IMPACT VERIFICATION AND LESSON SHARE FOR THE PROJECT ON STRENGTHENING COMMUNITY HEALTH SYSTEM THROUGH VILLAGE COVID TASK FORCES IN UGANDA

FINAL PROJECT REPORT

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List of Abbreviations and Acronyms

ACHEST	African Centre for Global Health and Social Transformation
ANC	Antenatal Care
CCHF	Crimean-Congo Hemorrhage Fever
CES	Community Engagement Strategy
CHEWs	Community Health Extension Workers
COVID-19	Coronavirus Disease 2019
DHO	District Health Officer
DPs	Development Partners
e-CHIS	Electric Community Health Information System
ECSA-HC	The East, Central and Southern Africa Health Community
EVD	Ebola Virus Diseases
JICA	Japan International Cooperation Agency
MoH	Ministry of Health
NCHS	National Community Health Strategy
PDM	Parish Development Model
PHC	Primary Health Care
RBF	Result Based Financing
TISC	Technical Inter-Sectoral Committee
TICAD	The Tokyo International Conference on African Development
UHC	Universal Health Coverage
VHTs	Village Health Teams

Executive Summary

Japan International Cooperation Agency (JICA) contracted the African Centre for Global Health and Social Transformation (ACHEST) in May 2022 for Impact Verification and Lesson Share for on "*Project for Strengthening Community Health System through Village COVID Task Forces in Uganda*." This follow-up exercises involved regular visits to the 4 pilot districts of Amuru, Busia, Mukono, and Ngora to monitor progress made in entrenching the District Health System and work of the VHTs in the districts, and ensuring that the activities of the various COVID taskforces established during the COVID-19 pandemic are streamlined into routine community health system activities.

The districts were encouraged to find ways of sustaining these efforts using available local resources and in partnership with other active Development Partners (DPs) in the districts. At the national level, ACHEST continued to advocate for transforming the COVID taskforces into health committees and to use the Community Engagement Strategy (CES) experience to inform the development of the National Community Health Strategy (NCHS). The lessons learned from CES implementation have been shared widely at national and international levels.

This report summarizes the experiences and lessons learned in entrenching community engagement efforts into the national health systems. The collaborative work between ACHEST and JICA has made some positive impacts in the project communities. Key highlights of the outcomes of this project are as follows:

1) The project helped to revitalize and enhance the capacity of the Village Health Teams (VHTs), as well as raise their visibility within the health systems. The role played by the VHTs has been highly appreciated by the Government, DPs, and communities. The VHTs under this project have become a useful resource in their communities, and are now supporting the programs by the Government and implementing partners at the community level. They were very effective in supporting COVID-19 control measures, including creating public awareness about COVID-19 vaccination and Standard Operating Procedures (SOPs). VHTs are engaged in the advocacy and mobilization of households for routine immunization, Antenatal Care (ANC) attendance, Water, Sanitation and Hygiene (WASH) practices, and other

public health interventions. However, in order for them to be effective in doing their work, efforts should be made in equipping them with digital tools, Village Health Registers, Referral forms and medicines, and ensuring that they are adequately trained, supervised, and compensated. The medicines used by VHTs are obtained through the DHO's office from routine national stocks supplies.

2) The project has demonstrated that the engaged and empowered communities can identify various problems that affect them, design appropriate solutions, and use locally available resources to resolve them. For instance, the concept of model homes was quickly accepted and adopted by the communities themselves using locally available resources.

3) The structures put in place to support the COVID-19 response have been adapted in the handling of other health conditions such as the recent Ebola Virus Disease (EVD) outbreaks in Mubende and its neighbouring districts; as well as Crimean–Congo Haemorrhagic Fever (CCHF) outbreak in Amuru district. The VHTs played a key role in creating awareness towards EVD, CCHF, and other health, conducting hygiene awareness campaigns, contact tracing, and alerts, and directing health officials to hot spots.

4) The recently launched NCHS has benefitted immensely from CES, and it is a direct output of the application of lessons learned from the implementation of the CES. ACHEST played a key role in influencing this major policy direction in the country. ACHEST also influenced policy direction for the utilization of VHTs trained under the JICA supported CES Project, who are now widely utilized in the implementation of community health programs by other DPs and the Government.

5) Based on the analysis of the field information collected and shared by VHTs, the performance indicators of healthcare service deliveries have improved across the board in all the pilot districts. This improvement is a result of the efforts of Village Health Committees and VHTs in mobilizing the populations in their community.

6) The experience with the COVID-19 response has brought to light the potential of the communities to take charge of challenges facing them. Sustainability of these efforts

rests in embedding community engagement activities into the district plans, and ensuring that the partners follow the '3 ONES'; namely, One district plan, One implementation arrangement, and One monitoring and evaluation mechanism. Such efforts are already underway, but implementation is hampered by low funding support from the Government and partners. On the other hand, a few health DPs are supporting the district plans and utilizing the VHTs who have become key players at the community level.

7) The legacy of this project is illustrated by the progress made in the 4 districts of Amuru, Busia, Mukono, and Ngora. These districts can be nurtured to become demonstration sites and Centres of Excellence in Integrated People-Centred Primary Health Care, where routine governance of communities is inseparable from the work of VHTs, community development workers, cultural and religious leaders, and civil society. The project has created a strong sense of ownership, self-determination, and social cohesion in the project villages; and has greatly helped to address people's needs for good health. It has also succeeded in raising awareness on the importance of community dialogue to gain consensus over critical matters confronting these communities.

All these lessons and experiences are important lessons that can be utilized for implementation of the existing Community Health Systems in Uganda and elsewhere.

Figure 1: A VHT with a community lady in the model home in Ngora.

1. Introduction

The National COVID-19 Task Force meeting chaired by H.E. the President of the Republic of Uganda decided to roll out the Community Engagement Strategy (CES) for COVID-19 in Uganda, in September 2020. This CES was officially launched by the Rt Hon Prime Minister in October, 2020. The objective of this strategy is that all people in Uganda are aware, empowered, and participating actively in the prevention and control of the outbreak of COVID-19 as both a duty and a right, using existing structures, systems, and resources as much as possible. The goal is to strengthen the existing Community Health Systems for Integrated People-Centered Primary Health Care (PHC) as the National COVID-19 response transitions beyond COVID-19.

The "*National Community Engagement Strategy for COVID-19 Response*" has been implemented through the Technical Inter-Sectoral Committee ((TISC) which was part of the National COVID-19 Taskforce, chaired by Prof. Francis Omaswa, from the African Centre for Global Health and Social Transformation (ACHEST).

With support from Japan International Cooperation Agency (JICA), in June 2021, ACHEST commenced the "*Project for Strengthening Community Health System through Village COVID Task Forces in Uganda*" (herein after referred to as "*JICA supported CES Project*."), and identified the 4 districts of Amuru, Busia, Mukono and Ngora to pilot the implementation of the CES to scale. The project set up the COVID Taskforces at district, sub-district and at village levels. The taskforces met regularly to follow up implementation progress, which was closely supported by the VHTs. Furthermore, VHTs were trained by ACHEST team on home-based care for COVID-19 cases, contact tracing, household mapping, health promotion and reporting with using the village health registries. They were also given skills in community-based surveillance and case detection including deaths, community-based drug distribution, appropriate referral of cases to the nearest health facilities, shielding of vulnerable members, strategic communication, creating awareness for health promotion, and education to gain and hold trust of the communities. They have maintained the village health register system with undertaking data management and reporting, and responded to other health needs as appropriate. JICA provided the necessary tools to support the work of the VHTs. The teams from ACHEST visited the districts every month to closely guide CES implementation during this JICA supported CES Project period.

Figure 2: A VHT taking temperature of a family member prior to COVID-19 sensitization in Busia.

The JICA supported CES Project implementation was closed in March 2022. The district leaders and officials who attended the final project stakeholders' meeting committed themselves to mobilize local efforts towards continuing the work initiated under this Project, and agreed to incorporate the CES activities into the routine district work plans. There was also the opportunity to entrench the CES approach in the Parish Development Model that was enacted by the Government of Uganda in the same year. The officials from these 4 pilot districts expressed the need for continued guidance and some support from ACHEST, JICA and other DPs for an extended period to nurture and ensure that the CES approach is fully anchored into the routine way of work in the districts.

2. Impact Verification and Lessons Share for the JICA supported CES Project

Following the JICA supported CES Project, ACHEST was contracted to continue to follow up the CES activities by the VHTs and COVID-19 Taskforce teams in each pilot district so as to thoroughly examine and verify the impact of the CES approach on the communities and their health promotion efforts. The support from JICA made it possible for ACHEST to continue this verification work. JICA also facilitated ACHEST to share the lessons obtained through the Project, with those devoting themselves to promoting PHC to achieve Universal

Health Coverage (UHC) worldwide, by attending several global and regional conferences and symposiums.

2.1 The outline of the follow-up monitoring for impact verification of the Project

Since May 2022, ACHEST with support from JICA has been monitoring how the districts were using lessons learnt from the CES implementation and scale up of Primary Health Care, by using the structures put in place. The districts were encouraged to find ways of sustaining these efforts, making use of available local resources and in partnership with other active DPs in the districts. In order to achieve this task, every 2-3 months, the ACHEST team visited the districts to monitor what the districts were able to achieve in terms of domesticating Community Engagement for COVID-19 Response to deal with other health challenges.

Specifically, the ACHEST team looked out for:

- Progress made in institutionalizing the CES structures and methods of work into routine operations of the district, sub-district, and village administrative structures. The checklist sought to find out if the District COVID Taskforces, Parish COVID Taskforces and Village COVID Taskforces were still operational, how often they were meeting, and what challenges they were facing;
- Define how the districts were engaging the VHTs;
- Look at how the tools provided by JICA during the CES Project have been utilized (providing insights on the use of cell phones, bicycles, computers, motorcycles, etc.), and the challenges being faced;
- Determine what measures were put in place for the sustainability of the CES activities in the districts;
- Examine the level of utilization of healthcare services in the district; that is to say, are VHTs still engaged in mobilizing the population to utilize the available services?
- Determine the emerging issues in the districts, such as arrangements made for implementing the new NCHS - in other words, how have the districts been attempting to incorporate the CES arrangements into the Parish Development Model (PDM)?
- Find out any opportunities for the districts to negotiate with other DPs for the continuity of Community Engagement for other emerging health conditions; and

- Any other relevant issues.

At the national level, ACHEST continued to advocate for transforming the COVID taskforces into health committees and to use the CES experience to inform the development of the NCHS. During this period ACHEST also developed policy briefs and power point materials for engaging policy and decision makers at national and international levels.

2.2 Key findings of the impact verification

In this section, the experience and lessons learned in entrenching community engagement efforts into the national health systems are summarized . Through the verification, some key findings regarding the impacts on the communities in which the collaborative work between ACHEST and JICA intervened have been identified; as well as a policy brief has been developed (Annex 1), based on the experience and lessons through the CES Project. The policy brief will soon be submitted to Ministry of Health (MoH). The findings through the Project have been summarized and disseminated widely at local and international levels such as during the 8th Tokyo International Conference on African Development (TICAD8) held in Tunisia in August 2022, and at the East, Central and Southern Africa - Health Community (ECSA-HC) – the 13th Best Practice Forum in Maseru, Lesotho in February 2023.

The key findings are as follows:

2.2.1 The roles of VHTs

The JICA supported CES Project helped to revitalize and enhance the capacity of the VHTs as well as raise their visibility within the health systems. The VHTs under this project have become a useful resource in their communities and are now supporting the Government and DPs' programs at the community level. They were very effective in supporting COVID-19 control measures, including creating public awareness about COVID-19 vaccination and SOPs that people should follow in their daily lives so as to prevent the spread of the disease. Furthermore, they are currently actively engaged in the advocacy and mobilization of households for routine immunization, ANC attendance, Water, Sanitation and Hygiene (WASH) practices, and other public health interventions.

ACHEST obtained several data sets from the DHO Teams during various regular interactions with them and the stakeholders meeting in March 2022; which showed general improvements in the Result Based Financing (RBF) indicators over the project period, as seen in Figures 3 and 4 of Ngora district.

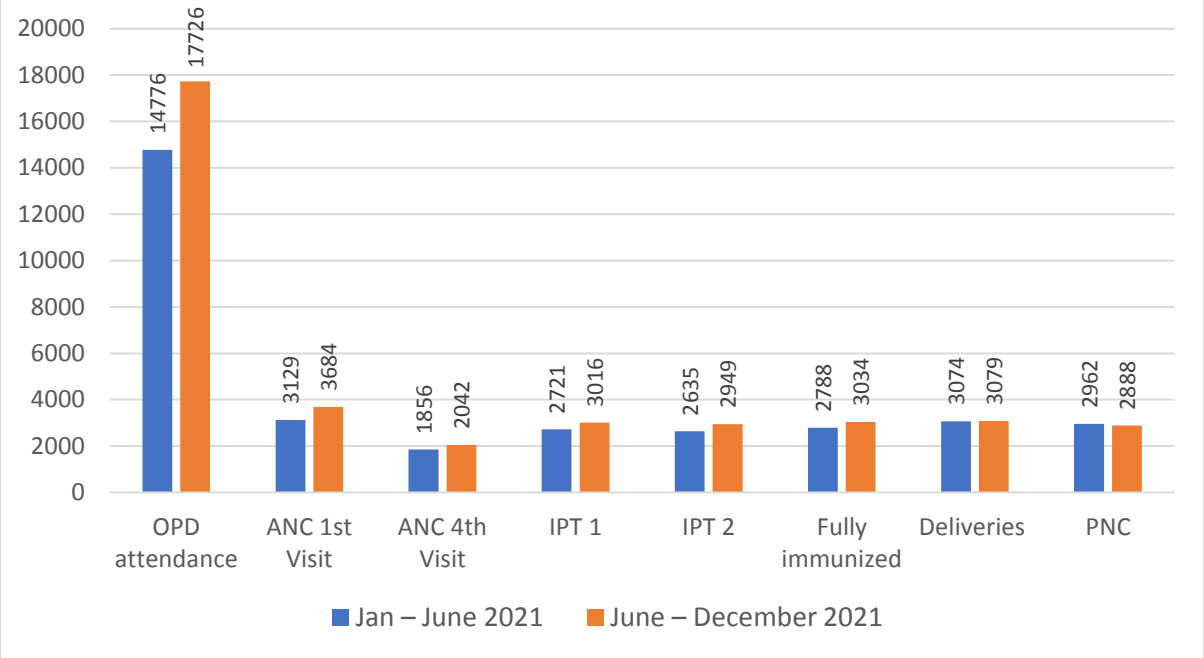


Figure 3: Comparison of RBF Indicators for 6-month period before and after the Project in Ngora district

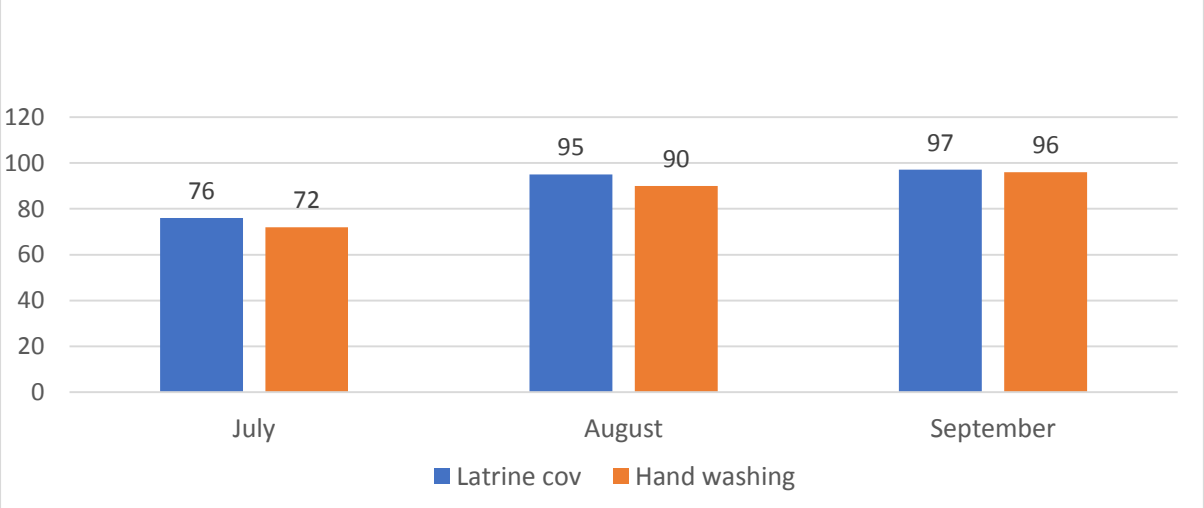


Figure 4: Improvements in Hand washing and Latrine Coverages (%) in Ngora District from July to September 2021

Almost all monitored RBF indicators improved since the JICA supported CES Project started; hygiene and sanitation improved, open defaecation no longer observed, handwashing facilities at more than 90%, and practical handwashing observed in the households. It was also reported from the ground level; increased child births in hospitals/health facilities, reduction in hygiene associated diseases like diarrheal illness, eye diseases and intestinal worms, increased antenatal care attendance with male involvement over the project period,

use of insecticide treated nets, and immunisation coverage improved. All these achievements were attributable to the important role played by VHTs in their communities.

Indeed, not only ACHEST but also other DPs have embraced working with VHTs and shown that Uganda's VHTs have been instrumental in ensuring robust health promotion, disease prevention, and referrals and linkages to the health system for people at the community level, as well as have proven essential for disease surveillance. For instance, the preliminary results of a large-scale randomized controlled trial of Living Goods[1], which is an international Non-Profit Organization and largely supports empowering community health workers, supported the VHTs in Oyam District. This trial shows an estimated 28-30% reduction in Under-5 mortality and a 27% reduction in infant mortality. It also found a 5-fold increase in pregnant women receiving ANC-focused home visit, an 8-fold increase in follow-ups for sick children who had been treated for malaria, diarrhoea, and pneumonia, and better health knowledge among VHTs, which led to increased numbers of children receiving correct treatments for illnesses.

VHTs play a key role in community health system to promote PHC for achieving UHC. Although they recaptured the spotlight for their significant presence in the community amid the COVID-19 pandemic, their performances should be continuously highlighted even for delivery of routine healthcare services and response to other emerging disease outbreaks. Without their daily home visits, less population in the communities would have accessed healthcare services when absolutely needed. Without their accumulative efforts and deep understanding of what has been happening in the communities, diseases detection might be delayed and rapid response would be impossible. Hence, VHTs are imperative at the front line when it comes to routine healthcare services and promotion as well as health emergencies.

2.2.2 Motivating factors for VHTs to continue their roles

VHTs are present in all parts of the health systems in Uganda. Their work, however, has been by large treated as voluntary, despite their enormous time commitment for the work. Nowadays, most incentives for the VHTs are donor-driven, in-kind, inconsistent, and non-

[1] https://livinggoods.org/wp-content/uploads/2022/08/Professionalizing-Ugandas-VHTs-for-Improved-Service-Delivery_A-case-study-of-Oyam.pdf (Accessed on March 10, 2023)

monetary. Indeed, lack of incentives and support to VHTs has been a major challenge to sustain the system since its inception more than 20 years ago.

It is against this background that the JICA supported CES Project decided to pay a facilitation of UGX 100,000 (US$25-30) per month from September 2021 to the end of the project in March 2022 (i.e. from the 4th quarter of 2021 till 1st quarter of 2022). The reason of this decision was to facilitate the VHTs' activities further so that we could realize the impact of our intervention and how important the incentive and motivation to VHTs is for the sustainable community health system.

The facilitation apparently led to the stunning achievement. As seen in Figure 5, the number of home visits by VHTs drastically increased during the time they were incentivized; namely, the VHTs' activities seemingly became more active after the introduction of the facilitation. The change might be affected by the procurement of equipment and the technical inputs and empowerment through the project. In the contrary, it was also observed that some VHTs have been apparently discouraged to continue their activities after the end of the Project when the facilitation was terminated (as can be seen from the drop in the figures in the 2nd quarter of 2022 compared to the previous quarters). We do not have the data for the 3rd and 4th quarter of 2022 to compare the trends.

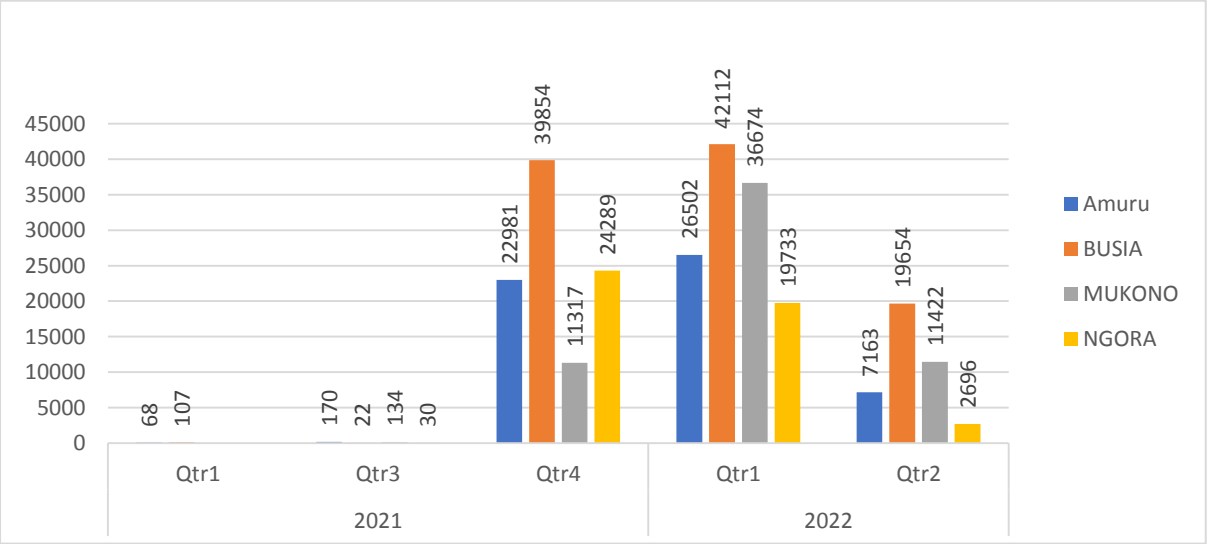
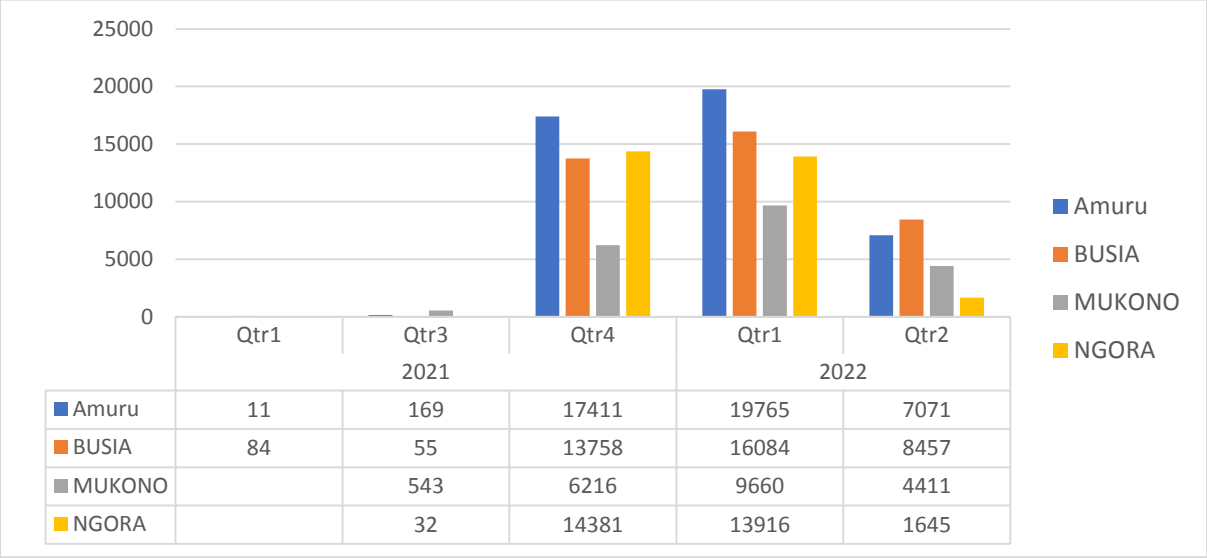


Figure 5:Number of Home Visits by VHTs in the 4 districts

* In terms of the 1st and 3rd quarter of 2021, the figures are probably inaccurate due to lack of information and data submitted.

Due to the increase in home visits by the VHTs, some good impacts were observed, such as an increase in the number of referrals to health facilities (Figure 6). Referral of the populations in the communities when needed is one of the tasks which VHTs are expected to do. Owing to the motivations, namely monthly facilitations given to them, it seems that the VHTs fulfilled their important role as expected such as by identifying the sick in the communities, and encouraging pregnant women and mothers with newborns/infants to go to health facilities regularly for necessary healthcare services. In fact, VHTs' responsibilities are not only referring the populations as needed, but also following up and monitoring the conditions of people who are discharged from health facilities to make sure their health recoveries and returning to a normal life.



	Qtr1	Qtr3	Qtr4	Qtr1	Qtr2
		2021		2022	
Amuru	11	169	17411	19765	7071
BUSIA	84	55	13758	16084	8457
MUKONO		543	6216	9660	4411
NGORA		32	14381	13916	1645

Figure 6: Numbers of Referrals to Health Facilities

* In terms of the 1st and 3rd quarter of 2021, the figures are probably inaccurate due to lack of information and data submitted.

Since the close of the JICA supported CES Project, some of the VHTs who were incentivized by the Project, have received support mainly from the other DPs working in the districts. The payment rates from the DPs are much smaller and not well regulated; plus, the payment is done mostly erratically. For instant, in the Oyam program, VHTs are currently paid a small transport refund of UGX 10,000 (US$3) via the PHC funds and Results Based Financing (RBF) from the Uganda Reproductive Maternal and Child Health Services Improvement Project (URMCHIP)[2], and an extra UGX 20,000 ($6) per month from the partners.

In terms of Mukono district, the work of ACHEST and JICA has been taken over by MoH and other partners including UNICEF, Africa CDC, Nama Wellness, Red Cross Society, and among others. During the EVD outbreak in central Uganda, UNICEF through the MoH and with support from AFENET and Africa CDC, trained and equipped over 200 VHTs and Village COVID taskforces with uniforms, bags, and other essential tools for the EVD response and protection in the district. Besides that, Africa CDC trained over 1,000 VHTs with support of gumboots, umbrellas and bags, and paid an amount totaling to USD 120 per month as facilitation. Lutheran World Federation also had an engagement with VHTs with an allowance of UGX 100,000 per month. This was done concurrently with CDC during the same period of time. Thus, there is no doubt that the incentives including materials and

[2] URMCHIP is a jointly financed project by the Ministry of Health (MoH), the World Bank, the Swedish International Development Agency (SIDA), and the Global Financing Facility.

equipment which could strongly assist VHTs in undertaking their work have been underlined more as a key to successful community health programs.

Training and capacity building of VHTs have been pointed out as another challenging area for achieving resilient and sustainable community health systems. Unfortunately, most government-supported VHTs have quite limited access to regular in-service training, and have never got opportunities to update their knowledge and skills on community health. Moreover, the estimated cost of regular training for VHTs could be overwhelming due to the existence of the quite large number of VHTs throughout the country. Apparently, the Government does not have enough budget and resources to give refresher training to all the VHTs; and this situation is in fact one of the reasons why the VHTs system has been deteriorating.

In the JICA supported CES Project, ACHEST made special efforts to train all the VHTs recruited into the Project in all the 4 Pilot Districts. Nevertheless, we faced the strong demands from the DHOs and District COVID Task Forces for training for other VHTs who were not benefitting from the Project as they are as well invaluable human resources in the communities. In addition, the districts also pointed out that some VHTs have been dedicating themselves for decades and have aged; and new VHTs should now be recruited to sustain the community health system. We assume that this could require further efforts and budget to train VHTs.

The costs and resources for regularly providing training to VHTs could hinder the expansion of community health programs in the country. It is an inevitable issue however if we believe revitalizing the community health system is key for UHC. In Oyam district, the DPs combined efforts and resources to ensure that VHTs got refresher training in Integrated Community Case Management (iCCM) and other Maternal, Newborn and Children Health (MNCH) areas. This cost sharing arrangement eases the burden on the funders whilst ensuring VHTs are well equipped to serve their communities more effectively. This approach would be worth to be adapted to other districts to revitalize their VHTs.

Based on our experience in the JICA supported CES Project, the role played by the VHTs has been highly appreciated by the Government, DPs, and communities. However, for them to be effective in doing their work, they need to be supported. This includes equipping them with digital tools and medicines, ensuring that they are adequately trained and supervised, and compensated. If well capacitated, VHTs are instrumental in linking communities to the formal health system and managing basic conditions at the community level, which can lead to improved health outcome.

Figure 7: VHTs who are well-equipped and ready to go to their communities in Ngora.

2.2.3 Engaged communities can identify problems that affect them

At local level, the Village COVID Taskforces (VCTFs) constitutes various stakeholders, including the LC1 Chairperson and council; together with the VHTs, Parish Chief, community development officers, religious and cultural leaders, school representatives, health facility representatives, civil society organizations, volunteers and private sectors. The VCTFs were engaged in community/public dialogues to fight against the disease. These dialogue meetings used to be held on a monthly basis during the peak of COVID-19 outbreak. The meetings have since scaled down considerably because the districts do not have the funds to sustain them. However, when opportunity arises, this approach is very useful to resolve a variety of social and health related issues affecting the community, including drug abuse among the youth, domestic violence, teenage pregnancies, and so on.

The JICA supported CES Project has demonstrated that engaged communities can identify problems that adversely affect their lives, design appropriate solutions, and use locally available resources to resolve them. It is also much easier to sell new initiatives through these community dialogue structures. For instance, the concept of model homes was quickly accepted and implemented by the communities themselves, using VHTs' instruction and locally available resources. The set up in the model homes showcases effective use of safe water supply, sanitation and hygiene practices (WASH), with clean toilets, bath shelters, drying racks for cooking utensils, rubbish pits, tippy tap handwashing contraptions, well-ventilated kitchens and separate houses for domestic animals. In addition, the compound should be clean and well slashed.

Figure 8: A clean toilet with a tippy tap in a model home in Ngora.

The structures to support the COVID-19 response including community dialogue arrangements were reactivated nationwide at the height of the outbreak. When needed, the structures have been adapted to handle other disease outbreaks such as the recent EVD outbreaks in Mubende and its neighbouring districts, as well as CCHF outbreak in the Amuru district. Indeed, the VHTs played a key role in creating awareness towards EVD and CCHF, and conducted other health and hygiene awareness campaigns, contact tracing, alerts, and directing health officials to hot spots. Thus, engagement of communities and revitalizing the community health structure is the most crucial factor to deal with various health concerns, and it can be facilitated with using locally available resources.

2.2.4 Difficulty of appropriate and timely data collection

Throughout the period of the JICA supported CES Project, the VHTs collected a wide range of data using the smartphones that they were provided with and trained for utilization. The data includes general demographic household data, population reached by VHTs, referrals made for different conditions, health services utilisation (outpatient visits, immunisation, ANC, etc), WASH information, deaths notified, and other health conditions seen. The data was transmitted electronically to Mukura Community Knowledge Centre in Ngora District through the Kobo system. It should be stated here that the Project also provided UGX 20,000 (US$ 6) per month to the VHTs in order to facilitate their data collection.

Regarding the community-based data collection by VHTs, it was discovered through the data analysis by ACHEST that the data submitted to the Knowledge Centre had major gaps and entry errors. Because of limited supervision of VHTs by the Health Assistants, less attention was paid to the quality of the data transmitted. This led to erroneous and abnormal figures reported; for example, the records on the number of deaths reported were too high, and not corroborated by the information obtained from the District Health Office (DHO) teams. As a result, it was rather difficult for ACHEST to utilize the data collected by the VHTs through the JICA supported CES Project.

In addition to the problem of the data quality, poor internet connectivity was another challenge because it did not allow VHTs to do timely submission of records. Although the Project provided some data allowance to the VHTs, they still faced the issue of regularly charging their smartphones as well as identifying and securing the location where they can access the mobile network to send the data to the collection system. Most of the VHTs therefore need to visit a neighbouring health facility or shop to charge their smartphones while using their own money to purchase the data bundles for the internet connection. This situation absolutely discourages them to continue the data collection and sending to the system. During the JICA supported CES Project period and even during the follow-up monitoring activities, many VHTs and DHO teams lamented over this situation and asked for further support.

Through the follow-up monitoring period for the JICA supported CES Project, it became obvious that most of the VHTs supported through the Project have limited know-how to utilize their smartphones. The VHTs were trained in how to utilize the smartphones for data collection at the beginning of the project. But many of them are still less familiar and confident with the devices, which caused the situation that they have not updated the software of the smartphones; which ended in the phones failing to work. The software was finally updated with ACHEST's support during the monitoring visits. It therefore seems there is a danger that the VHTs may in the future give up using their smartphones for collecting data if they do not have enough know-how on any trouble shooting issues in their smartphones.

The JICA supported CES Project demonstrated the great potentials of the VHTs to capture and transmit the data collected from the community to the health facilities and/or DHOs.

The community health information and data collected by VHTs is vital for health authorities to keep monitoring health status of the communities and detect any signs of an outbreak and potential health threats in a timely manner. Besides, the accumulation of health data and information is fundamental for the evidence-based approach in health for reasonable policy making, and effective and efficient practices to quality healthcare services.

Appropriate and timely data collection from the communities has become more and more significant as strengthening the community health system has been one of underlying approaches towards UHC. Recently, the Government of Uganda through MoH has launched the NCHS through which integrated community health service delivery programs are provided with mobilizing VHTs and Community Health Extension Workers (CHEWs). In the meantime, MoH has introduced the electric Community Health Information System (e-CHIS) to some pilot districts, especially for VHTs and CHEWs by providing smartphones and installing applications with support from DPs. The VHTs in Amuru who were supported in the JICA supported CES Project have also been integrated with this development, and currently have started sending the information and data to the e-CHIS dashboard.

It is a fact that most VHTs are likely to have difficulty in collecting the data and information in an appropriate manner with good understanding, without securing the stable internet connection, and using the smartphones due to limited know-how. Amid the rapid expansion of the e-CHIS as a basic tool of data collection from the communities, capacity building of VHTs and sustainable ICT support for data collection will be one of the top priorities for the productive community health system.

2.2.5 Project Sustainability

Scheirer and Dearing3 have defined sustainability of public health interventions as "*the continued use of program components and activities for the continued achievement of desirable program and population outcomes"*. This definition has been adapted by Schell et al4, who consider the element of time and thus define sustainability as "*the ability to maintain programming and its benefits over time"*. Project sustainability therefore connotes the ability of projects which used to be supported through funds, to continue to realize the same benefits even after the end of

[3] Scheirer MA, Dearing JW. An agenda for research on the sustainability of public health programs. AmJ Public Health. 2011; 101(11). 2059-67.
[4] Schell SF, Luke DA, Schooley MW, Elliot MB, Herbers SH, Mueller NB, Bunger AC. Public Health program capacity for sustainability: a new framework. Implement Sci. 2013; 8:1

external funding. Projects that are sustainable can even expand to provide benefits for more periods of time. This will not matter if special support of financial, technical and managerial aspects has been phased out. The assumption is that the project lasts long after outside support is withdrawn.

As far as the JICA supported CES Project is concerned, the key factors for sustainability were greater community participation and strong governance structures in place, with full involvement of local civic leaders, cultural and religious leaders, and finances. Sustaining these efforts mainly rests in embedding community engagement activities into the district plans, and ensuring that health development partners follow the '3 ONES' – namely, *One district plan, One implementation arrangement, and One monitoring and evaluation mechanism*. Although such efforts have already been underway, implementation is still hampered by low funding support from the Government and partners. In the meantime, health DPs have been supporting the district plans and fully utilizing the VHTs who have become key players at the community level. The project has created a strong sense of ownership, self-determination, and social cohesion in the villages where we worked; and has greatly helped to address population health needs. Therefore, we require more robust efforts and commitment from the Government in this regard.

Throughout the JICA supported CES project and even after, ACHEST has also been advocating for integration of the CES activities into other Government programs such as the PDM which will make available resources for social development at the local level and this should provide some additional funding for its operations. There is also a great potential in introducing health insurance scheme at the district level which will further avail some resources locally that can be used to handle some of the funding shortcomings. Presently there are no districts which already have the insurance scheme. Needless to say, any future progress would highly depend on the leaderships of DHOs to introduce and sustain this new system.

The district leaders are all in agreement with these options for sustaining the activities and interventions initiated under this JICA supported CES Project. Above all, remarkably, the new NCHS recently launched by MoH adapted most of its operational plans from the Project and should directly absorb all the activities initiated by the Project. The tools and equipment supplied by JICA under the Project are currently being utilized to support other community

engagement activities. In particular, the MOH and its partners are using mobile phones for expanding the e-CHIS. This sounds a positive step forward, and it would be highly appreciated if the Government could continue to make efforts in line with the need for sustainability by fully utilizing the existing assets accumulated by the previous projects.

2.3 Sharing the experience and lessons learned

Throughout the JICA supported CES Project, and later during monitoring activities for verification of its impacts, various lessons had been identified as mentioned above. Besides analyzing the impact of the Project, ACHEST has been actively engaged in sharing the experience and lessons learned with stakeholders in community health after the end of the Project, by participating in various national and global opportunities to deliver our key messages.

One of the occasions to present the outcomes of the Project and lessons learned was the TICAD 8, which was held in Tunisia in August 2022. Professor Francis Omaswa of ACHEST team was invited as a presenter to the online side event/webinar on "*Re-Imagining Resilient and Sustainable UHC in Africa,"* and presented the key factors and efforts for UHC based on the lessons learned from the JICA supported CES Project. This online webinar was a perfect moment as the presenters were requested to share the good practices in each country amid the COVID-19 pandemic. In Uganda, the good practice shared was in revitalizing of the existing community health system through strengthening VHTs' activities under the National Community Engagement Strategy for COVID-19 Response. Therefore, our achievements and lessons learned in the JICA supported CES Project was greatly highlighted in Professor Omaswa's presentation which drew attention from the participants.

On another occasion, Dr. David Okello of ACHEST team shared lessons from Uganda on Community Engagement for Health & COVID-19 Response at ECSA-HC – the 13th Best Practices Forum in Maseru, Lesotho from 5-9 February 2023. In the presentation, the significance of the roles of community health workers, namely VHTs in Uganda, for not only the emerging outbreaks but also in general health matters was emphasized. It was stressed as well that strong community systems should be recognized as a bedrock to the attainment of UHC.

At the local level, ACHEST and other DPs remain highly engaged in the CES sub-Committee activities. This has guided some of the directions taken by MoH's community health programs and initiatives, where the experiences and lessons learnt during the JICA supported CES Project were appropriately deployed. For sustainability of the achievements of this project, ACHEST advocated to the districts to incorporate the CES activities into the district plans, using a bottom-up planning approach, and integrating with other sectors and DPs. As alluded to already, all the districts in Uganda have initiated their plans to incorporate VHTs in the implementation structures of the Government's blue print on PDM.

ACHEST has shared widely the experience and lessons learned from the targeted districts with other districts in various meetings organized by MoH and DPs. For instance, ACHEST made presentations in meetings organized by Living Goods in Oyam, Mukono, Kalangala, and Mbarara districts; and other joint meetings between MoH and DPs, such as the one held with participants from UNICEF and Living Goods in Serena Hotel, Kampala, which invited the districts who are accelerating community health activities. Other partners working in remote communities in Uganda have taken a keen interest in the experience of ACHEST and have sought to adopt the lessons learned.

Figure 9: Professor Francis Omaswa, the MoH Permanent Secretary and her Commissioners as well as Community DPs in a community health retreat held in Kalangala District.

2.4 ACHEST's continued support to the Government of Uganda in community health and CES approach

ACHEST and its DPs have been engaged in the CES activities throughout the country. For the year ending of 2022, implementation of the e-CHIS platform has taken shape in the pilot districts of Buyikwe, Oyam, and Otuke districts. This new development has been supported by DPs like Living Goods, and the Malaria consortium; whereas for the districts supported by the JICA supported CES Project, mobile phones and other supplies are used for facilitating the collection of household data and reporting directly to the central databases at the MOH through e-CHIS. This could show the momentum for harmonization of DPs' efforts to maximize the impacts even with very limited resource availability.

At the Technical Inter-Sectoral Committee (TISC), ACHEST continues to be active and chairs the bi-weekly meetings of the National Community Engagement Strategy for COVID-19 response. The CES sub-Committee continues to lobby the Government and DPs to reactivate structures put in place during the COVID-19 outbreak. If activated, these will help respond to any health outbreak in the country. The Committee has succeeded in progressively getting the buy-in of other health DPs to implement jointly the e-CHIS which has taken shape in other districts. From now on as well, ACHEST will continue the dedication to enhance the community health systems in partnership with the Government of Uganda and DPs.

In his various deliverables to MoH and DPs, Professor Omaswa has emphasized the fact that individuals and communities are better placed to identify and respond to their own needs. Acknowledging the fact that Community Health is the ''bone marrow'' for the health sector and bearing in mind Uganda's Vision of "A trans-formative Ugandan society from a peasant to a modern and prosperous country within 30 years'' and the Ministry of Health's vision of "A responsive, sustainable health system that is positioned to respond to current and future public health challenges". Professor Omaswa further highlights the need to protect and promote the health and wellbeing of all the people in Uganda. In addition, DPs engaged with ACHEST now appreciate the fact that healthy and productive communities contribute to the socio-economic transformation of the country. These are the central messages of the lessons learned from ACHEST's engagement with the communities in the pilot districts.

Figure 10: Community people enjoying safe water from a borehole in Ngora.

3. Recommendations from the JICA supported CES Project

Going forward to achieve UHC through strengthened and resilient community health systems, ACHEST would like to particularly recommend as follows;

1. The lessons learned from the JICA supported CES Project should be incorporated and utilized during the implementation of the new NCHS.

2. Village COVID Task Forces should become the Village Health Committees and meet regularly for community dialogues.

3. There is need to continue to model the successful practices in the pilot districts under the Project and to expand them to other districts.

4. Appendixes

4.1 Appendix 1: Links to the Publication on community engagement

(1) Professionalizing Uganda's Village Health Teams for Improved Service Delivery: https://livinggoods.org/wp-content/uploads/2022/08/Professionalizing-Ugandas-VHTs-for-Improved-Service-Delivery_A-case-study-of-Oyam.pdf

(2) Scheirer MA, Dearing JW. An agenda for research on the sustainability of public health programs. AmJ Public Health. 2011; 101(11). 2059-67.

(3) Schell SF, Luke DA, Schooley MW, Elliot MB, Herbers SH, Mueller NB, Bunger AC. Public Health program capacity for sustainability: a new framework. Implement Sci. 2013; 8:1

(4) Okello D, Emulu EP, Omaswa F. Inter-sectoral collaboration for universal health coverage at community level. *Africa Health Journal.* 2021; 43(1): 11-13: Accessed at https://africa-health.com/wp-content/uploads/2021/02/AH-2021-01-11-ISC.pdf

(5) National Community Engagement Strategy for COVID-19 response: Accessed at https://achestdatabase.achest.org/sites/default/files/publications/NATIONAL%2BCOMMUNITY%2BENGAGEMENT%2BSTARTEGY%2BFOR%2BCOVID-19%2BBook_2.pdf

(6) Intersectoral Collaboration for health in Uganda; a vehicle for UHC: Accessed at https://achestdatabase.achest.org/sites/default/files/publications/Final%20ISC%20Report%20by%20ACHEST%202020.pdf

4.2 Appendix 2: Policy Brief and Presentations (PPTs)

(1) Policy Brief

(2) Presentation (PPT) for TICAD 8

(3) Presentation (PPT) for ECSA-HC – the 13th Best Practice Forum

AFRICAN CENTER FOR GLOBAL HEALTH AND SOCIAL TRANSFORMATION (ACHEST)

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POLICY BRIEF ON COMMUNITY ENGAGEMENT FOR COVID-19 AND HEALTH RESPONSE IN UGANDA.

Lessons from JICA-ACHEST PARTNERSHIP; 2021 to 2023

Introduction:

Japan International Cooperation Agency (JICA) worked with the African Center for Global Health and Social Transformation (ACHEST) as a Technical Partner to test and model approaches for the engagement of communities in the prevention and control of COVID-19 in Uganda from April 2021 to March 2023. This work was guided by the Sub Committee of the National Community Engagement Strategy for COVID-19 Response which was launched in October, 2020 by the Prime Minister, Rt. Hon. Ruhakana Rugunda. The National Subcommittee operated under the Technical Intersectoral Committee of the National Task Force and was chaired by Professor Francis Omaswa from ACHEST. Four districts in various parts of Uganda, namely, Amuru, Busia, Mukono and Ngora were selected for the intervention.

The Objective is that all people in Uganda are aware, empowered and are participating actively in the prevention and control of the outbreak of COVID-19 as both a duty and a right, using existing structures, systems and resources as much as possible. Empowering individuals and communities is based on the premise that good health starts with, and is created by individuals, their families and the communities, and is supported, where necessary, by skills, knowledge and technology of the professionals. Individuals have the primary responsibility for maintaining their own health and that of their communities.

The strategy was to strengthen the existing Community Health Systems for Integrated People Centered Primary Health Care as the National COVID-19 response transitions to Phase 4 manifested by widespread community transmission in most of the districts of Uganda. Whole of Society Approach through Inter-sectoral Collaboration was employed which has been recognized as the most effective interventions for achieving SDGs, UHC and Pandemic control.

COVID-19 was seen as an opportunity to implement to scale the existing multi-sectoral Community Health Strategy which was first articulated in the National Health Policy and Strategic Plan launched in the year 2000. Uganda will therefore have a strong Integrated People Centered Primary Health Care system for the current COVID-19 response and remain as the foundation of a strong health system and first line of defense against infectious diseases. This approach is expected to accelerate the achievement of SDGs and UHC in

Uganda through enhanced ownership of the health and development agenda by communities themselves.

With reference to COVID-19, this will ensure that infections are minimized or do not occur in the community and if they occur, will enable prompt identification, testing, treatment and rehabilitation as needed.

Methodology:

The National Community Engagement Strategy called for the establishment of Village COVID Task Forces at every village in Uganda led by the elected LC1 Chairperson and comprising, Community Health Workers known as Village Health Teams (VHTs), cultural and religious leaders, representatives of other sectors. These are supported and supervised by the Health Assistants and health facility staff at the nearest Health Center III. They were linked to the District health system and reported to the District COVID Task Force and shared data with the Health Statistician. The VHTs received additional training and were provided with a tool kit for 160 VHTs per district including a back pack, a reflector jacket, bicycle, smart phone, first aid box, temperature gun, umbrella, rain coat and gum boots. They also received an allowance of UGX 100,000 (one hundred thousand only) per month.

The role of the VHTs included the following activities:

1. Community based surveillance and case detection including deaths.
2. Community case management including supporting self-isolation, community-based drug distribution and referrals as appropriate.
3. Community contact tracing and reporting.
4. Community shielding of vulnerable members.
5. Strategic Communication, creating awareness, information and education to gain and hold trust of the communities as well as promoting household hygiene and sanitation.
6. Maintaining the Village Health Register on households, data management and reporting.
7. Responding to other health needs as appropriate including maternal and child health.

The Village COVID Task Forces met regularly for community dialogue where they discussed local issues with roll out of implementation of the Community Engagement Strategy and identified problems and agreed local solutions. ACHEST staff visited each district initially every month and later every two months to receive progress reports and provide support supervision and encouragement.

Results:

1. The key result of the intervention was to demonstrate that empowered and organized communities have capacity to own and take charge of their own health.

2. Reports from the health facilities indicate that diarrheal and other water borne diseases are no longer seen at the health facilities.
3. There is an increase in the number of women attending Antenatal clinics and coming to deliver at health facilities as well as taking the use of modern family planning services.
4. Household hygiene has improved with many households achieving minimum standards for model homes.

Challenges:

1. The youth particularly boys in the communities are engaged in idleness and consumption of alcohol and drugs.
2. Payment of allowances for VHTs was implemented for one quarter of FY2021/22 and then stopped. There is a string call to have at least one VHT per village to get paid allowances to allow then to devote more time to their work.
3. Male participation in supporting their spouses to attend antenatal and delivery services is too low. This leaves the women to struggle on their own without male support.
4. VHTs need regular supply of Referral forms and support supervision from the Health Assistants.
5. VHTs should be represented at the Parish Development Committees and be part of PDM

Recommendations:

1) The lessons learnt from this project should be incorporated and used during the implementation of the new National Community Health Strategy.
2) Village COVID-19 Task forces should become the Village Health Committees and meet regularly for Community Dialogue.
3) There is need to continue with modelling the successful practices in the current project districts and to expand to new districts.

Community Engagement for COVID-19 in Uganda

Lessons for UHC in Africa

TICAD8 Side Event
25.08.2022
Francis Omaswa
ACHEST

National Community Engagement Strategy for COVID-19 Response

- In September, 2020, National Taskforce (NTF) for COVID-19 presided over by the President of Uganda established Community Engagement Strategy (CES) for COVID-19 Response.
- The National CES Sub-committee of the NTF appointed comprising: MoH, MoLG, JLO, GLSD, MoES, CSOs, HDPs.
- CE Strategy launched by Prime Minister 20.10.20
- The CES Sub-committee meets weekly. Chair Francis Omaswa

CES Strategy & Objective

- Strengthen the existing Community Health System for Integrated People Centered Primary Health Care
- Ensure that infections are minimized in the community.
- Enable prompt identification, testing, treatment and rehabilitation as needed in communities.

- **Objective**: All people in Uganda aware, empowered and participating in the prevention and control of COVID-19 as both a duty and a right, using existing structures, systems and resources as much as possible

Operationalization of CES

- Government established COVID-19 Taskforces at all levels of local government (District, Sub county, Parish and Village).
- Village COVID Task Forces (VCTFs) mobilized communities, to raise awareness about the COVID-19 and ensure adherence to SOPs.
- Every month VCTFs with Village Health Teams (VHTs) convene a community dialogue to identify local solutions to wide range of issues emerging from the community: teenage pregnancy, GBV, water sources
- Community Health Workers (VHTs) facilitated to work with VCTFs. VHTs visit households respond to other health needs including hygiene. Government provided some equipment and financial support to VCTFs and VHTs
- The VHTs trained to support the village committees: to improve PHC, nutrition, sanitation and hygiene home visits, advocate for model homes, and liaison with the Health facilities.

Structures and Functions by level

Structure	Functions
Village COVID Taskforce (VCTF): LC1 Chairperson and Council with the Village Health Team of five or more members, one of whom will be a full time paid Community Health Worker, Parish Chief, CDOs, Religious and Cultural leaders, School representatives, Health facility representatives, CSOs and Volunteers, private sector	1. Community based surveillance and case detection including deaths, 2. Community case management including supporting self-isolation, community based drug distribution and referrals as appropriate 3. Community contact tracing and reporting 4. Community shielding of vulnerable members 5. Strategic Communication, creating awareness, information and education to gain and hold trust of the communities 6. Maintaining the Village Health Register on households, data management and reporting 7. Responding to other health needs as appropriate
LCII with the Parish Council and Planning Committee, Parish Intelligence officers:	Oversight and support, law and order. Monthly meetings.
LCIII with the Health Assistants, Gombolola Intelligence Officers, Community Development officers, Schools, Health Centers, Agricultural extension workers, CSO, Religious leaders, Cultural leaders	Inter-sectoral collaboration, treatment of illnesses, planning and resource mobilisation
District COVID Task Force, Chair RDC, LCIV County Chief, and LCV Chair, CAO, Constituency Committee and Member of Parliament, with District Planning Committee, DHO and District Health management Team, Information/Communication officers, Religious and Cultural Leaders, Partners	Overall leadership, information and communication, supervision, enforcement, planning, resource mobilization, monitoring, evaluation: Monthly meetings

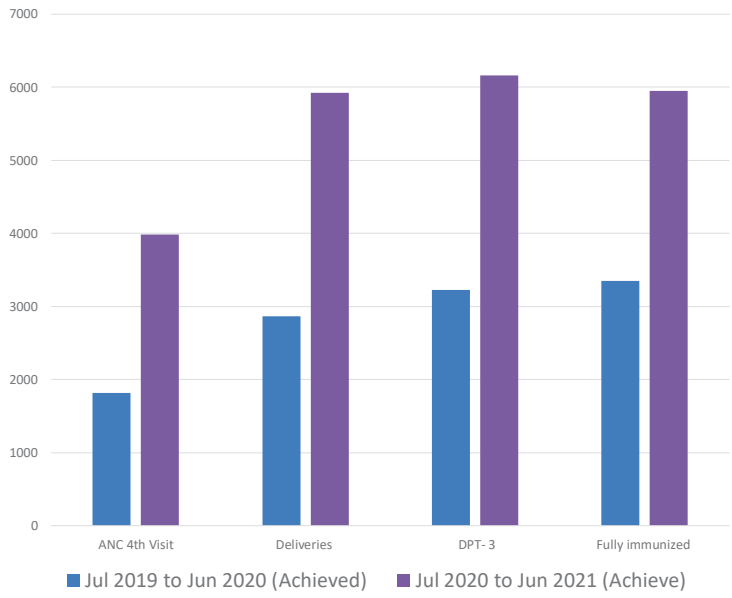
JICA Support

- 160 VHTs per district were trained and equipped with bicycles, smartphones and backpacks containing: a reflector jacket, thermometer, Village Health Register, referral forms, UMAC tapes, first aid box, umbrella, sanitizers, and water bottle.
- JICA paid monthly allowances of UGX 100K and UGX 20K for airtime during Q2 & 3 FY2021/22.
- One laptop for data management for the District statistician in each of the four districts.
- One Desk top computer for weekly data management by the Community Knowledge Center at Mukura, Ngora district
- Two motorcycles were given to each district for supervision

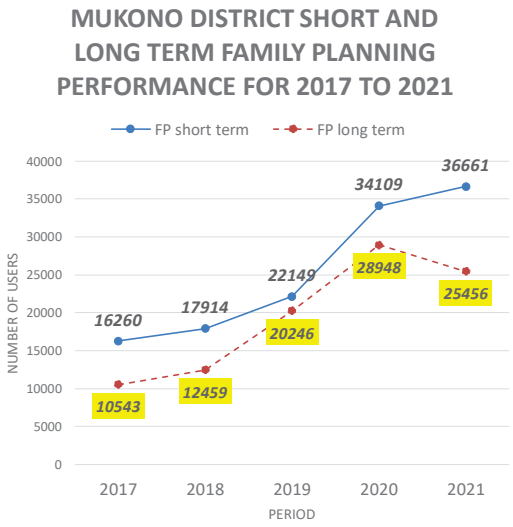
Achievements

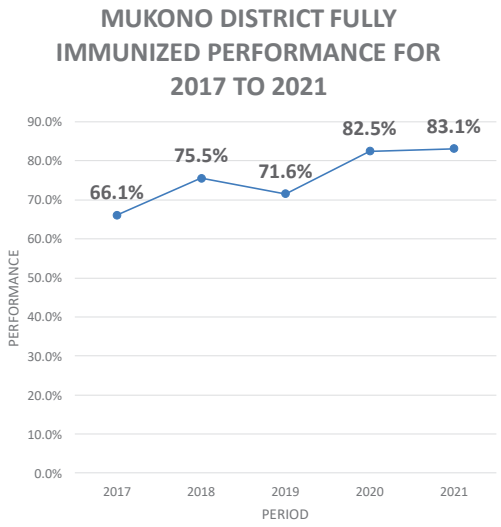
- All monitored RBF indicators improved in 2020/2021 F/Y.
- Home based care and trust built with communities and health facilities. Community Health System strengthened
- Hygiene and sanitation improved in the community
- Model homes with all standard requirement of a house, latrine, kitchen Animal house, rubbish pit, cloth drying line, clean compound, bathe shelter and clean paths promoted by VHTs
- VHTs (CHWs) are able to send reports using electronic data systems
- VHTs (CHWs) have gained popularity, influence and respect

Performance of monitored indicators for Ngora District



Performance Indicators in Mukono District





Home made tippy tap at entrance

Model Home in Amuru

Lessons Learnt

- Organized Communities capable of owning and taking responsibility for their health and achieving Social Cohesion through regular Community dialogue sessions - “Ainapakina”.
- Organized communities improve relations with the health facilities and the performance of the community health system and PHC
- Equipping, training, supervising and paying VHTs (CHWs) is essential for them to perform their roles effectively.
- District health plans should be developed and implemented using bottom-up and “three ones” approach
- District Health performance benefits from regular Supportive Supervision from the Center

Way forward for Africa

- COVID-19; an opportunity to accelerate pursuit of SDGs through Community Health Systems for IPC PHC
- Embrace Inter-sectoral collaboration and Swaps for health
- Empower people and balance health promotion with medical care
- Increase demand for health by sharing responsibility with population
- Establish and Monitor Service Standards by level for Quality Assurance
- Generate and use data disaggregated and share with people
- Strengthen Leadership, Governance and HRH

Community Engagement for Health & COVID-19 Response

Lessons from Uganda

ECSA-HC BPF, Maseru, Lesotho
05- 09 February ,2023

Presented by David Okello

Introduction

Community engagement for health has been advocated since the Alma Atta Declaration over 40 years ago and shown to be effective.

- It has strong potential to achieve UHC in Africa
- Implementation to scale of integrated people-centered and people-led PHC has been limited in most African countries.
- As part of COVID-19 response, Uganda implemented the National Community Engagement Strategy (CES) for COVID-19 response from October, 2020 to date.
- CES was also used to support the control of the recent Ebola VD outbreaks in Uganda

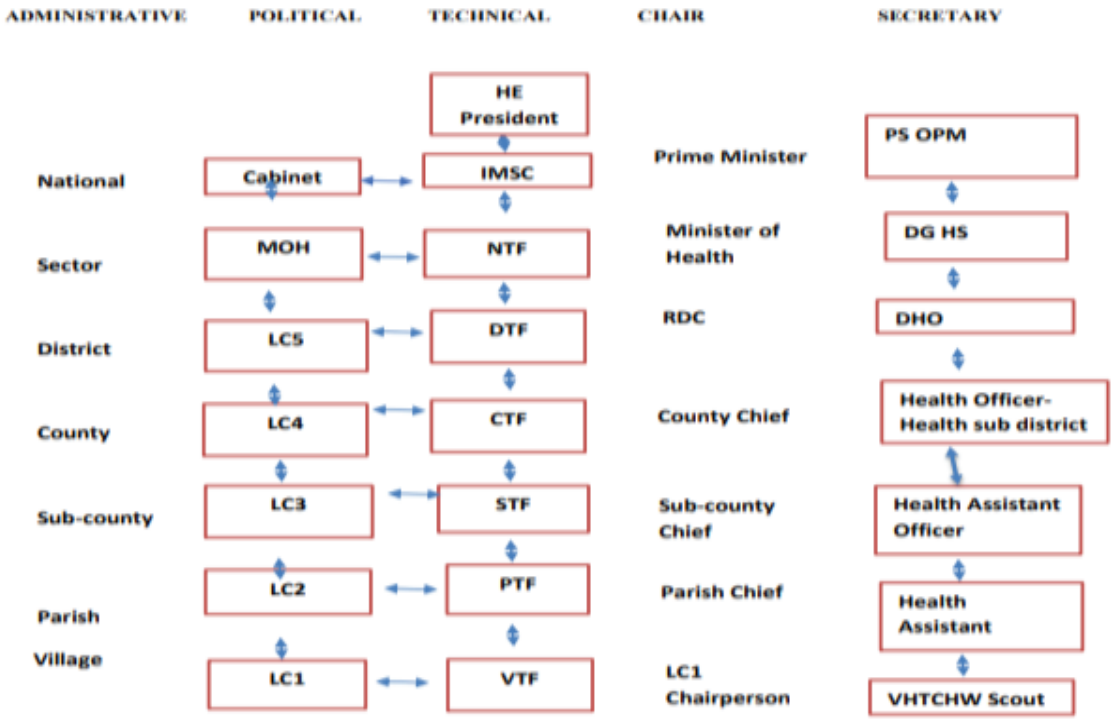
Methodology

- The National CES for COVID-19 Response was launched by RT Hon. PM October, 2020
- Village COVID Task Forces (VCTFs) were established in all districts in the country, aligned to existing governance structures
- VCTFs were led by the elected leaders and membership included;
  - ✓ Community Health Workers known as Village Health Teams (VHTs)
  - ✓ Cultural and religious leaders
  - ✓ Extension workers from community development, agriculture, schools, women groups and opinion leaders
- VCTFs met regularly for community dialogue on health matters and other issues of concern to the community

Methodology cntd'

- VHTs were equipped, trained and paid to visit homes regularly and keep household health registers
  - They educate the population in promoting health and disease prevention
  - Keep household hygiene, model homes and providing home based care for COVID-19 and other illnesses.
- They also undertook case finding, contact tracing and referrals as needed.
- Also served as the link with the health facilities.
- Four pilot districts of **Amuru**, **Busia**, **Mukono & Ngora** followed closely by ACHEST as learning sites with the support of Japan International Cooperation Agency (JICA) and the Government of Uganda.

Implementation Structures



Structures and Functions by level

Structure	Functions
Village COVID Taskforce (VCTF): **LC1 Chairperson and Council with VHT of 5 or more members, one of whom will be a full time paid Community Health Worker, Parish Chief, CDOs, Religious and Cultural leaders, School representatives, Health facility representatives, CSOs and Volunteers, private sector**	1. Community based surveillance and case detection including deaths, 2. Community case management including supporting self-isolation, community based drug distribution and referrals as appropriate 3. Community contact tracing and reporting 4. Community shielding of vulnerable members 5. Strategic Communication, creating awareness, information and education to gain and hold trust of the communities 6. Maintaining the Village Health Register on households, data management and reporting 7. Responding to other health needs as appropriate
LCII with the Parish Council and Planning Committee, Parish Intelligence officers:	Oversight and support, law and order. Monthly meetings.
LCIII with the Health Assistants, Gombolola Intelligence Officers, Community Development officers, Schools, Health Centers, Agricultural extension workers, CSO, Religious leaders, Cultural leaders	Inter-sectoral collaboration, treatment of illnesses, planning and resource mobilisation
District COVID Task Force, Chair RDC, LCIV County Chief, and LCV Chair, CAO, Constituency Committee and Member of Parliament, with District Planning Committee, DHO and District Health management Team, Information/Communication officers, Religious and Cultural Leaders, Partners	Overall leadership, information and communication, supervision, enforcement, planning, resource mobilization, monitoring, evaluation: Monthly meetings

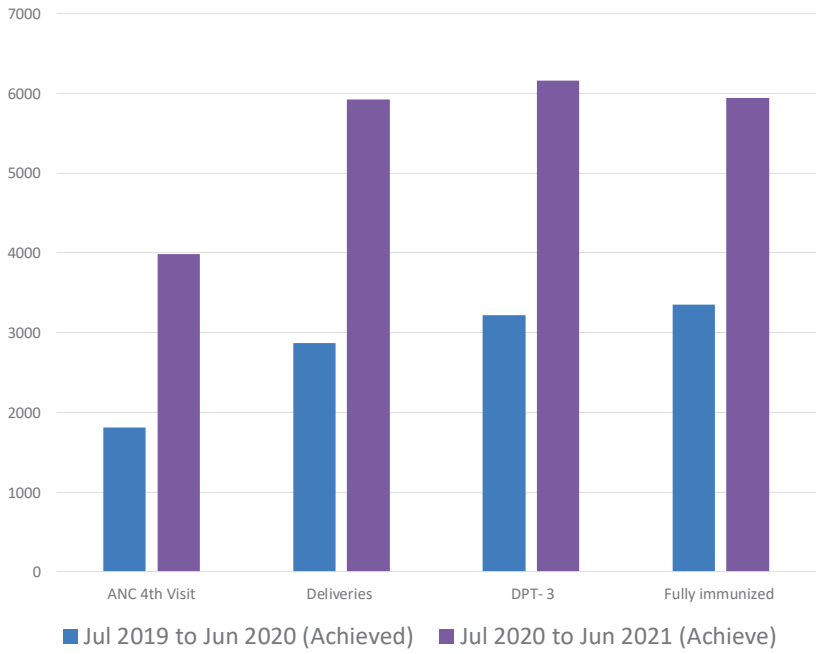
Achievements

- All monitored RBF indicators improved
- Home based care and trust built with communities and health facilities.
- Hygiene and sanitation improved in the community
- Model homes with all standard requirement of a house, latrine, kitchen Animal house, rubbish pit, cloth drying line, clean compound, bathe shelter and clean paths promoted by VHTs
- VHTs are able to send digital reports using smart phones
- VHTs have gained popularity and respect

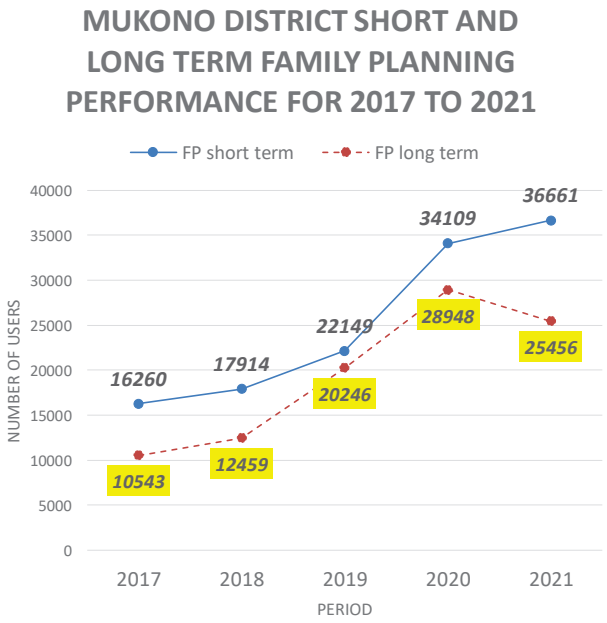
Achievements (Ngora HCIV)

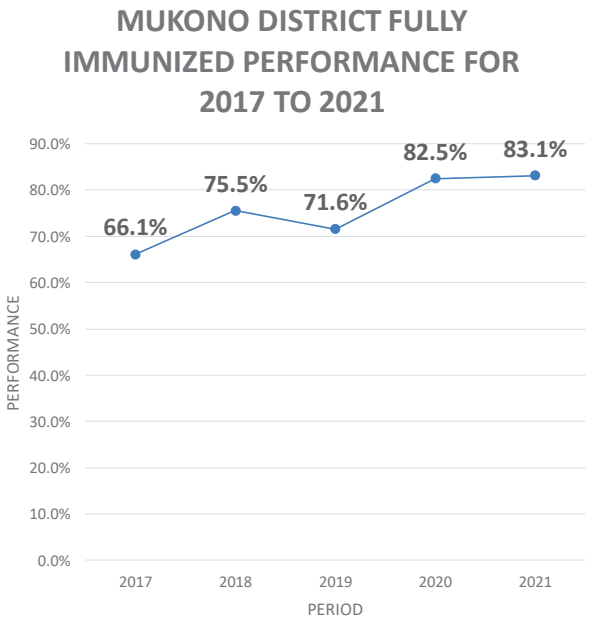
- ✓ Reduction in hygiene associated disease conditions like diarrhea, eye diseases, intestinal worms
- ✓ Increased ANC attendance with more male involvement.
- ✓ Increased hospital deliveries, no reports of TBA deliveries
- ✓ Increased OPD attendance especially for <5 children
- ✓ Improved community surveillance that led to a decrease in Covid cases
- ✓ Improved working relationship between H/Facilities and community
- ✓ Enhanced financial support to H/Facilities thru RBF and IPs

Performance of monitored indicators for Ngora District



Performance Indicators in Mukono District





Home made Tippy Tap at Entrance

Model Home in Amuru

Meeting of stakeholders to share lessons learnt

Challenges

- ✓ Inadequate funding for regular support supervision for district and sub-district level

  (Districts need regular Integrated support supervision from the center)

- ✓ Overwhelming number of patients /clients in the facility due to success of Community Engagement Strategy
- ✓ Only 160 VHTs supported

  Remainder need similar support

- ✓ Limited integration of District Health planning and implementation

Lessons Learnt

- ✓ Organized Communities are capable of owning and taking responsibility for their health including achieving Social Cohesion through regular Community dialogue sessions
- ✓ CES improves relations with the health facilities
- ✓ Equipping, training, supervising and paying VHTs is essential for them to perform their roles effectively

Lessons Learnt cntd'

- ✓ District health plans should be developed and implemented using bottom-up and "three ones" approach
- ✓ CES benefits from regular Supportive Supervision from the District and line Ministries
- ✓ CES is first line of defense against infectious diseases
- ✓ CES responds to other population health needs; maternal and child health, NCDs, sanitation, etc.