Integrating Community Health Program
UGANDA COUNTRY SNAPSHOT

USAID
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FOR GOD AND MY COUNTRY

PATHFINDER

LAST MILE HEALTH

Acknowledgements

Contents

Acronyms

CEMH	Community Empowerment and Mobilization for Health
CHEW	Community Health Extension Worker
DHO	District Health Officer
DHT	District Health Team
DRC	Democratic Republic of Congo
GDP	Gross Domestic Product
HSD	Health Sub-District
HUMC	Health Unit Management Committee
ICCM	Integrated Community Case Management
ICH	Integrating Community Health
iCHC	Institutionalizing Community Health Conference
LMH	Last Mile Health
MDG	Millennium Development Goal
MOFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
NaCHLII	National Community Health Learning and Improvement Initiative
NCCC	National CHEW Coordination Committee
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
TBA	Traditional Birth Attendant
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VHT	Village Health Teams
WHO	World Health Organization

Preface

Accelerating the Integration of Community Health Worker Programs through Institutional Reform

Approximately half of the world's population do not have access to essential health services. A growing emphasis on the roles of communities recognizes community engagement, including community health workers (CHWs), as a means of realizing the full potential of the primary healthcare (PHC) system.[1] High performing CHW programs at scale are an integral component of responsive, accessible, equitable, and high-quality PHC.

Recognizing the potential for community health to address gaps in coverage, improve financial protection, and support access to quality care, the Declaration of Astana in 2018 committed to strengthening the role of community health in PHC as a means to accelerate progress toward universal health coverage (UHC). Before the Declaration of Astana, the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) also helped to reposition communities as resources for health systems strengthening and sources of resilience for individuals and families.

The United States Agency for International Development (USAID) initiated a collaboration with the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation in 2016 to advance country commitments toward communities as resources in PHC systems to accelerate progress towards the achievement of the SDGs. The Integrating Community Health (ICH) collaboration fueled a global movement with more than twenty countries to elevate national priorities and progress for institutionalizing community health in primary health care systems. USAID, in collaboration with UNICEF, invested in catalytic partnerships with governments, their trusted NGO partners, and communities across 7 countries (Bangladesh, the Democratic Republic of Congo

(DRC), Haiti, Kenya, Liberia, Mali, and Uganda) to institutionalize reforms and learning, with a focus on CHWs. In alignment with these efforts, the Bill & Melinda Gates Foundation supported the development of new evidence and knowledge regarding performance measurement, advocacy and pathways to scale in the seven focal countries via the Frontline Health Project with Population Council and Last Mile Health as lead partners. Using Last Mile Health's Community Health Reform Cycle framework, the Country Snapshots highlight the ICH collaboration's catalytic partnerships to strengthen national CHW programs as an essential component of PHC and to place these programs within the context of institutional reforms and political commitment needed for national progress in health outcomes.

Re-envisioning health systems to achieve UHC requires leadership and political commitment from within countries. Countries must mobilize the whole society—both public and private sectors as well as communities—as essential resources in this effort. The community component of PHC must be designed to enable the health system to reach the most underserved, respond to pandemics, close the child survival gap, and accelerate the transformation of health systems. Without a major expansion of support for national CHW programs, the measurable acceleration urgently needed to reach the health-related targets of the SDGs by 2030 is unlikely. With a decade remaining to achieve the SDGs and faced with the challenge of the COVID-19 response, building global political momentum with countries and funders is critical to support urgent national priorities, evaluate progress, and develop and share new knowledge to inform bold political choices for a whole of society approach to health systems strengthening.

Community Health Institutionalization as a "Reform Cycle"

The Country Snapshots featured in this series highlight the seven ICH countries' reform efforts within a framework for institutional reform: the Community Health Systems Reform Cycle (often referred to here as the "reform cycle").[2] Countries experience community health systems reform as a process and pathway to institutionalizing community health. The likelihood that any particular reform is successfully institutionalized in an existing policy environment depends on political will and buy-in from key stakeholders, the technical design of the policy, the available capacity and resources to launch and govern the intervention, the ability to learn, and the willingness to adapt and improve the program over time.

The reform cycle framework has guided—and been refined through—a descriptive analysis of the ICH countries' reform journeys. Country Snapshots, reflecting the ICH investment on community health systems reform, demonstrate the practical linkages between available literature and specific country experiences. This framework provides health systems leaders with an approach to plan, assess, and strengthen the institutional reforms necessary to prioritize community health worker programs as part of national primary health care strategies to achieve universal health coverage.

The reform cycle traces several stages of institutional reform, which are summarized below. Reforms may encompass an entire community health worker program or target specific systems components, such as health information systems. While reforms may not always follow each stage in sequence and timing can vary depending on the complexity of the program or activity, deliberate and comprehensive planning can strengthen buy-in and overall effectiveness.

THE COMMUNITY HEALTH SYSTEMS REFORM CYCLE

MANAGEMENT & LEARNING
Key stakeholders regularly review program data to inform problem-solving at the national or subnational level.

PROBLEM PRIORITIZATION
Actors identify a meaningful and relevant problem.

COALITION BUILDING
A group is formed around a compelling problem or vision.

GOVERNANCE
Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights.

SOLUTION GATHERING
Potential solutions are gathered, drawing from existing local and international programs.

LAUNCH
New policies, processes, and organizational structures are implemented, and key actors execute their new roles.

READINESS
Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program.

DESIGN
Key decision makers, stakeholders and planners map out different options for program design.

PROBLEM PRIORITIZATION

Actors identify a meaningful and relevant problem. They diagnose pain points and unmet needs, and connect them to priority areas for reform, where possible. Actors acknowledge the need for reform within the community health system and commit to a joint vision for addressing gaps.

COALITION BUILDING

A group is formed around a compelling problem or vision. Members define the coalition's goals, roles, size, and composition. Diverse members fill critical roles in the reform effort (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).

SOLUTION GATHERING

Potential solutions are gathered, drawing from existing local and international programs. Actors define criteria and metrics to assess solutions, and specific ideas for reform are piloted, where possible. Promising solutions are prioritized for integration into the health system.

DESIGN

Key decision makers, stakeholders, and planners map out different options for program design. Where possible, evidence about the options, expected cost, impact, and feasibility are identified. Through consultations, workshops, and other channels, stakeholders offer feedback on options, and decision makers select a design. This may include operational plans, training materials, job descriptions, management tools, data collection systems, and supply chain processes.

READINESS

Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program. Stakeholders also translate program design into costed operational plans that include clear strategies and tools for launch and rollout. Investment plans for sustainable financing and funding mechanisms are put in place. Stakeholders are prepared for their new roles and responsibilities, and potential areas of policy/protocol conflicts are addressed.

LAUNCH

New policies, processes, and organizational structures are implemented, and key actors execute their new roles. As these shifts progress, learning is gathered to demonstrate momentum and identify challenges to achieving scale. Particular attention is paid to issues around rollout, and timely design and implementation shifts are made as needed.

GOVERNANCE

Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights. Processes for risk and issue management, stakeholder engagement, and cross-functional communication are established. Actors monitor program progress to advance clear decision-making and address critical issues or challenges.

MANAGEMENT & LEARNING

Key stakeholders regularly review program data to inform problem-solving at the national or subnational level. Stakeholders engage in continuous learning and improvement, identifying challenges and changes to program design and other systems bottlenecks.

Country Snapshots of Institutional Reform

PURPOSE AND GOALS OF COUNTRY SNAPSHOTS

- Describe the community health landscape within each country
- Present the country's vision for community health reform and situate progress to-date within the framework of the reform cycle
- Articulate the primary community health institutionalization challenges that the country is or was facing at the outset of the ICH investment
- Trace the policy and advocacy process taken by country stakeholders to move reform forward, using the ICH investment as a catalyst
- Identify lessons learned and opportunities for strengthening existing reforms arising out of the ICH investment

The Country Snapshots complement other resources generated within and beyond the ICH investment, such as the countries' Community Health Acceleration Roadmaps, ICH Country Case Studies, and Frontline Health Project Research Studies. The Country Snapshots place a unique emphasis on tracing the process of policy choice, advocacy, and implementation. Together, these complementary initiatives are catalyzing community health systems reform and advancing efforts towards a strong primary health care system and UHC.

APPROACH AND METHODS

The Country Snapshots highlight examples of a country's reform journey through the specific stages of institutionalization outlined in the framework. Country Snapshots both demonstrate the features of each stage within the country context and elevate salient examples of countries' learning and success. The Country Snapshots reflect a process of desk reviews and consultations with country stakeholders. Stakeholders include but are not limited to current and former ministry of health representatives, leaders from non-governmental and technical organizations, and members of multilateral and bilateral institutions. The Country Snapshots elevate both existing

insights captured in policy and strategy documents that are often difficult for those not working within the country to access, as well as novel perspectives gained through methods such as workshops or in-depth interviews with key stakeholders. Where the Country Snapshots draw on existing materials, citations are noted. Insights and country stakeholder recommendations on the reform cycle's application serve not only to validate the framework, but also to highlight ways in which the framework can help trace powerful narratives of reform and accelerate community health systems policy and advocacy efforts.

These narratives reveal opportunities to accelerate the prioritization of community health worker programs and primary health care strategies with the goal of UHC. The Country Snapshots reflect valuable feedback from stakeholders on how the framework can help advance community health systems policy and advocacy.

Key Resources

- USAID Vision for Health Systems Strengthening 2030
- Astana Declaration
- CHW Resolution
- CHW Guidelines
- Exemplars—Community Health Workers
- Community Health Roadmap
- Institutionalizing Community Health Conference 2017
- Institutionalizing Community Health Conference 2021
- Community Health Community of Practice
- Global Health: Science and Practice Supplement 1: March 2021
- Journal of Global Health: Advancing Community Health Measurement, Policy and Practice

Community Health Landscape
Health Access and Outcomes

Uganda is a presidential republic in East Africa, formed as a state in 1962 following independence from British colonial rule, and practices a multiparty, democratic, parliamentary system. As of 2018, the estimated population of Uganda was 42.72 million, with an annual population growth rate of 3.7% and Gross Domestic Product (GDP) of 27.46 billion USD.[3] Table 1 outlines Uganda's performance in various health indicators.

TABLE 1: Various Health Indicators for Uganda[4]

Indicator	2019
Life expectancy at birth (years)	63.0
Adult mortality rate, female (per 1,000 people)	264
Adult mortality rate, male (per 1,000 people)	340
Age-standardized mortality rates attributed to noncommunicable diseases, female	587.1
Age-standardized mortality rates attributed to noncommunicable diseases, male	701.9
Child malnutrition, stunting (moderate or severe) (% under age 5)	28.9
Current health expenditure (% of GDP)	6.2
Life expectancy at birth, female (years)	65.2
Life expectancy at birth, male (years)	60.7
Life expectancy index	0.661
HIV prevalence, adult (% ages 15-49)	5.9
Mortality rate, infant (per 1,000 live births)	35.4
Infants lacking immunization, DPT (% of one-year-olds)	1
Infants lacking immunization, measles (% of one-year-olds)	14
Malaria incidence (per 1,000 people at risk)	200.7
Tuberculosis incidence (per 100,000 people)	201.0
Mortality rate, under-five (per 1,000 live births)	49.0

In recent years, significant progress has been made in Uganda to reduce maternal mortality, under five mortality, and infant mortality. However, challenges remain in trying to achieve UHC—the primary goal of Uganda's latest national Health Sector Development Plan (HSDP, 2015/16-2019/20).[3]

The leading causes of death in Uganda include HIV, malaria, lower respiratory infections, diarrheal disease, tuberculosis, and noncommunicable diseases. Infant deaths are largely caused by neonatal disorders.[5] A majority of the population has access to health facilities and services—72% live within 5km of a health facility—but there are vast disparities between those who live in rural areas versus the capital city of Kampala.[3]

Health worker shortages are a challenge within Uganda's primary health care (PHC) system. There are currently only 0.4 health providers—physicians, nurses, and midwives—serving every 1,000 Ugandans.[6] This is well below the WHO

recommendation of, at minimum, 4.45 health providers for every 1,000 people to achieve 80% coverage of the health needs outlined in the Sustainable Development Goals.[7] In addition, 70% of medical doctors and 40% of nurses and midwives are based in urban areas, serving only 12% of the population in Uganda.[8] Uganda needs a strong community-based health workforce to compensate for the shortages of health providers in certain areas.[6] Lack of access to health services, especially among rural populations, compromises the health and well-being of Ugandans, and contributes to the 75% of the disease burden in Uganda that is attributed to preventable diseases.[3]

Health System Overview

In Uganda the health system is decentralized and broken down into various units as indicated in Table 2.[9]

TABLE 2: Structure of the Uganda Health System

HEALTH UNIT	PHYSICAL STRUCTURE	LOCATION	POPULATION
Health Centre I / CHW	None	Village	1,000
Health Centre II	Outpatient services only	Parish	5,000
Health Centre III	Outpatient services, maternity, general ward, laboratory	Sub-county	20,000
Health Centre IV	Outpatients, wards, theatre, laboratory, blood transfusion	County	100,000
General Hospital	Hospital, laboratory, x-ray	District	100,000 – 1,000,000
Regional Referral Hospital	Specialist services	Region	1,000,000 – 2,000,000
National Referral Hospital	Advanced tertiary care	National	Over 20,000,0000

The national level Ministry of Health (MoH) is responsible for functions such as[9]:

- Setting policies and guidelines for program implementation and service delivery
- Capacity building
- Monitoring and evaluation
- Supportive supervision
- Resource mobilization
- Coordination

The district level government is empowered to plan strategically, build partnerships and coalitions, and establish contextualized accountability measures for health service delivery. Each district has a health department and a district health team, which has the mandate to plan and implement health services.[9]

Community Health Workers Overview

In 1999, the MoH in Uganda established Village Health Teams (VHTs) as a cadre of community health workers in order to "combat the high disease burden of communicable diseases and the rising rates of noncommunicable conditions as well as to ensure equitable access to health services."[10]

About 15 years after the VHT started, several assessments showed gaps in the community health system, and in 2016 a new cadre of Community Health Extension Workers (CHEWs) was proposed to address some of the challenges identified.

General statistics regarding the VHTs and CHEWs are indicated in Table 3.[11]

TABLE 3: Community Health Quick Stats[11]

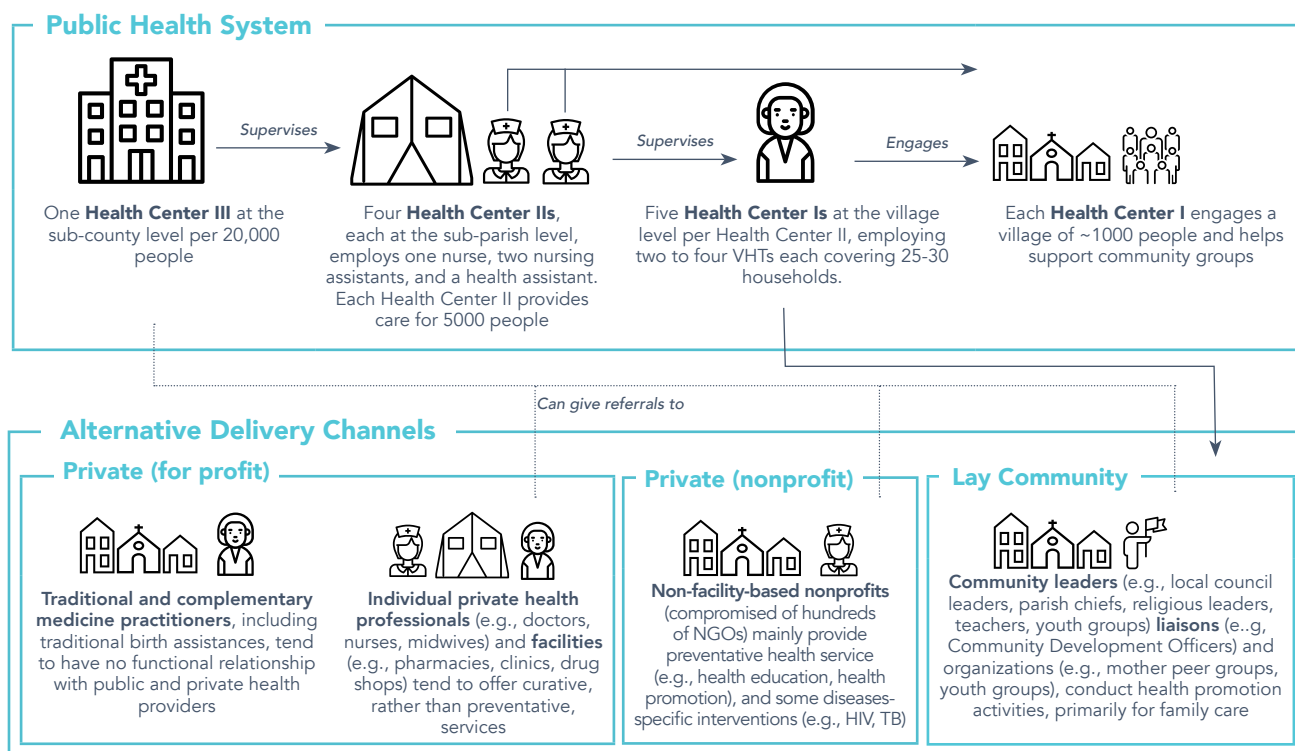| Main community health policies / strategies	The Second National Health Policy	Village Health Team Strategy and Operational Guidelines	Health Sector Development Plan 2015/16 – 2019/20	Community Health Extension Workers Strategy in Uganda 2015/16 – 2019/20
Last updated	2010	2010	2015	2016
Number of community health provider cadres	2 main cadres			
	Village Health Teams (VHTs)		Proposed Community Health Extension Workers (CHEWs)	
Recommended number of community health providers	Information not available		15,000 CHEWs	
Estimated number of community health providers	179,175 VHTs[a]		1,500[b]	
Incentivization	Partner-led incentives, unregulated		Standardized allowance paid by government	
Recommended ratio of community health providers to beneficiaries	1 VHT: 25-30 households or 5 VHTs: 1 village		1 CHEW: 500 households or 2,500 people	
Community-level data collection	Yes			
Levels of management of community-level service delivery	National, district, sub-county, parish, village			
Key community health program(s)	CHEW: iCCM; RMNCH; national TB and Leprosy Control and HIV/AIDS Control programs (CB DOTS); Expanded Program on Immunization			

[a] As of 2015
[b] CHEWs were introduced in 2016 with the intention of having 1,500 in place by the end of the year

The community health structure and delivery channels are detailed in Figure 1.[12]

FIGURE 1: Uganda: Community Health System Structure and Delivery Channels

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.[12]

Public Health System

One **Health Center III** at the sub-county level per 20,000 people

Supervises

Four **Health Center IIs**, each at the sub-parish level, employs one nurse, two nursing assistants, and a health assistant. Each Health Center II provides care for 5000 people

Supervises

Five **Health Center Is** at the village level per Health Center II, employing two to four VHTs each covering 25-30 households.

Engages

Each **Health Center I** engages a village of ~1000 people and helps support community groups

Can give referrals to

Alternative Delivery Channels

Private (for profit)

Traditional and complementary medicine practitioners, including traditional birth assistances, tend to have no functional relationship with public and private health providers

Individual private health professionals (e.g., doctors, nurses, midwives) and **facilities** (e.g., pharmacies, clinics, drug shops) tend to offer curative, rather than preventative, services

Private (nonprofit)

Non-facility-based nonprofits (compromised of hundreds of NGOs) mainly provide preventative health service (e.g., health education, health promotion), and some diseases-specific interventions (e.g., HIV, TB)

Lay Community

Community leaders (e.g., local council leaders, parish chiefs, religious leaders, teachers, youth groups) **liaisons** (e..g, Community Development Officers) and organizations (e.g., mother peer groups, youth groups), conduct health promotion activities, primarily for family care

Descriptions of the roles of various government bodies as they pertain to community health, the existing VHT program, and the proposed CHEWs are below (drawn and adapted from conversations with Ugandan stakeholders and the Community Health Systems Catalog Country Profile for Uganda).[11]

- **At the national level,** the MoH provides coordination, strategic leadership, and guidance for the health system. It also builds district capacity, mobilizes resources, monitors and evaluates programs, and collaborates with implementation stakeholders. For community health programs (VHTs and the proposed CHEWs), the MoH develops strategies and policies, standards and implementation guides, curricula, and frameworks for data integration into the health management information system.

- **At the district or city level,** the top tier of the local council system, the health system administrator (District Health Officer for a district or the Director of Health Services for a city) oversees and monitors program implementation, develops action plans, mobilizes resources, trains district trainers, and provides technical support to the lower levels. The health system administrative body at this level coordinates the community health worker selection process (VHTs and the proposed CHEWs).

- **At the constituency/municipality/division level,** the health system administrator (Health Sub-District In-charge at a district, the Municipal Medical Officer at a municipality or the Division Medical Officer in a city) oversees health programs and provides supportive supervision, technical support, and capacity building for health center staff (including VHTs
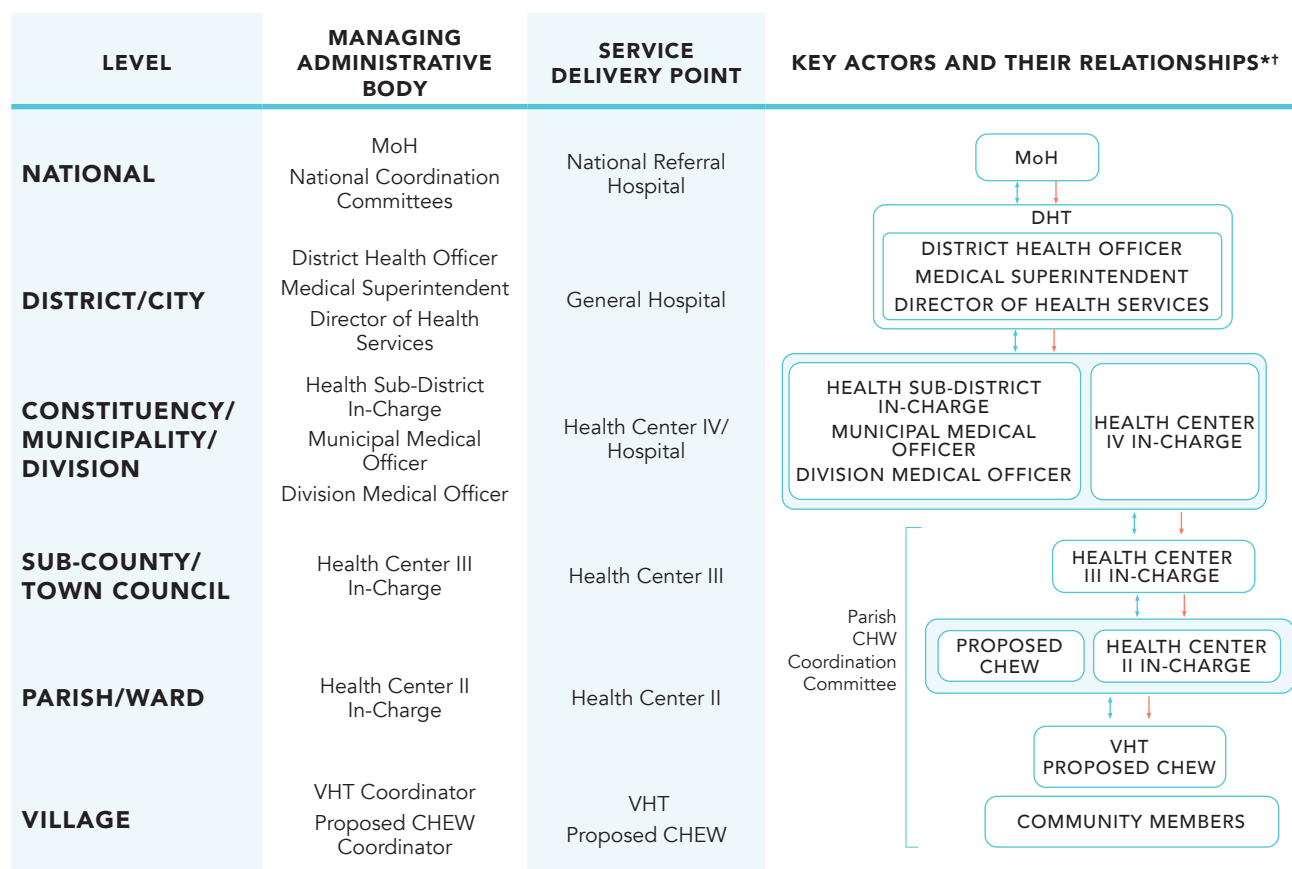
and the proposed CHEWs) at the lower levels. Community health worker supervision is led by the In-charge in close collaboration with either the Health Inspector or the Health Assistant.

- **At the sub-county/town council level,** the Health Center III In-charge oversees health program implementation and supervises health center staff. Each Health Center III is supported by community health workers (VHTs and the proposed CHEWs) who are coordinated and supervised by either the Health Assistant or a senior VHT.

- **At the parish/ward level,** the Health Center II In-charge oversees health program implementation, including oversight of service delivery by community health workers (VHTs and the proposed CHEWs). The proposed CHEWs will be supervised by the Health Center II In-charge and will spend 50% of their time at the Health Center II managing health priorities and developing annual action plans. They will spend the other 50% of their time in the community providing health services and supervising VHTs.

Figure 2 shows the flow of community health-related information between various levels of the health system[11].

FIGURE 2: Health System Structure in Uganda with Key Actors and Information Flow

LEVEL	MANAGING ADMINISTRATIVE BODY	SERVICE DELIVERY POINT	KEY ACTORS AND THEIR RELATIONSHIPS*†
NATIONAL	MoH National Coordination Committees	National Referral Hospital	
DISTRICT/CITY	District Health Officer Medical Superintendent Director of Health Services	General Hospital	
CONSTITUENCY/ MUNICIPALITY/ DIVISION	Health Sub-District In-Charge Municipal Medical Officer Division Medical Officer	Health Center IV/ Hospital	
SUB-COUNTY/ TOWN COUNCIL	Health Center III In-Charge	Health Center III	
PARISH/WARD	Health Center II In-Charge	Health Center II	
VILLAGE	VHT Coordinator Proposed CHEW Coordinator	VHT Proposed CHEW	

* NGOs and development partners support at all levels and work in close collaboration with the government in community health planning and implementation.

Supervision →
Flow of community-level data →

Community Health Systems Reform

Community Health Systems Reform Cycle Overview

COMMUNITY HEALTH REFORMS IN UGANDA USING THE REFORM CYCLE

In this Country Snapshot, the reform cycle will be used to analyze and review the steps and processes that Uganda has undertaken around national-level community health institutionalization. The case will be made that:

1. From 1999 to 2014, in developing the first cadre of community health workers (VHTs), Uganda went through the entire reform cycle process from problem prioritization to management and learning.

2. From 2014 to present, a new reform cycle began, building on the management and learning of the previous cycle. With support from the ICH investment in Uganda, this second cycle has focused on the proposed cadre of CHEWs. This cycle has progressed from problem prioritization through program readiness and is poised for launch.

Reform Cycle: Village Health Teams

Details around the development of the VHTs in Uganda are not well documented, but it appears that the process went through several stages of the reform cycle—starting from problem prioritization through management and learning.

PROBLEM PRIORITIZATION, COALITION BUILDING, AND SOLUTION GATHERING

Due to rising national health needs and targets set forth by the Poverty Eradication Action Plan (PEAP)[13] and Millennium Development Goals (MDGs), Uganda emphasized community empowerment and mobilization for health (CEMH) to harmonize efforts. CEMH was recognized as one element of the Uganda National Minimum Health Care Package in several key MoH strategy documents. A growing coalition of stakeholders acknowledged that a strong community health system would be critical to delivering high quality and equitable health services, particularly to vulnerable and rural communities.

In 2001, recognizing the high disease burden of preventable diseases, Uganda's MoH prioritized a community-based approach to primary health care through volunteer Village Health Teams (VHTs) to deliver basic health services and education and "as a bridge in health service delivery between community and health facilities."[3]

The creation of VHTs followed in the path of other community health worker programs from around the world (ranging from the Chinese barefoot program in the 1950s to other examples in Thailand, Tanzania, and Zimbabwe)[30] and reflected Uganda's commitment to the 1978 Alma Ata Declaration and the 2008 WHO Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.[53]

DESIGN, READINESS, AND LAUNCH

The design and development of Uganda's VHT system can be traced back to these national strategic documents[9]:

National Health Policy (1999):[14]

- VHTs are established

Health Sector Strategic Plan I (2000/01 – 2005/06):[15]

- VHT strategy is recommended, recognizing the need for health services for rural areas and populations
- VHT program is launched by the MoH

Health Sector Strategic Plan II (2005/06 – 2009/10):[15]

- VHT strategy is implemented

VHTs are generalist community health workers who function at the village level under the Health Center I. They are meant to be the "first point of contact for health care delivery in communities as well as the provider of health messages and the provider of support for patient follow-up and retention in care".[11] The VHT system was designed to extend health services to households, and to mobilize and empower communities to take part in the health system.[16]

VHTs offer a package of community health services at the village and household levels. This includes prevention of childhood illnesses like pneumonia, malaria, and diarrhea through integrated community case management (iCCM), and community-based distribution of contraceptive methods, like injectables. Working in teams of five individuals per village, the 179,175 VHTs serve 25

to 30 households each. The VHT strategy suggests a transport refund of 10,000 Uganda Shillings (about 3 USD) to cover expenses related to their work, but the VHTs are volunteers and do not receive a stipend from the MoH. Rather, it is the role of the implementing partner organizations, dependent on VHTs to execute a wide range of community health projects, to provide training, supervision, and monetary and non-monetary incentives (e.g., bicycles, supply bags, and t-shirts). Specifics of VHT recruitment, training, support and incentives, equipment and supplies, and supervision are outlined in greater detail elsewhere.[8–10]

In 2010, the MoH published VHT Strategy and Operational Guidelines[17]—focusing on roles and responsibilities, guiding principles, implementation strategy, coordination, motivation, and sustainability. This document helped to incorporate lessons from the first nine years of VHT implementation from 2001 to 2010.

MANAGEMENT & LEARNING

In the management and learning stage of the reform cycle, government stakeholders "utilize learning and data to inform improved performance of the system."[2] This iterative process is often necessary for advancing community health reform.

Over the years, as the VHT program was implemented and rolled out, different implementation partners—working primarily on vertical programming using VHTs—assessed various gaps and highlighted important opportunities for VHTs.[7,18–29] Many of the challenges raised by these studies concerned supportive supervision, sustainable financing, partnerships between VHTs and other health workers, regular provision of supplies and transportation allowances, sustained motivation of VHTs, and community engagement and ownership.

Starting in 2014, nearly 15 years after VHTs were first introduced, the MoH embarked on an assessment[30] to review the VHT system. This first-ever system-wide assessment of VHTs resulted in the identification of various gaps and prompted the proposal of the CHEW cadre to address challenges.[54]

PROJECT: National Village Health Teams Assessment in Uganda

IMPLEMENTERS: Ministry of Health, Pathfinder International, Ideal Development Consults Limited

SUPPORT: UNFPA, GAVI Health Sector Support, WHO

DATE: March 2015

GOALS:

- Establish and ascertain the number, coverage, and functionality of VHTs in Uganda
- Develop an improvement framework and strategy for VHTs

OBJECTIVES:

- To establish the number and sociodemographic profiles of the VHTs in Uganda
- To establish the training that was provided to the VHTs (duration, content, methods, and materials)
- To establish the partners working with VHTs and the activities VHTs are currently implementing
- To review the extent to which the VHT implementation guidelines are being implemented by the MoH, the districts, and partners
- To identify approaches for VHT motivation mechanisms and arrangements
- To assess the functionality of VHTs in Uganda

METHODS:

- Qualitative and quantitative mixed methods study: interviews, key informant interviews, focus group discussions, data collection
- Assessment conducted in all 112 districts in Uganda from Nov. 2014 to Jan. 2015

HIGH LEVEL FINDINGS:

- The VHT strategy has been implemented to varying levels across the districts.
- Funding of the program by government has been gradually reducing since its inception, leaving the implementation partners to fund most of the activities.
- Districts have different levels of capacity to coordinate, train, and supervise VHT activities but have been hampered by lack of funds.
- Coordination and supportive supervision to partners and districts by the MoH have not been conducted as desired due to funding constraints.

RECOMMENDATIONS FOR GOVERNMENT:

- Review VHT strategy
- Commit to financing and institutionalizing VHT strategy
- Create VHT coordination structure
- Develop national and district level VHT databases for monitoring and evaluation
- Streamline VHT training and refresher courses
- Create a conducive working environment for VHTs, including supportive supervision and economic development opportunities

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After the National VHT Assessment identified critical gaps in the existing system, a desk-based review and benchmarking activity was conducted to gain a deeper understanding of international experiences.[31] This included a review of community health worker programs in seven countries across Latin America, Southeast Asia, and Sub-Saharan Africa to determine which aspects of each program might fit Uganda's needs. The MoH study focused on selection, training, incentives, and supervision as key themes. Ethiopia's health extension program served as a model for how Uganda could link communities and community health providers to health centers. The MoH also identified financial incentives for supporting and motivating community health providers.[12]

Based on what it had learned, in 2016 the MoH recommended the introduction of CHEWs to serve as salaried supervisors of the VHTs with a standardized scheme of additional incentives (including a salary and other non-financial incentives).[11,54] Major issues addressed in the CHEW policy included: selection, training, supervision, and incentivization.

And thus began the start of a second reform cycle process in Uganda, which was supported by the ICH investment and will be detailed below.

The ICH Investment as a Catalyst for Reform

OVERVIEW OF THE ICH INVESTMENT

The Integrating Community Health Program (ICH) is a collaboration between the USAID and UNICEF to support countries in implementing proven health interventions at scale and to help end preventable child and maternal deaths.

ICH aims to strengthen the role of community health approaches in reducing barriers to health coverage and to support national policies and implementation plans. USAID will invest over 9 million USD through a collection of seven different awards, which will leverage an additional 10 million USD in investments from other sources (along with support in the form of trainings, equipment, and direct assistance to community health workers).

These awards support USAID's goal of ending preventable child and maternal death in priority countries across Africa, South Asia, and the Caribbean.[32]

ICH INVESTMENT IN UGANDA: PATHFINDER AND LAST MILE HEALTH

Following on the heels of the management and learning stage of the VHT reform cycle, the ICH investment emerged to support the MoH with the second cycle of reform for the CHEW policy and strategy.

The ICH investment in Uganda was primarily implemented by Pathfinder International and Last Mile Health. Overviews of the two projects and their goals are below.

PROJECT: Integrated Systems Strengthening for Community Health Extension Workers[33]

IMPLEMENTING PARTNER: Pathfinder International

DATES: 2016 to 2019

OVERVIEW: The goal is to support the Government of Uganda to achieve effective high-impact health and nutrition interventions at scale, preventing child and maternal deaths, creating an AIDS-free generation, and realizing other health goals.

KEY OBJECTIVES:

- Institutionalization through effective and efficient linkages of community health projects
- Measurement to influence systems and policies to operationalize CHEW strategy
- Inclusive and effective partnerships to sustain the CHEW strategy

ACTIVITIES INCLUDED:

- Support the Ministry of Health as the country plans for a major shift from volunteer, part-time village health teams to full-time, paid CHEWs with formal, standardized pre-service training and health system support
- Develop key tools and mechanisms to facilitate CHEW recruitment, training, and deployment processes, as well as monitoring and supervision plans
- Provide technical assistance to district local government administration units and community health departments to ensure government buy-in and inclusion of the community health worker program budget at the national, district, and sub-county levels
- Implement a series of monitoring and evaluation and implementation learning studies to better understand the CHEW implementation process

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PROJECT: Policy and Advocacy to Scale Frontline Delivery: Integrating Community Health—Uganda*

IMPLEMENTING PARTNER: Last Mile Health

DATES: 2018 to 2020

OVERVIEW: Last Mile Health's focus is on providing support to Pathfinder in Uganda in informing the national policy dialogue. The goal is to also to be the backbone support for the National Community Health Learning and Improvement Initiative (NaCHLII) to ensure that on-going efforts led by the District Health Team (in Mayuge District) are aligned with stakeholder priorities and broader community health systems strengthening

ACTIVITIES INCLUDED:

- Design a comprehensive strategy and operational design for the learning initiative
- Co-create a learning agenda that incorporates critical topics of national and district level policy and program relevance
- Support Pathfinder and country stakeholders in advocacy strategy—moving from policy to practice
- Develop concise materials that help facilitate conversations with key stakeholders as to the purpose, value and role of the learning initiative related to national policy discussions
- Identify key advocacy related milestones nationally and globally and support Pathfinder to prepare for these meetings

* LMH received ICH support for work in multiple countries—this table only highlights the work that was done by LMH in Uganda.

In the next section we will see how the ICH investment supported the acceleration of Uganda's community health system institutionalization and reform agenda by targeting each stage of the reform cycle and ensuring that learnings are utilized for further policy refinement and reform.

Reform Cycle: Community Health Extension Workers

BACKGROUND AND INTRODUCTION

Successful community health institutionalization efforts depend on a carefully choreographed, problem-driven political process.[2]

As previously noted, the proposed CHEWs program emerged from a national assessment that highlighted challenges in the existing VHTs in Uganda. This problem-driven focus has pushed the CHEW policy and strategy to undergo five stages of the reform cycle to date: from problem prioritization through program readiness. Progress paused before launch, as the policy was approved by the Cabinet but later recalled by President Yoweri Museveni due to questions and challenges that needed to be addressed further.

Key activities from the CHEWs reform narrative thus far—many supported by the ICH investment— are highlighted below and grouped under each stage of the reform cycle. Note that the activities are not organized chronologically as many of them took place simultaneously and the reform cycle is not linear.

THE COMMUNITY HEALTH SYSTEMS **REFORM CYCLE**

MANAGEMENT & LEARNING
Key stakeholders regularly review program data to inform problem-solving at the national or subnational level.

PROBLEM PRIORITIZATION
Actors identify a meaningful and relevant problem.

COALITION BUILDING
A group is formed around a compelling problem or vision.

SOLUTION GATHERING
Potential solutions are gathered, drawing from existing local and international programs.

DESIGN
Key decision makers, stakeholders and planners map out different options for program design.

READINESS
Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program.

LAUNCH
New policies, processes, and organizational structures are implemented, and key actors execute their new roles.

GOVERNANCE
Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights.

PROBLEM PRIORITIZATION

In the problem prioritization stage, actors diagnose and frame a compelling problem or opportunity that sets the foundation for the rest of the cycle. They identify a meaningful and relevant problem, define pain points and unmet needs and, where possible, connect the problem to priority areas for reform. Relevant actors acknowledge the need for reform within the community health system while committing to a joint vision for addressing gaps.[2]

The VHTs were developed in 2001 in response to the challenges of accessing health care in rural areas and as a pathway to achieving community-based primary health care. The CHEWs were developed in 2016 to complement the VHT program. This addition represented a strong prioritization of the problem—namely, that the VHT system had gaps and opportunities for improvement.

The development of the CHEW strategy exemplifies how the MoH and other key stakeholders were able to prioritize the problem (gaps in the VHTs) and then use research findings (from VHT assessments and other resources) for evidence-based decision making and to inform a national policy.

The purpose of the CHEW strategy was to deploy a community-based health workforce 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. [16]

The plan was to have two CHEWs deployed to each parish to serve about 2,500 people and be full-time, salaried employees (unlike the VHTs). The CHEWs would provide services in the following major health extension package areas:

- Prevention and control of communicable diseases
- Prevention and control of noncommunicable diseases
- Family and reproductive health services
- Hygiene and environmental sanitation
- Health promotion, education, and communication
- Community health service management
- First aid
- Disaster and risk management
- Vital statistics and data management

The CHEWs were also expected to mobilize and train other volunteers to implement health interventions.[8]

COALITION BUILDING

In the coalition building phase, a group is formed around a compelling problem or vision. Members understand the group and individual roles and goals, and coalition size and composition is determined accordingly. Diverse members can fill critical roles for reform (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).[2]

NATIONAL CHEW COORDINATION COMMITTEE

In 2017, the MoH established a National CHEW Coordination Committee (NCCC) with the involvement of key line ministries, including the Ministry of Finance, Planning, and Economic Development (MOFPED), and the Ministry of Public Service. The MoH also engaged partners to coordinate and monitor the rollout and implementation of the CHEW strategy. Some of the accomplishments of the NCCC included:[16]

- The development of key advocacy and informational materials on the policy and strategy, which informed further consultations with line ministries, local government leadership, and key partners
- The development of implementation guidelines, training materials, district sensitization plans, and CHEW trainee selection criteria
- The start of consultations with MOFPED, under the leadership of the Minister of Health and Permanent Secretary, in order to obtain the Certificate of Financial Implication, a requirement for any new government policy to ensure sustainable financing for the program
- Policy and strategy revisions to strengthen and clarify critical areas identified during consultations and discussions with key stakeholders in preparation for the policy presentation to the Cabinet.

In 2018, district readiness assessments took place and CHEW trainee selection occurred in 13 districts. (more details in the readiness stage). Political will and leadership for the program was at an all-time high, and in June 2018 Parliament approved 3 billion UGX for the CHEW program for the following fiscal year. Health Development Partners, UNICEF, USAID, and Department for International Development (DFID) also committed over 1.2 million USD for the training of CHEWs in the first year of implementation.

In early 2019, a team led by the Minister of Health Dr. Jane Ruth Aceng presented the CHEW strategy to the Cabinet. Cabinet members responded positively, approving the strategy. However, shortly after, President Museveni recalled the approval of the CHEW strategy. He asked important questions and requested changes be made to the strategy to ensure that the program would be sustainable, government-led, and cost-effective.[34,35]

BUILDING CONSENSUS AROUND CHALLENGES

The requested changes from the President were meant to address concerns expressed during the regional consultation meetings of district leaders. Those concerns included how the new CHEW cadre would be integrated within the existing VHT program (i.e., how they would work together and whether VHTs become CHEWs). He also had questions about cost effectiveness and collaboration with non-health stakeholders.

The President asked Minister Aceng and her team to address concerns and questions related to:

- **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 the household level

- **Age difference between CHEWs and VHTs:** The requirement that CHEWs be no more than 35 years old meant that many experienced VHTs would be left out and that it would be a challenge for a younger CHEW to supervise an older and more experienced VHT.

- **Compensation for CHEWs:** VHTs, many of whom have worked as unpaid volunteers for over 12 years, would likely feel dissatisfied that CHEWs would receive a monthly allowance of 50 USD.

- **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 many existing VHTs did not qualify.

- **Cost of new cadre and lack of advocacy to support financing of CHEW program:** There were questions around financial sustainability and continued support from the Ministries of Health and Finance.

- **Uncertainty of funding:** There was concern that donor commitments would not be renewed.

One of the key learnings from this experience was the importance of seeking stakeholder consensus during policy reform. Many of the questions posed by the President had been raised by stakeholders but were not addressed by the promoters of the reform. In fact, it was those same stakeholders who eventually reached out to the President who, in turn, requested clarification from the MoH team.

After the recall of the CHEW policy, the NCCC and the momentum it created were leveraged to continue the work of institutionalizing community health in Uganda. LMH and Pathfinder worked together to ensure that the right set of reformers, authorizers, champions, and implementers were on board. National community health challenges were prioritized through a series of workshops with these key stakeholders, resulting in a learning agenda that highlighted opportunities sitting at the intersection between need, demand, and feasibility (see Appendix A). Unaddressed conflicts were also elevated through meetings and one-on-one conversations to better understand the trajectory that the CHEW policy took and to rebuild

some of the trust that had been lost among key stakeholders.

Others have also noted the potential challenges of implementing the CHEW strategy—with a focus on what should be addressed before implementation takes place.[31,36]

NATIONAL LEARNING AND IMPROVEMENT INITIATIVE

Building upon the efforts of the NCCC, NaCHLII is a Government of Uganda-led coalition of implementers, donors, and researchers dedicated to building a high performing community health system, shaping national community health policy, and informing global community health best practices. It was created to address some of the barriers to the successful implementation of national community health policies and plans:

- Coordination, governance, and accountability challenges that exist among a myriad of government- and NGO-managed community health efforts

- A history of promising program pilots, but few that are scaled or integrated into national policy
- Learning that is scattered and rarely focused on scaling up or integration into policy planning
- Community health policies developed in siloed fashion—focused on specific cadres (such as the CHEW cadre without accounting for the existing VHTs) and disease areas (such as maternal and child health)
- Policies with insufficient costing or integration into the health care system
- Fragmented support of VHTs from various NGOs, which has led to more focus on donor reporting versus government reporting

Overall, NaCHLII aimed to have regular continuous evaluation of national community health programs and to develop a more systematic way to capture and routinely share learning. NaCHLII had four key objectives, each led by different partners as seen in Table 4.

TABLE 4: NaCHLII Key Objectives

KEY OBJECTIVE	PARTNER(S)	OUTCOMES ACHIEVED
1) Build Operational Foundation for NaCHLII: Create a community of collaborative, coordinated learning about community health by building the operational foundation of NaCHLII and the Mayuge learning site	Pathfinder	• Created strategy document • Gathered evidence to inform NaCHLII design • Established individual workplans per objective • Developed NaCHLII terms of reference • Procured physical space in Mayuge District
2) Design and Implement Research and Learning Activities: Collate existing data and develop new evidence to test, refine, and model key priorities of Uganda's community health system	Pathfinder and Makerere University	• Completed formative assessment to identify gaps in the health system in Mayuge District, and to prioritize learning areas and performance metrics to assess progress
3) Inform the National Policy Process: Advocate for and inform the national community health systems dialogue by building a coalition and leveraging NaCHLII evidence	Living Goods	• Identified chair (Minister of Health Dr. Jane Ruth Aceng) to lead national community health steering committee • Supported MoH to engage with other sectors and line ministries • Provided guidance and support to the MoH to help accelerate the national policy reform process • Identified opportunities and platforms for community health learning to influence policy process (e.g., CHW Symposium in Bangladesh in 2019 and the Institutionalizing Community Health Conference)
4) Build District Capacity: Identify capacity building needs and build leadership capacity of district health team to improve governance, coordination, and evidence for decision-making	Mayuge District Health leadership and Pathfinder	• Established an effective coordinating mechanism that brought together implementing partners, district leadership, and community representatives • Supported research and learning through the formative assessment with Makerere University

SOLUTION GATHERING

During the solution gathering stage, reform coalitions develop a shared set of criteria to assess potential solutions to the identified problem. Then, armed with these criteria, the reform coalition must cast a wide net to identify possible solutions. Where possible, the coalition seeks rapid feedback from a wide array of health sector stakeholders.[2]

For this solution gathering stage, as noted above, key stakeholders in Uganda drew on lessons learned from local and global resources to create a way forward together. This was shown by activities such as:

- Factoring in feedback from the President around the CHEW questions to be clarified
- Developing a shared learning agenda with key priorities
- Creating a national community health learning and improvement initiative
- Conducting the Mayuge District Formative Assessment (done by Makerere University)
- Using research done by other partners to indicate challenges and possible solutions

DESIGN

In the design stage, the reform coalition connects the policy or program reform goals that have been drawn from the prioritized problem (e.g., increased service coverage) with intervention designs (e.g., CHW recruitment and training). These designs, sourced via the solution gathering process, may include new innovations, expansions of existing innovations, or revisions of programs already in place. Critically, stakeholders should ask themselves how the proposed interventions will function within the current system. At this stage, reformers must encourage the system to develop new capabilities to address the prioritized problem. At the same time, they must exercise caution to avoid "premature load bearing," where

new program designs are overly optimistic about technical, political, and operational capabilities and, therefore, fail to deliver the expected results.[2]

With the data, tools, experience, and recommendations from the assessments that were conducted on the VHT program, the MoH and other stakeholders designed and developed detailed plans for a new community health worker cadre employing CHEWs. Pathfinder supported the new policy by facilitating regional consultation meetings and national workshops to review and finalize the CHEW policy and strategy. Pathfinder also provided technical support to the MoH through meetings and workshops on operational guidelines for the CHEW strategy, including the budget, monitoring, and evaluation framework, and implementation plans for the first two years.[37]

PROGRAM READINESS

During the program readiness stage, health systems actors secure the resources necessary for launch. Resources may be financial, material, human, programmatic, planning, or political commitments by stakeholders supportive of system reform.[2]

REGULATORY IMPACT ASSESSMENT
With the support of Living Goods, the MoH underwent a Regulatory Impact Assessment,[38,39] which included "a rigorous literature review, field work, and problem analysis and articulation to provide the context for regulation." [39] This assessment was important for approval in Uganda for new policies, bills, and regulations to the Cabinet.[39]

FINANCIAL CLEARANCE
Pathfinder coordinated meetings between MoH and the Ministry of Finance to advocate for a certificate of financial clearance which influenced the Ministry of Finance to issue a financial clearance letter to implement the CHEW program in the country. This cleared the policy for presentation to the Cabinet.[37]
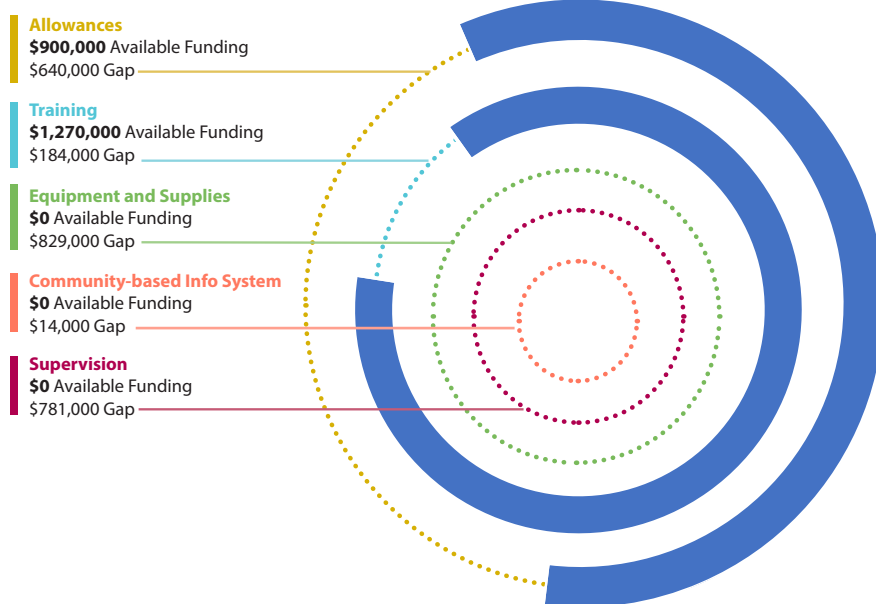
RESOURCE MAPPING

In November 2018, the Financing Alliance for Health worked with key stakeholders (MoH, the National CHEW Coordination Committee, Mayuge District, and Pathfinder) to discuss resources for community health and developed an investment case for CHEWs.[37] The analysis showed that for the first year of the project, across the five costing areas (training, equipment and supplies, supervision, allowances, community-based information systems), there would be a funding gap of 53%. (See Figure 3.)

FIGURE 3: Resources for Community Health in Uganda and the Funding Gap for CHEWS (Financing Alliance For Health)[37]

To date, $2.17 million had been raised for CHEWs program to partly cover the costs of training and renumerating year

CHEW STRATEGY BUDGET

Allowances
$900,000 Available Funding
$640,000 Gap

Training
$1,270,000 Available Funding
$184,000 Gap

Equipment and Supplies
$0 Available Funding
$829,000 Gap

Community-based Info System
$0 Available Funding
$14,000 Gap

Supervision
$0 Available Funding
$781,000 Gap

FUNDING SOURCES

The Government of Uganda, through the Ministry of Finance, Planning, and Economic Development (MOFPED) committed
$900,000
for CHEW's allowances

Health Development Partners (HDPs) availed
$1.2 million
for CHEW's training

A shortfall of
$2.4 million
exists (53% of the total year 1 budget)
Resource mobilization is required to fill this gap and that of subsequent years

DISTRICT READINESS ASSESSMENT

In 2016, a rapid situation analysis / district readiness assessment was conducted by IntraHealth and funded by USAID, with the MoH as a key partner.[8]

PROJECT: Rapid Situation Analysis of Community Health Workforce in Uganda

IMPLEMENTERS: IntraHealth and MoH

SUPPORT: USAID

DATE: July 2016

GOALS:
- Understand existing community health worker systems in Uganda
- Support plans to strengthen the community health workforce in Uganda

OBJECTIVES:
- To determine the type, categories, numbers, distribution, location of the CHWs and the organizations using the CHWs
- To identify the existing CHW management structures specifically: recruitment mechanisms, terms of employment, duties performed, reporting structures and linkages with health facilities and other health workers
- To study the nature of support provided to CHWs to carry out and sustain their work (e.g. systems for skills and career development, support supervision, regulation, tracking and monitoring CHWs)

METHODS:
- Qualitative and quantitative mixed methods study involving structured questionnaire and interviews
- Assessment conducted in 68 districts in Uganda across the regions of Uganda-Central, Western, Northern, West Nile, Eastern, and Karamoja

HIGH-LEVEL FINDINGS:
- Results were categorized as follows:
  » Description of CHWs (sites assessed, categories of the CHW, location, and functions)
  » Support (training, incentives, skills and career development, and supervision)
  » Management (recruitment, monitoring, tracking, and regulations)
- The community health workforce is a "formidable force both in numbers and function"
- Uganda has both generalist and specialist categories of CHW
- The assessment elicited more weaknesses than strengths in areas such as coordination, standardization of training materials, selection and recruitment process, CHW expectations, and tracking CHWs at national and district levels

RECOMMENDATIONS FOR GOVERNMENT:
- Enlist health workers/supervisors to guide VHT selection
- State VHT roles and responsibilities, including working conditions, from the time of selection
- Harmonize all VHT data tools and registers
- Develop plan for replacement of VHTs who have dropped out
- Equip VHTs with the required tools and equipment
- Motivate the CHW through incentives such as: monthly remuneration, refresher training, regular supply of logistics etc.

CHEW TRAINING IN PILOT DISTRICTS

In preparation for anticipated CHEW training, Pathfinder supported MoH in a number of readiness activities, including:[37]

- The training of 1,640 CHEWs, including 154 from Mayuge District. A workshop was organized in December 2018 to orient 26 MoH National Tutors to train CHEWS. Pathfinder printed 1,640 CHEW resource books, job aids, training materials, and training site assessments. The MoH is prepared to conduct CHEW training, though it remains unapproved.

- An assessment of CHEW training facilities in the 13 pilot districts using the MoH assessment tool in January 2019. The CHEW readiness study was done in collaboration with the MoH Community Health Department. The study was designed to assess the preparedness and ability for pilot districts to implement the CHEW strategy and their capacity to conduct CHEW training. Among the key findings:

  - About 80% of District Health Team members had heard about CHEWs, but in many districts there was some confusion between VHTs and CHEWs. Sensitization was recommended to address this.

  - Of the 52 sites, only 32 (61%) were suitable for CHEW training. The study recommended three training approaches: residential, non-residential, and a combined approach. The residential approach was the most expensive approach with 95% of the costs attributed to both accommodation and meals for participants. The study recommended that MoH renegotiate with training institutions to bring down the cost. In addition, the report provided recommendations and actions for each district to improve their readiness for the program. MoH also used the findings from the report to engage Health Development Partners to advocate for CHEW training financing.

- The selection of CHEW candidates in the 13 pilot districts in April 2018. Meetings were held in all 13 districts with respective district stakeholders. Support was provided to districts to mobilize and formulate selection committees.

This resulted in 1,640 CHEW trainees being selected. A database exists in MoH.

Amref Health Africa also supported the operationalization of the CHEW strategy in Uganda through their Health Systems Advocacy Partnership Project (from 2016 to 2020)[40] and supported the CHEWs training curriculum.[41]

GLOBAL CONFERENCES

Support from the ICH investment enabled the MoH and community health stakeholders in Uganda to engage with a larger global network at various forums, including:

- The Institutionalizing Community Health Conference in March 2017 in Johannesburg, South Africa.[42] Action areas that came out of the meeting included 1) the need for increased governance, 2) a CHEW policy to take a Community Health System perspective, and 3) the development of a roadmap to institutionalize community health systems.[37]

- The Fifth Global Symposium on Health Systems Research in Liverpool, UK, in October 2018.[43] The MoH presented a poster entitled, "Supporting Renewed Government Commitment to Community Health in Uganda: Pathfinder International's Approach to Integrated Systems Strengthening for Community Health Extension Workers." The poster highlighted the role of community participation in the development and implementation of the CHEW program and lessons learned from the CHEW pilot activities in Mayuge.[37]

- The Second International Symposium on Community Health Workers in Dhaka, Bangladesh in Nov 2019. The ICH partnership and the Uganda MoH delegation contributed to the global learning agenda by presenting on the key policy processes, learnings, and challenges of NaCHLII and the Mayuge District Coordination projects. The team also conducted a learning visit to Matlab, a learning lab near Dhaka, to share experiences in community health, learning agenda developement, and government health leadership.

COMMUNITY HEALTH ROADMAP

Despite initial challenges to the CHEW strategy, the MoH, with support from partners and donors, continued to express commitment to community health. Even in the absence of a new community health strategy, local stakeholders and partners were able to continue making progress—for example, by translating hard-earned lessons into several key initiatives, including the Community Health Roadmap—and focus strategic priorities.[12]

The Roadmap has support from various organizations such as USAID, UNICEF, The Rockefeller Foundation, and the Community Health Acceleration Partnership (hosted by WHO Ambassador for Global Strategy, the World Bank, and the Bill & Melinda Gates Foundation). The Roadmap's vision is to "elevate national community health priorities and create a common agenda for investments in community health to strengthen primary health care."[12] This global effort is supporting 16 high-opportunity countries in defining national investment priorities.

In Uganda, the six 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.[12] The priorities are:

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

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, in collaboration with partners, the MoH has worked to advance these priorities by:

1. 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

2. Integrating data systems to feed information from the community level into the national health information management (HMIS/DHIS2) system

3. Hosting stakeholder dialogues around CHW implementation guidelines and multisectoral coordination to avoid the creation of duplicative services. This has led to the development of the National Community Health Coordination Committee

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

The Roadmap goals 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 activities listed above under the program readiness stage of the reform cycle indicate a sustained path to the policy development process, including the mobilization of resources, authorization, governance structures, and leaders.

Opportunities and Next Steps

As the ICH investment is coming to a close in Uganda, sustained investments by USAID and other partners, such as UNICEF and the Rockefeller Foundation, are advancing community health advocacy and policy in order to achieve primary health care services for all. NaCHLII continues to influence the national coordination around community health by developing the terms of reference for the National Community Health Steering Committee and by continuing to advocate for the pilot of the CHEW program.

As this second reform cycle of the CHEWs is currently pending progress toward the launch stage, it is important to recognize and leverage the work and activities that have gone into supporting the previous stages of both reform cycles.

Two key factors have been crucial to the institutionalization of community health at a national level in Uganda thus far: 1) moving towards a systems lens and systems design versus focusing on an individual health worker cadre; and 2) a consistent learning and improvement orientation within the MoH.

For example, with both NaCHLII and the new community health steering committee there has been an emphasis on the community health system as a whole—as opposed to either the VHTs or the CHEWs cadres alone. The learning and improvement orientation of the MoH has been demonstrated by the use of the VHT assessment, the sharing of lessons learned at various forums and conferences, the development of new research, and the creation of NaCHLII. Recently, the President's Emergency Plan for AIDS Relief has asked organizations working in community health in Uganda to standardize VHT payments.

Momentum has been building. Together, these two factors helped restart a new cycle of reform with better governance, stronger coalitions, and missing perspectives from necessary stakeholders.

As the COVID-19 pandemic has highlighted the crucial role that frontline health workers play,[44–48] the framework of the reform cycle can continue to inform the institutionalization of community health in Uganda.

A new Community Engagement Strategy for COVID-19 Response was launched by Prime Minister Ruhakana Rugunda in 2020 and the government has pledged to pay allowances to VHTs. Minister Rugunda has stated: "The investment we are going to do, to pay 100,000 Shillings to one village health worker, the return on investment on that for Uganda, will be much bigger than the investments that we are putting on the roads, the dams and all the other infrastructure we are doing."[49,50]

Additionally, many implementing partners have supported the Government of Uganda, VHTs, and the country's community health system during the COVID-19 pandemic, including:

- Ensuring the continuation of essential health services[45,47,48,51]
- Training on COVID protocols for community health workers and frontline health workers[45,47,48,51]
- Directly providing community health workers with personal protective equipment[45,49,51]
- Strengthening home-based care[48]
- Investigating COVID clusters[48]

As of early 2021, the MoH has indicated support for the revitalization of the CHEW policy and the ways that a CHEW program pilot could help implementation. During a recent presentation, the MoH noted the costs and roles for various ministry departments and proposed partners.[52]

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Appendix A
Learning Agenda Key Questions:

Category	Learning Priority	Existing Learning and Stakeholder Interest
Access to essential medicines	Reduce stock outs and medicine expiration through improved logistics management (community health warehouse)	Procurement approaches administered through RHITES-EC provide good base of knowledge
Leadership/ Governance	1. Improve district and local government leadership for community health programming 2. Establish national and sub-national policy development processes that promote inclusive and effective community health policies and strategies 3. Improve district coordination of community health activities that incorporate existing structures, cadres, organizations, and sectors (e.g., implementation partner (IP) mapping, quarterly review meetings, resource mapping, and partnership frameworks)	Significant base of implementation experience through the USAID SDS and DMC quality improvement and district coordination models as well as lessons from DHT and IP coordination through (throuhg World Vision) Alignment with district and national partner strategic priorities

Health information systems	1. Better harmonize and integrate across various health information systems: harmonized indicators, data collection tools, and reporting processes; integrated various existing data systems and mHealth tools
	2. Regularly collect and effectively use data to inform government and IP activities and decision-making at all levels – national, district, facility, CHW
	3. Data reporting (timeliness, quality, accuracy)
	   3.1. Standardizing routine and non-routine data collection and reporting
	   3.2. Strengthening district management data analysis/use (e.g., strengthening biostatistician capacity and district dashboards)
	   3.3. Making data available at community level
		Significant innovation occurring now: Catchment area planning and action approach (UNICEF); and district dashboards using DHIS2 data and CHW registry (Living Goods)
		
		Significant partner engagement across these topic areas
		
		ntraHealth and development of CHW registry: a major recommendation from the VHT assessment

Service delivery	1. Strengthen relationship between facility, community health workers, and community
	   1.1. Clear roles and responsibility of CHW vs. facility health worker (attitudes and norms)
	   1.2. Linkage and referral completion, inclusive of private sector facilities, where feasible
	   1.3. Catchment area planning and action
	   1.4. CHW registration
	2. Implement and scale multisector models to community health service delivery (e.g., model households, iCCM excellence, and other CHW multisector approaches, such as BRAC and IntraHealth)
		Lessons learned from Model Households pilots in Mayuge
		
		Multisector approaches to community health: BRAC (financial inclusion) and IntraHealth (agriculture, environment, WASH)
		
		iCCM excellence: training methodology; demonstrated within Mayuge district

Health workforce	1. Implement comprehensive and standardized community health worker training (pre-service, in-service): data-driven and based on government identified needs 2. Improve community health worker recruitment and selection 3. Identify and scale fit for purpose incentives (e.g., improve harmonization of incentives, understand link between incentives and motivation, and improve financial/non-financial balance) 4. Supportive supervision and performance management (e.g., guidelines, tools, and processes)	Consistently identified as key topics in major policies and strategies Opportunity to align learning from other ICH countries as well as global (e.g., WHO guidelines) Central to developing high performing community health system and addressing performance gaps

Community Engagement	1. Deploy community engagement and accountability mechanisms
	  1.1. ACHEST community engagement and accountability
	  1.2. Using existing community structures
	  1.3. Community perceptions study design
		Community engagement (ACHEST/AMREF)
		
		Citizens Voice and Action (World Vision)
		
		Lessons from Health Unit Management Committee (Ministry of Health)