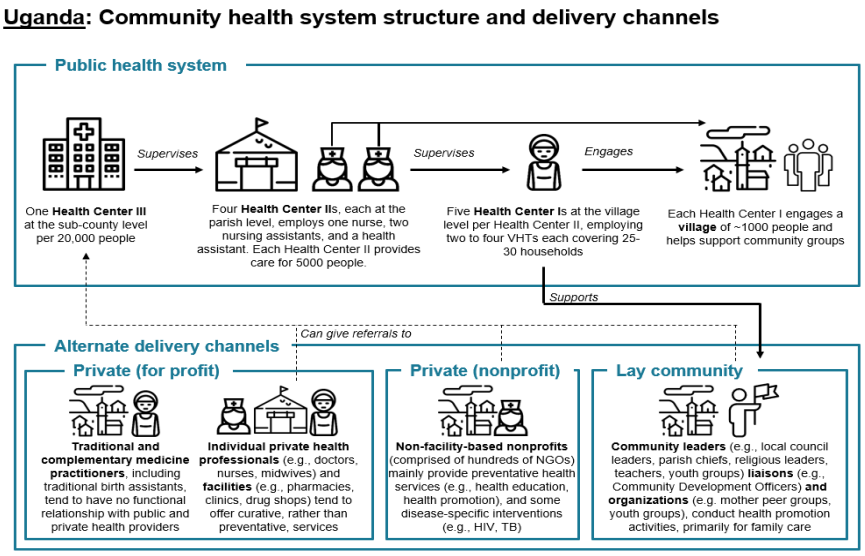


Figure 1: Each district has a health department and a district health team. Other elements of the community health system structure and delivery channels in Uganda include private for-profit professionals, nonprofit and faith-based healthcare providers, traditional practitioners, and the lay community, which include Health Unit Management Committees (HUMCs), traditional birth attendants (TBAs) and other traditional providers, and actors/committees from other sectors (agriculture, education, environment) that influence health.

Scaling the Community Health System through Community Health Workers (VHT and CHEW)

Village Health Team Strategy

In 2001, the MOH made a community-based approach to PHC a priority. To make quality health services for Ugandans more accessible, the MOH established Village Health Teams (VHTs). Creating the VHTs through the VHT strategy filled a human resource gap. It was designed to extend health services to households and mobilized and empowered communities to take part in the health system.[6]

VHTs offer a package of community health services at village and household level: prevention of childhood illnesses like pneumonia, malaria, and diarrhea through integrated community case management (ICCM) and community-based distribution of contraceptive methods including injectables. Working in teams of five individuals per village, the 179,175 VHTs serve between 25 to 30 households each and are in all districts[7]. While the VHT strategy suggests a transport refund of 10,000 Uganda Shillings (about $3) to cover expenses related to their work, the VHTs are volunteers and do not receive a stipend from the MOH; rather, implementing partner organizations, who have come to depend on VHTs to implement a wide

range of community health projects, provide training, supervision, and monetary and non-monetary incentives, such as bicycles, carry bags, or t-shirts.

In 2014, the MOH conducted a national VHT assessment, which found that although the VHTs perform a valuable service to their communities, they face multiple challenges in fulfilling their mandate.[8] Challenges include lack of community involvement, poor reporting systems, weak referral structures, insufficient funding for incentives and supplies, and low motivation. There was not a well-established system to manage and support the VHTs, leading to a high rate of attrition. VHTs' reliance on NGOs and partners[1] for support led to intermittent assistance, fragmented geographic coverage, and inconsistent functionality. The assessment recommended a comprehensive overhaul of the VHT strategy, including revising the policy, management, supervision, and governance of the VHT structure. This meant amending how VHTs are selected and trained, redefining their roles and responsibilities, and streamlining coordination from National level and district level through coordination committees. Table 1 shows how the CHEW Policy addressed the gaps and challenges of the VHT strategy.

Table 1: CHEW Policy Response to VHT Gaps and Challenges[9][10][11]

	VHT Strategy Gaps and Weaknesses	CHEW Policy Reformation
Health System	VHTs are not recognized as part of the formal primary health system	CHEWs will be employed by the MOH and linked to the health center.
Coordination	Poor coordination due to human resource and financial constraints	The parish CHEW coordination committee will monitor the CHEW program, mobilize community resources, and provide administrative oversight to CHEWs.
Funding	VHT operational guidelines specify the various forms of motivation for VHTs, however, it does not describe how these should be equitably distributed and who should provide incentives.	CHEWs will be funded by the MOH and NGOs
Referral	VHTs can refer to primary care, although there have been some problems with referral uptake	Will focus on strengthening and improving overall linkage of the community health system to the PHC system
Supervision	Poor supervision, with only 70% of VHT members reported having been supervised in the VHT assessment.	Health Center IIs and the Parish CHEW coordination committee will supervise CHEWs.
Compensation	VHT are volunteers and lack compensation.	CHEWs will be compensated with a monthly stipend.
Training	~70% of VHTs have undergone basic training, which are usually 5-7 days. Limited training opportunities and inconsistent, refresher trainings	CHEW training will take place over six months. Refresher trainings will be conducted every two years

[1] Partners include: Pathfinder, FHI360, Marie Stopes, PSI, UNICEF, Baylor, PATH, IntraHealth, JPIEGO, WellShare International, Engender Health, Reproductive Health Uganda, AMREF and many local organizations

Guidelines	Lack of guidelines to standardize the quality of care	The MoH will develop curricula, standards and implementation guides.
Selection Process	VHT selection process is by popular vote during a community meeting. This caused problems due to bias.	A district health officer, who is part of the DHT, will coordinate the CHEW selection process.

Community Health Extension Worker (CHEW) Policy

In 2016, in response to the assessment's findings, the MoH began developing the Community Health Extension Worker (CHEW) strategy and policy to complement the VHT program. The purpose of the CHEW strategy was to deploy a community-based health work force to supervise VHTs, strengthen linkages between the community and primary health care systems, and fully engage communities through social mobilization and emphasis on community accountability. [12]

In 2017, the MOH established a National CHEW Coordination Committee (NCCC) with the involvement of key line ministries (Ministry of Finance, Planning and Economic Development (MOFPED) and Ministry of Public Service) and partners to coordinate and monitor activities for the roll out and implementation of the CHEW Strategy. The NCCC also developed key advocacy and informational materials on the policy and strategy. These materials helped inform further consultations with line ministries, local government leadership, and key partners. Additionally, implementation guidelines, training materials, district sensitization plans, and CHEW trainee selection guidelines were developed.

CHEW's would be a flexible workforce connecting community health to the primary health system. Referral networks would be developed in which VHT could refer clients to CHEWs, and both cadres could refer clients to the health centers. The health centers could also refer clients to CHEWs for follow-up. Further, standardized reporting forms and procedures for CHEWs were developed to expand the data collection system at the community level to provide more comprehensive data for decision-making. The selection criteria for CHEW's included a Minimum of Uganda Certificate of Education (O level), which is different from VHT's in which education was not part of the criteria. Further, CHEW's would be paid a MoH salary to support retention of these valuable care team members and solidify their place in the workforce.

NCCC members began consultations with Ministry of Finance, Planning, and Economic Development, under the leadership of the Minister of Health and Permanent Secretary, in order to obtain the Certificate of Financial Implication (CFI), a requirement for any new government policy to ensure sustainable financing for the program. Throughout 2017, the policy and strategy was revised in order to strengthen and clarify critical areas identified during consultations and discussions with key stakeholders in preparation for the policy presentation to Cabinet.

In 2018, district readiness assessments took place and CHEW trainee selection occurred in 13 districts. Political will and leadership for the program was at an all-time high, and in June 2018, Parliament approved 3 billion UGX (approximately 804,061 USG) for the CHEW program (for Fiscal Year 2019/20) and Health Development Partners, UNICEF, USAID, and

DFID committed over 1.2 million USD for the training of CHEWs in the first year of implementation.

However, this all changed in late 2018, when the MOH CHEW team underwent a leadership transition, which caused a gap in knowledge and understanding of the CHEW policy and strategy. Communication began to fail and governance mechanisms for the CHEW program became non-functional. NCCC ceased to continue meeting as per the mandate, some members began to not participate at the same time as new members were added, causing additional gaps in institutional memory and overall group cohesion.

In early 2019, a new team from MOH, led by the Minister of Health, presented the CHEW policy to the Cabinet, which was approved. Unfortunately, shortly after, the President recalled the approval and asked for changes to be made to ensure the program was going to be a sustainable, government led, and cost-effective initiative. These changes were meant to better address concerns expressed during the regional consultation meetings of district leaders. Those concerns included how the new CHEW cadre would be integrated with the existing VHT program (i.e. how would they work together, could VHTs become CHEWs, etc.), cost effectiveness, and collaboration with non-health stakeholders.

Shortfalls of the initial CHEW Policy

- **Distance and households to be covered by CHEWs:** CHEWs could not provide the same kind of household attention as VHTs, which would affect interventions, such as ICCM, delivered at household level.
- **Age difference between CHEWS and VHTs:** The age requirement to be selected as a CHEW trainee being a maximum of 35 years old meant that many experienced VHTs would be left out, plus, it would be a challenge for a CHEW younger than the older and more experienced VHTs they were to supervise.
- **Compensation for CHEWs:** VHTs, who have worked as volunteers for more than 12 years, would likely feel dissatisfied that CHEWs would receive a monthly allowance of $50.
- **Lack of clarity about defined roles of CHEWs and VHTs:** The roles of VHTs and CHEWs intersect, requiring more clarity and consistent messaging about how the two roles would be differentiated and how they would work together.
- **Criteria for CHEW selection:** Although communities took part in nominating their CHEW candidates, the selection criteria focused on education and age and therefore meant that whilst some existing VHTs were eligible, many did not qualify.
- **Cost of new cadre and lack of advocacy to support financing of CHEW program**
- **Uncertainty of funding:** Fear donor commitments would not be renewed.

Moving Forward: Optimizing Policies and Systems for Community Health

Despite the initial pause with the CHEW Policy, the MoH, with support from partners and donors, continued to express commitment and progress to community health– some in direct response to the policy setback. In the absence of a policy, local stakeholders and partners worked to embed some of the functions of the CHEW policy into other initiatives such as:

- Community Health Roadmap- Government of Uganda developed national investment priorities. See here for more information on this global effort to support 16 high opportunity countries in defining national investment priorities.
- National Community Health Learning and Improvement Initiative (NaCHLII)
- Developing a community health financial plan and advocacy agenda

Community Health Road Map

In 2019, after the challenges in approving the CHEW policy, the MoH continued to refine the CHEW policy and began developing a new Community Health Roadmap– which acted as a way to focus strategic priorities even in the absence of new official policy. The 6 main priorities outlined in the roadmap present opportunities to strengthen the community health system through a costed community health strategy that includes all cadres and parts of the community health system to reduce fragmentation across Uganda's community health cadres and system components[13]. The costed strategy will inform revisions to the CHEW Policy and facilitate advocacy efforts for increased financing, coupled with donor resource mapping.
Over the past year, the MoH in collaboration with partners has worked to to advance these priorities through[14]:

Community Health Roadmap Priorities

1. Develop a comprehensive, costed, evidence-based community health strategy that includes all community health cadres and other system components.
2. Strengthen community health leadership, governance, and multi-sectoral collaboration throughout the entire health system (national to community level).
3. Strengthen and sustain investment in supervision and motivation of community health cadres.
4. Strengthen and improve the community health supply chain.
5. Invest in the scale up of appropriate technology for community health implementation and supervision.
6. Invest in the active engagement of communities to increase participation, ownership, and capacity to be agents of their own health.

- Working to develop a comprehensive costed community health strategy with the plan to integrate community health supply chains into the national health system's forecasting procurement and distribution platform
- Integrating data systems to feed information from the community level into the national HMIS/DHIS2 system
- Stakeholder dialogues around CHW implementation guidelines and multi sectoral coordination and collaboration to avoid the creation of parallel/overlapping services. This has

led to the development of a National Community Health Coordination Committee (NCHCC). See below.

- Conversations with other government agencies to better coordinate the activities of various government ministries that play a role in delivering health services at the community level (e.g., Ministry of Education, Ministry of Gender, Labor, and Social Development)

This is just the beginning; the roadmap will be continually strengthened as new information and evidence is gathered to ensure a country-level platform that expands access to health at the community level. The NCCC helped build the foundation for collaboration among government and NGO partners involved in community health. This foundation helped maintain momentum towards developing the Community Health Roadmap and the NaCHLII initiative, which will be described in the next section.

Linking Learning with Policy Reform: The Innovation, Evidence and Learning Agenda

The National Community Health Learning and Improvement Initiative (NaCHLII)
Uganda also has a strong platform for community health, but many strategies, policies and plans have fallen short in implementation. Historically, learning around community health was scattered and often directed to donor reporting and international conferences, rather than informing local practice and policy. Further, many organizations develop promising practices that are never tested at scale, and efforts that do go to scale are not fully documented, leading to a missed opportunity for learning.

Objectives of NaCHLII are to:

- Build an operational foundation for the initiative.
- Design and implement research and learning activities.
- Inform national policy process and global CHW agenda.
- Strengthen district capacity

To generate learning that informs and influences policy and program implementation to achieve a high performing and institutionalized community health system, the MoH with support from the ICH collaboration partners developed the National Community Health Learning and Improvement Initiative (NaCHLII). The initiative is modeled after similar efforts in Ghana, Bangladesh, and Ethiopia—countries with high-performing community health programs. It is a Government of Uganda led consortium of implementers, donors, and researchers dedicated to strengthening the community health system, shaping national policies, and informing global best practice. The future plan of NaCHLII is to act as a critical member to the National Community Health steering committee, to develop and drive a national learning agenda for community health and to organize an annual learning forum.

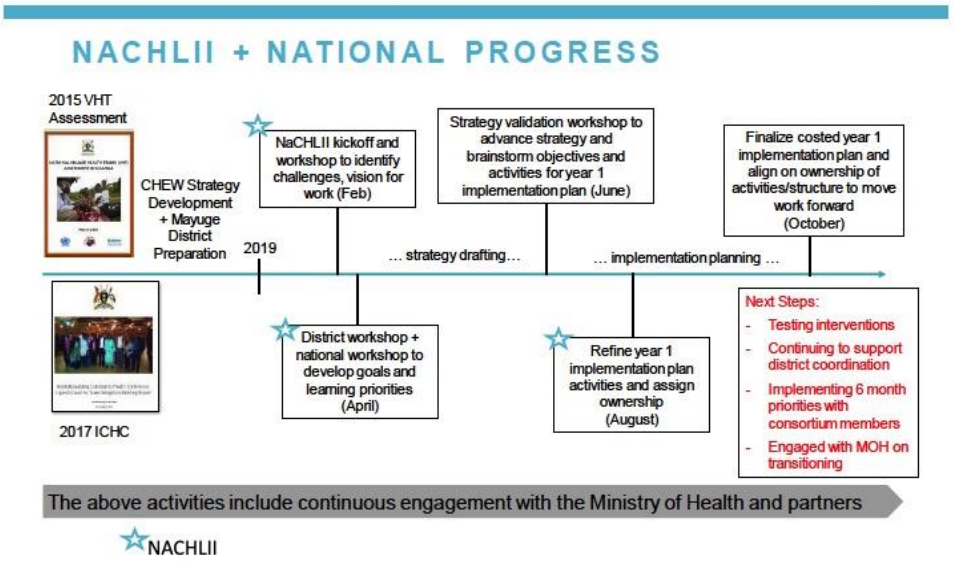
It supports the development of new directions in Uganda by highlighting promising practices for behavior change such as model households new research focusing on motivation and

incentives of community health workers, and district level multi-sectoral governance and innovations. The initiative includes a learning and improvement center in Mayuge district, where policies and guidelines are tested in a real-world setting and the learning from the testing process is packaged to directly inform policy implementation at scale. A multi-sector district coordination group, under the leadership of the district health team, manages this process. The coordination committee meets regularly to share information, coordinate activities, and identify and implement strategies to improve community health service delivery. One promising approach the MOH and partners are currently testing at the center is the "Model Household approach." The goal of this approach is to scale up health promotion, multisectoral district coordination to improve leadership at the district level, and to generate evidence to standardize incentives for CHWs. In the model, CHWs are empowered as change agents, in order to promote health, they need to model these practices at home (model homes) and then influence their respective (30-50) households. To become a model, one goes through training on practices including *household hygiene, proper housing, energy saving practices, tree planting, animal and poultry management, backyard gardening and waste management.* The approach was presented during the recently held annual health promotion conference, and it was adopted as a strategy to be scaled up in the country among all community health workers. This model represents a participatory community driven multi-sectoral approach to improve community health. In addition to the model household approach other key policy relevant questions being addressed include determining an appropriate combination of financial and non-financial incentives through implementation research[2], improving district leadership and governance through the district coordination group referenced above.

The district's ownership of the initiative and the multiple partners[15] involved in its implementation show its promise as a platform that can be used to help refine and test elements of a revised CHEW Policy and a broader community health strategy to inform national decisions. These structures and processes will lay the foundation for a more evidence based and comprehensive community health strategy to take shape and adapt over time. The NaCHLII can also build district capacity to plan and fund community health activities locally. In the next year, Pathfinder and its partners plan to work on strengthening MOH leadership of NaCHLII and hope to secure long-term financing for the learning initiative. Stakeholders agree that coordinated learning and ensuring that this learning is directly informing policymaking remains central to accelerating the drafting and adoption of the CHEW Policy and accelerating the institutionalization of community health in Uganda.

[22] For more information on ICH Incentive research see:
https://chwcentral.org/?taxonomy=resources_topics&term=performance-based-incentives

Figure X: Evolution of National Community Health Learning and Improvement Initiative (NaCHLII)



Community Health System Strengthening (CHSS) advocacy agenda

The CHSS advocacy agenda is focused on accelerating key policy reforms to strengthen community health in Uganda. The advocacy agenda mainly focuses on implementing Uganda's Community Health Roadmap, which lays out the six key investment priorities [16]. The most pressing reform is to develop a national community health strategy, which will harmonize and coordinate all community health activities and will engage policymakers to increase investments in community health, including but not limited to paying CHWs. The second agenda is to track the implementation of the community health strategy. In the future, the agenda seeks to strengthen national coordination by inaugurating the National Community Health steering committee. Such a committee will drive national advocacy efforts in community health and advocate for political support in the quest to pilot the CHEW policy.

Overcoming the financial burden of community health

Consideration must be given to the financial challenges of any community health strategy. Without adequate resources, policies are likely to fail. Even in difficult economic times,

governments, donors and other stakeholder should be mindful of this and support the important work of community health and community health workers. In Uganda, the Ministry of Health's strong support and understanding of the importance in health promotion and education led them to direct all Local Governments to contribute 20% of their total Primary Health Care (PHC) budget to disease prevention and health promotion for the financial year 2019/2020.[17] . The Government intends to fund community health through the PHC fund, and through donor projects such as USAID RHITES, Uganda Health Systems Strengthening Project (UHSS) and intelligent Community Health Information Systems funded by the Rockefeller Foundation and implemented by UNICEF. Both UHSS and the Rockefeller project will support the development of the Community Health strategy, CHEW policy pilot, leadership and information systems. These investments will contribute to the much-needed resources to optimize policy and systems support. Currently, the government seeks donor support in training of CHWs and catering for their allowance.

USAIDs Support to Community Systems in Uganda

USAID, in collaboration with UNICEF and the Bill and Melinda Gates Foundation, provides key support to the government of Uganda to elevate community systems as a health sector priority. Though trusted its partners, USAID supported the Government of Uganda to build on the recommendations of the Village Health Team Assessment in 2014 to reorient and align civil society organizations, multilateral institutions and donors towards a more comprehensive and collaborative approach to primary health care. Through this process, the Government of Uganda elevated focal priorities to develop and implement a comprehensive, costed community health strategy and formed a coalition of health systems actors to support Uganda's new policies, strategies, and governance structures/stewardship for community health. Currently, the Government of Uganda, alongside its key partners, is well poised to advance the US Governments (USG) supported resolution on CHWs for a comprehensive approach to community participation in health as part of the Ugandan health system. This includes the new national steering committee for community health and greater accountability for roles and contribution of communities in the health systems through digitization and use of community health data.

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Conclusion: Progress towards 2030

The Ugandan experience described here is about the power of commitment to community health and the importance of building a strong multi-sectoral approach to invest in the community health system. The diverse coalition was able to move forward progress in institutionalization even when there were policy setbacks. Taking a holistic approach ensures foundations are in place to fully take advantage of the potential benefits of a stronger, more integrated community health workforce approach thus enhancing public health.

Preparatory work in collaboration, learning and adaptation combined with the strong commitment of the MoH, partners and donors, sets the stage for continued growth. This preparedness opens an opportunity to advance CHW and the public health policy agenda. Working collaboratively, the MoH, partners and donors plan to operationalize the Community Health Roadmap and the CHSS advocacy agenda. The MOH is in the process of approving the CHEW policy to strengthen and institutionalize CHWs and increase advocacy on investing in community health and monitoring of PHC funding. Driven by national leadership, donors and implementing partners, leadership and accountability has been streamlined and strengthened. Similarly, the national community health steering committee also provides leadership in partner coordination and setting the learning agenda. Now is the time to leverage increased investments from the Uganda Health Systems Strengthening Activity, the Uganda Learning Activity, and the UNICEF Rockefeller initiative to draw on the successes and challenges of the past to identify concrete pathways forward.

The Ugandan experience illustrates the importance of understanding the political process and building advocacy power through effective cooperation and lobbying for desired policy change. As the political will grows from the launch of the WHO guidelines for community health, the Astana declaration on primary healthcare, the community health roadmap, and the World Health Assembly 2019 resolution on UHC, there is a strategic window of opportunity to shape national community health policy. Countries like Uganda have an opportunity to invest in community-based workers who, with strategic training and support, could then transition to becoming higher-skilled health workers who would be more likely to work in the rural and remote settings that they originated from. This could help to tackle the broader health workforce shortage and maldistribution challenges in Uganda.

While there is no one-size-fits-all model for strengthening community health and integrating CHEWs into the health system, the experience to date offers valuable lessons and an exciting opportunity to improve community health and positively impact the social determinants of health, enhancing patient care, and improving access to health care and social services.

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