THE REPUBLIC OF UGANDA

Ministry of Health

Community Health Extension Workers

National Policy

October 2018

Foreword

Despite major strides to improve the health of the population over the last 10 to 15 years, high morbidity and mortality from preventable causes remains among Ugandans. The major health problems of the country largely arise from preventable communicable diseases, non-communicable diseases and nutritional disorders. Government therefore recognised the need to develop a health care delivery system designed to improve the health status of households, with their full participation, using local technologies and resources as the majority of Ugandans live in rural areas, many of which are remote and lack health services.

In 2001, the Ministry of Health (MOH) developed the Village Health Team (VHT) strategy as an innovative approach to empower communities to participate in improving their own health as well as strengthen the delivery of health services at both community and household levels, however, it did not achieve its objectives. Needless to say, due to a wide-range of factors, the burden of disease from preventable causes, such as, malaria, malnutrition, respiratory tract infections, HIV/AIDS, tuberculosis and perinatal and neonatal conditions remains high. The VHT Assessment commissioned by the MOH in FY 2014/15, indicated gaps in the selection and training of VHTs, their roles and responsibilities, coordination and funding mechanisms, monitoring and evaluation, and inadequate data, all of which have had a bearing on sustainability of the VHT programme.

The programme has proved unable to deliver high impact interventions since it has been hinged on volunteerism as the main pillar. This has caused demotivation and inequitable provision of incentives across the cadre. Furthermore, the majority of VHTs are older, poorly educated, and inadequately perform required duties. The successful provision of community health services requires full-time engagement, which cannot be cost-free. To address the existing as well as the emerging health problems and redress the weakness of the current VHT strategy, the Ministry of Health has developed this Policy to establish a community health extension workers (CHEWs) programme for Uganda in line with the National Health Policy II, which focuses on health promotion, disease prevention, early diagnosis and treatment of disease in a cost-effective and affordable manner within the primary health care approach.

The CHEWs Policy provides a framework for strategic partnerships and increased investments for community health program. It is also in line with the UN general assembly resolution that encourages developing countries to use CHEWs to fill the human resource gaps and improve community health. Furthermore, the policy will guide the planning, implementation, monitoring and evaluation of community health extension work in Uganda.

Having been developed through a wide process of consultations involving different stakeholders, I pledge my full support to the implementation of the policy and equally look forward to the support of all stakeholders in the roll out of the policy.

Hon. Dr. Jane Ruth Aceng
Minister of Health

Acknowledgement

This National Policy on the establishment of community health extension workers (CHEWs) for Uganda is the result of wide consultations with a range of stakeholders at national and sub-national levels. The consultations involved Government Departments, UN Agencies, Development Partners, Local Governments, community-based organisations (CBOs) and Civil Society Organisations (CSOs). The Ministry of Health would like to express its appreciation to all individuals and organisations that have contributed to the development of this Policy. In particular, the Ministry of Health would like to acknowledge the contribution of technical team chaired by Dr. Christopher Oleke for their dedication and commitment to the development of the Policy.

Special thanks go to the Ministry of Health, Top Management, Senior Management, and the Director General.

In a special way, the Ministry of Health extends great appreciations to the under-listed partners for their technical and financial contributions:

GAVI HSS

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WHO

Pathfinder International Uganda

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United States Agency for International Development (USAID)

Living Goods

Makerere University

Malaria Consortium

John Snow International/ USAID Maternal Child Survival Project

Jhpiego

Pace

White Ribbon Alliance

University Research Co., LLC/ USAID ASSIST Project

Intrahealth

List of Abbreviations and Acronyms

CHW - Community Health Worker

CHEW Community Health Extension Worker

HEW - Health Extension Worker

HMIS - Health Management Information System

HPAC - Health Policy Advisory Committee

HSDP - Health Sector Development Plan

HRH - Human Resources for Health

MOH - Ministry of Health

VHT - Village Health Team

WHO - World Health Organisation

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1. Introduction

1.1 Background

In pursuit of Uganda Vision 2040, the health sector aims to ensure a healthy and productive population that effectively contributes to socio-economic growth. Health education, promotion, and disease prevention is a top priority for the country. In Uganda, 75% of the disease burden is preventable. Communities need to be reached out to with comprehensive robust information on disease prevention and health promotion, for both non communicable and communicable diseases. This can be achieved by the consolidation of the Primary health Care System, which is the whole of society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people's needs and preferences as early as possible along the continuum of care from health promotion and disease prevention to treatment, rehabilitation and palliative care and as close as feasible to people's everyday environment. Primary Health Care has three components

a) Meeting people's health needs through comprehensive promotive, protective preventive, curative, rehabilitative and palliative care through the life course by strategically prioritizing key health care services

b) Systematically addressing the broader determinants of health including social economic and environmental factors and individual behavior

c) Empowering individuals and families and communities to optimize their health as advocates for polices that promote and protect their health.

Community Health Extension workers close the gap between communities and the formal Health system. They play an important role in referral, health promotion and disease prevention at community level and their effective involvement leads to better health outcomes.

In 2001, Ministry of Health established the Village Health Teams (VHT) strategy as an innovative approach to empower communities to participate in improving their own health as well as strengthen the delivery of health services at both the community and house hold levels. Despite implementing this strategy for 15 years, the disease burden from preventable causes such as malaria, malnutrition, HIV/AIDS, Tuberculosis, diarrheal diseases and diseases related to poor sanitation and personal hygiene, remains high, thus contributing to the poor health statistics of the country

According to the National VHT assessment in Uganda, conducted in 2014/2015, a number of gaps and challenges were identified in the design and implementation of the strategy namely; Lack of community involvement, insufficient initial and continuing education, lack of a well defined criteria for selection, insufficiencies and inconsistencies in program funding, poor supervision, lack of basic medical supplies and equipment for that level, poor documentation and

reporting, weak referral system and linkage with the health system and lack of standardization of incentives.

A number of countries are already investing in Community Health Workers (CHWs) as one of the strategies to promote public health as well as achieve the health-related SDGs. Such countries have made remarkable progress in addressing the high burden of preventable diseases. Ethiopia, for example, has trained 38,000 (female) Health Extension Workers (HEWs) to focus on maternal, newborn and child health, nutrition, hygiene and sanitation malaria, Tuberculosis and HIV interventions. Tanzania continues to train Health Extension workers as part of the formal health system. Other examples include Malawi, Rwanda etc.

1.2 The 2014 National VHT Assessment[1]

In 2014, the MOH sanctioned an evaluation of the VHT strategy's impact and commissioned a national assessment survey. The overall objective of the assessment was to determine the national status and functionality of VHTs in Uganda in order to improve the planning and delivery of health services to households and communities.

The assessment showed that the VHT strategy has been implemented at varying levels across districts. Funding of the strategy by the government has been gradually reducing since its inception, leaving partners to fund most of the activities. As a result, VHTs receive limited training, mainly focused on the priorities of the donors and implementing partners. Districts have different levels of capacity to coordinate, train, and supervise VHT activities which have been hampered by lack of funds. Coordination of partners and supportive supervision of district health services by the MOH has not been as desired due to funding constraints.

The report recommended a comprehensive overhaul of the strategy including policy formulation, well defined criteria for selection, proper training with the desired content, redefinition of roles and responsibilities of VHTs, and effective coordination structures at the national and district level.

The key recommendations are:

1. There is need to review the whole strategy of VHTs including selection, training, contents, redefinition of roles and responsibilities of VHTs, and coordination structure at the national and district level.

2. Government should have a clear commitment to adequately finance and institutionalise the VHT strategy and ensure regular payments of VHTs for sustainability of the program.

3. A strong VHT coordination structure, as well as clear monitoring and supervision mechanisms, should be established at all levels of government.

[1]National VHT assessment in Uganda, MOH/Pathfinder/UNFPA, May 2015

4. The MOH should establish an accurate database for VHTs at the national level to aid monitoring and supervision of the program. Each district should also be supported to create district specific VHT databases.

5. The MOH should streamline training and refresher courses for VHTs to ensure quality and equity in capacity building for all VHTs and control over VHT activities.

6. Lastly, government and all relevant stakeholders should create a conducive working environment for VHTs. This should include efforts to improve working relationships between VHTs and health workers and supporting economic development opportunities for VHTs.

1.3 Justification for the Community Health Extension Worker Policy

The Government of Uganda is committed to ensure attainment of a good standard of health by all people of Uganda in order to promote a healthy and productive life. Furthermore, Uganda is a signatory of the United Nations Millennium Declaration in 2000, the Ouagadougou Declaration on Primary Health Care in 2008, and the World Health Organisation's Resolution 67/123 on Universal Health Coverage (UHC) in 2012.

The rationale for the development of the Community Health Extension Worker (CHEW) policy is to provide the highest possible level of equitable access to health services for all people in Uganda, in line with the MOH's mission statement. This is also in line with NDP II, which focuses on provision of accessible and quality health care to all people in Uganda through delivery of promotive, preventive, curative, palliative, and rehabilitative health care aimed at realization of Uganda Vision 2040 and Sustainable Development Goal (SDG) 3, ensuring healthy lives and promotion of well-being for all at all ages.

Uganda's health indicators on reproductive, maternal, newborn and child mortality and morbidity remain poor despite the continued investment in the VHT strategy by the Government of Uganda and development partners. During the decade between the establishment of the VHT strategy in 2001 and the 2016 Uganda Demographic and Health Survey (UDHS), the progress on several key indicators has been at best modest. For instance, Uganda has made slow progress in addressing maternal mortality and expanding access to reproductive health (Millennium Development Goal 5). The maternal mortality ratio is 336 maternal deaths per 100,000 live births as per the 2016 UDHS. The need for a new strategy arises from the above-mentioned limitations and weaknesses of the VHT strategy as well as evidence from other countries showing that (i) CHWs can undertake actions that lead to improved health outcomes, if they are carefully selected, appropriately trained and adequately and continuously remunerated, (ii)

institutionalisation is key to the sustainability of CHW strategy[2], and (iii) there exists virtually no evidence that volunteerism can be sustained for long periods.[3]

The CHEWs Policy will set the foundation for the strategy, by describing the vision, mission, key goals and principles, and include the governance, financing, sustainability and legal and regulatory framework for their operations. The strategy will define and expound the standard of training of the CHEWs, define their detailed scope of work, set support supervision guidelines, streamline governance and coordination, and lay out a sustainable financing mechanism**.**

Finally, this CHEW Policy will build on some of the key strengths of the Ugandan health care system, namely its decentralised nature, its pre-existing experience with VHTs, the existence of the National Minimum Health Care Package[4], and the free health services in the public sector[5].

2. Vision, Mission, Goal, and Guiding Principles

2.1 Vision

A healthy and productive community that actively participates in promoting their own health.

2.2 Mission

To establish an effective and sustainable community health structure that empowers communities to take responsibility for improving their own health for wealth creation.

2.3 Goal

To establish and strengthen the CHEWs strategy as an official link from the community to the national health system in order to ensure equitable distribution of essential community and household-centred health services.

2.4 Guiding Principles

Integration **-** The CHEWs will be the focal point for community mobilisation to access and utilise available health services holistically.

Equity and universal access to health **-** The activities of CHEWs will benefit all members of the community, with special focus on the poor, vulnerable, most at risk, disabled, and the hard to reach populations.

[2]Two of the most successful programmes are the Ethiopian Health Extension Workers Programme and the Brazilian Family Health Programme, which have integrated CHWs into health services and institutionalised community health committees as part of municipal health services to sustain social participation.

[3]World Health Organization, Community health workers: what do we know about them?, The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers, January 2007.

[4]The National Minimum Health Care Package includes (1) health promotion, environmental health, disease prevention, and community health initiatives, including epidemic and disaster preparedness and response; (2) maternal and child health (MCH); (3) prevention, management, and control of communicable diseases; and (4) prevention, management, and control of non-communicable diseases.

[5] The Government of Uganda abolished user fees in all public facilities in 2001.

Honesty and social-accountability- The CHEWs will perform their roles in a transparent manner and at all times address the needs of the local population. In executing their duties, the CHEWs will be the link between the communities and the formal health care system and will be accountable to both parties.

Gender equity - The CHEW strategy will be responsive to equal opportunity in accessing and utilising the available health services. CHEWs will also encourage active participation of males and females in discussing the issues that affect their health with the view of coming up with solutions.

Ownership and sustainability- The CHEWs strategy will actively promote community participation and involvement in planning, delivery, utilisation, and ownership of health services.

Evidence-based/ interventions- The operation of the CHEWs strategy will be based on scientifically proven evidence.

3. Priority Areas, Policy Objectives, and Strategies

3.1 Policy Priority Area I: Human Resource Development and Management

In Uganda, more than three quarters of the burden of disease is due to preventable causes. The Health Sector will build the capacity of CHEWs to effectively empower communities to prevent diseases and promote health.

Specific Policy Objective

To establish, train, and deploy adequate and competent CHEWs for the delivery of quality, preventive, promotive, and selected basic curative health services at the community level.

Policy Strategies

- Develop standard operating procedures for the CHEWs
- Training of the CHEWs
- Recruit, deploy, and retain the CHEWs (motivation)
- Provide tools, equipment, and supplies for CHEWs
- Establish effective monitoring and supervision systems
- Establish regulation
- Provide equitable remuneration

3.2 Policy Priority Area II: Governance and Leadership of Community Health Extension Workers

Streamline the governance and leadership structures of CHEWs at National, District, Sub-county, and Parish level.

Specific Policy Objective

To develop clear governance and leadership structures of CHEWs in line with the decentralised health care delivery system.

Policy Strategies

- Institutionalise the CHEW in the existing community structure
- Streamline reporting and supervision
- Adopt Public Private Partnership (PPP) approach
- Streamline coordination and inter-sectoral collaboration

3.3 Policy Priority Area III: Community Involvement and Engagement

Strengthen community participation and involvement in decision-making and implementation processes to promote empowerment, self-reliance, responsibility and ownership for health actions.

Policy Objective

To ensure that communities, households, and individuals are empowered to play their role and take responsibility for their own health and well-being and to participate actively in the management of their local health services.

Policy Strategies

- Provision appropriate and timely health information to individuals and communities to facilitate skills development and informed decision making.
- Establish partnerships between the communities, CHEWs, and health facilities.
- Create and sustain community dialogues to motivate, encourage, and mobilise communities for health actions.
- Enhance information, education, and communication about health and other development issues to create understanding with community.

3.4 Policy Priority Area IV: Multi Stakeholder Coordination and Collaboration

Strengthening multi-sectoral coordination and collaboration to promote co-operation and networking in addressing the diverse nature of the determinants of health.

Policy Objective

To strengthen coordination and collaboration between government and non-governmental actors in the implementation of CHEWs strategy.

Policy Strategies

- Support national, district, and lower level coordination bodies to provide oversight and guidance to CHEW strategy implementation.
- Ensure stakeholders work with and through the existing health institutional arrangements to avoid creation of parallel services and/or mechanisms.
- Set standards and guidelines for engagement in the CHEW strategy.

3.5 Policy Priority Area V: Financing the Community Health Extension Worker Strategy

CHEWs will be institutionalised in the formal health care delivery structure and paid a consolidated allowance.

Policy Objective

To mobilise financial resources for implementation of the CHEW Strategy.

Policy Strategies

- Develop a costed implementation plan.
- Mobilise resources from Government, Development Partners, Private Sector, and the Community.

3.6 Policy Priority Area VI: Monitoring and Evaluation

Monitoring and evaluation are integral and important components of the CHEW strategy and provide information for both technical and managerial purposes, and to inform policy.

Policy Objective

To develop a monitoring and evaluation framework for the CHEW Strategy.

Policy Strategies

- Develop a Performance Monitoring and Evaluation Plan.
- Develop data collection tools in line with HMIS.
- Develop indicators and targets for Monitoring CHEW Performance.
- Streamline the reporting of key performance indicators for the CHEW strategy, in line with HMIS.
- Develop and maintain an up-to-date medicine, supply, and other equipment inventory for CHEWs.

4. Implementation Arrangement

The CHEW policy shall be implemented as an integral part of the National Health Policy II following the decentralisation arrangement of the Government of Uganda and in line with the Public-Private Partnership approach. Oversight will be provided by the Top Management Committee, Health Policy Advisory Committee (HPAC), National Coordination Committee, and Senior Management Committee. The CHEWs Strategy shall be implemented within the broader framework of the Health Sector Development Plan (HSDP).

Within the MOH, the CHEWs strategy is managed by a Community Health Division under the department of Community Health. CHEWs will be managed at National, District and Community levels; with different roles for all stakeholders in the Public, Private, Faith-Based Organisations and Civil Society. At the national level, responsibilities include resource mobilisation, development of policy, standards and guidelines, technical support, planning, budgeting, advocacy, training and social mobilisation, surveillance and research. The CHEWs

strategy will be monitored through a data flow mechanism in line with HMIS and other programmatic approaches.

At the district level, CHEWs will be managed and supervised through the existing Local Government structures; the District Health Officer will have the overall responsibility but may assign relevant officers to oversee the operations of the CHEW strategy at even lower levels. Responsibilities include co-ordination of CHEWs strategy, supportive supervision, monitoring, and evaluation.

At the health sub-district level, the In-Charge will have responsibility to oversee the operations of CHEWs.

At the sub-county level, the In-Charge of the Health Centre III will assign relevant officers to oversee and supervise the daily operations of CHEWs.

5. Dissemination

The MOH, local governments, and other stakeholders at all levels shall engage in communicating and disseminating the policy.