ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: UGANDA

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Advancing Partners & Communities

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ACRONYMS

APC	Advancing Partners & Communities
CHEW	community health extension worker
CHS	community health system
CSO	civil society organization
DHO	district health officer
DHT	district health team
FP	family planning
HMIS	health management information system
iCCM	integrated community case management
IUD	intrauterine device
LC	local government
MOH	Ministry of Health
NCD	non-communicable disease
NGO	nongovernmental organization
RMNCH	reproductive, maternal, newborn, and child health
TB	tuberculosis
UNMHCP	Uganda National Minimum Health Care Package
USAID	Unites States Agency for International Development
VHT	village health team
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

UGANDA COMMUNITY HEALTH OVERVIEW

Village health teams (VHTs) operate as the foundation of Uganda's community health system. In 2001, they were introduced as part of a strategy to harmonize and integrate vertical health programs at the village level. VHTs filled a human resource gap, extended health services to households, and mobilized and empowered communities to take part in the health system. However, while the VHT program expanded services to previously underserved populations, morbidity and mortality rates for infectious diseases remained high. In 2014, the country conducted a national assessment of the VHT program and identified serious gaps and implementation challenges including a lack of community involvement, a poor reporting system, weak referral structures, and insufficient funding to support incentive schemes and supplies. In response to the assessment findings, the Ministry of Health (MOH) revamped the entire community health system and introduced community health extension workers (CHEWs) in 2016.

The CHEW program is based on an MOH 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. As a result of this exercise, CHEWs are salaried and the MOH plans to offer them a standardized scheme of additional incentives.

Each community health provider program is guided by its own set of policy and strategy documents. The *Village Health Team Strategy and Operational Guidelines*, along with additional implementation plans, handbooks, and participant manuals, detail the program structure, including VHT roles and responsibilities, supervision, selection, and incentives. The CHEW program is guided by the *Community Health Extension Workers Strategy in Uganda, 2015/16–2019/20*, which outlines structures for integrating the new cadre into the existing health system, and provides general information on roles, selection process, training, and incentives. Additional guidance, including training manuals detailing how CHEWs will operate, is being developed.

Table 1. Community Health Quick Stats

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			
	Community health extension workers (CHEWs)		Village health teams (VHTs)	
Recommended number of community health providers	15,000 CHEWs		*Information not available*	
Estimated number of community health providers	1,500 CHEWs[1]		179,175 VHTs[2]	
Recommended ratio of community health providers to beneficiaries	1 CHEW : 500 households or 2,500 people		1 VHT : 25–30 households or 5 VHTs : 1 village	
Community-level data collection	Yes			
Levels of management of community-level service delivery	National, district, county, sub-county, parish, village			
Key community health program(s)	CHEW; iCCM; RMNCH; national TB and Leprosy Control and HIV/AIDS Control programs; Expanded Program on Immunization.			

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

A number of other strategies and policies guide Uganda's community health system. The 2010 *Second National Health Policy* offers a framework to address a rapidly growing population and changes in disease burden, such as increases in HIV and AIDS and non-communicable diseases (NCDs). It also guides delivery of the Uganda National Minimum Health Care Package (UNMHCP) and emphasizes greater community participation and partnerships to improve health.

Table 2. Key Health Indicators, Uganda

Indicator	Value
Total population[1]	36.6 m
Rural population[1]	80%
Total expenditure on health per capita (current US$)[2]	$52
Total fertility rate[3]	5.4
Unmet need for contraception[3]	28.4%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	34.8%
Maternal mortality ratio[4]	336
Neonatal, infant, and under 5 mortality rates[3]	27 / 43 / 64
Percentage of births delivered by a skilled provider[3]	74%
Percentage of children under 5 years moderately or severely stunted[3]	28.9%
HIV prevalence rate[5]	7.1%

[1]PRB 2016; [2]World Bank 2016; [3]Uganda Bureau of Statistics and ICF 2017; [4]World Health Organization 2015; [5]UNAIDS 2015.

Over the past 15 years, Uganda has developed a series of five-year strategic health and development plans that outline system structures and facilitate collaboration between the MOH, development partners, and other stakeholders. Each plan builds on the previous one to achieve the goals of universal health care, economic growth, and poverty reduction. The *Health Sector Development Plan, 2015/16–2019/20* is the most recent document. It expands upon the *National Health Policy* to provide specific, short-term implementation strategies and objectives, such as promoting intersectional collaboration and improving health infrastructure. The plan outlines roles and responsibilities for health actors from the national to the community levels and sets targets for reducing infant and maternal mortality and increasing vaccination coverage and the contraceptive prevalence rate.

In 2016, Uganda introduced the community health extension worker (CHEW). While other cadres operate on a volunteer basis, the MOH determined that CHEWs should be salaried to support and motivate them to excel at their jobs.

A multitude of other documents provide structure for specific health areas, such as integrated community case management (iCCM), reproductive, maternal, newborn, and child health (RMNCH), tuberculosis (TB), HIV and AIDS, malaria, and immunization.

Civil society organizations (CSOs) contribute to policy development at the national level and support VHT and CHEW program implementation. A wide range of community groups work in collaboration with VHTs and CHEWs to ensure community ownership of health services and encourage use of health centers.

The *CHEW Strategy* highlights policy gaps, including the lack of guidance for VHTs in urban settings. VHT policy documents largely focus on implementation in rural areas, and do not address the challenges that urban VHTs may encounter. Many policies must be updated to accommodate the addition of CHEWs at the village level.

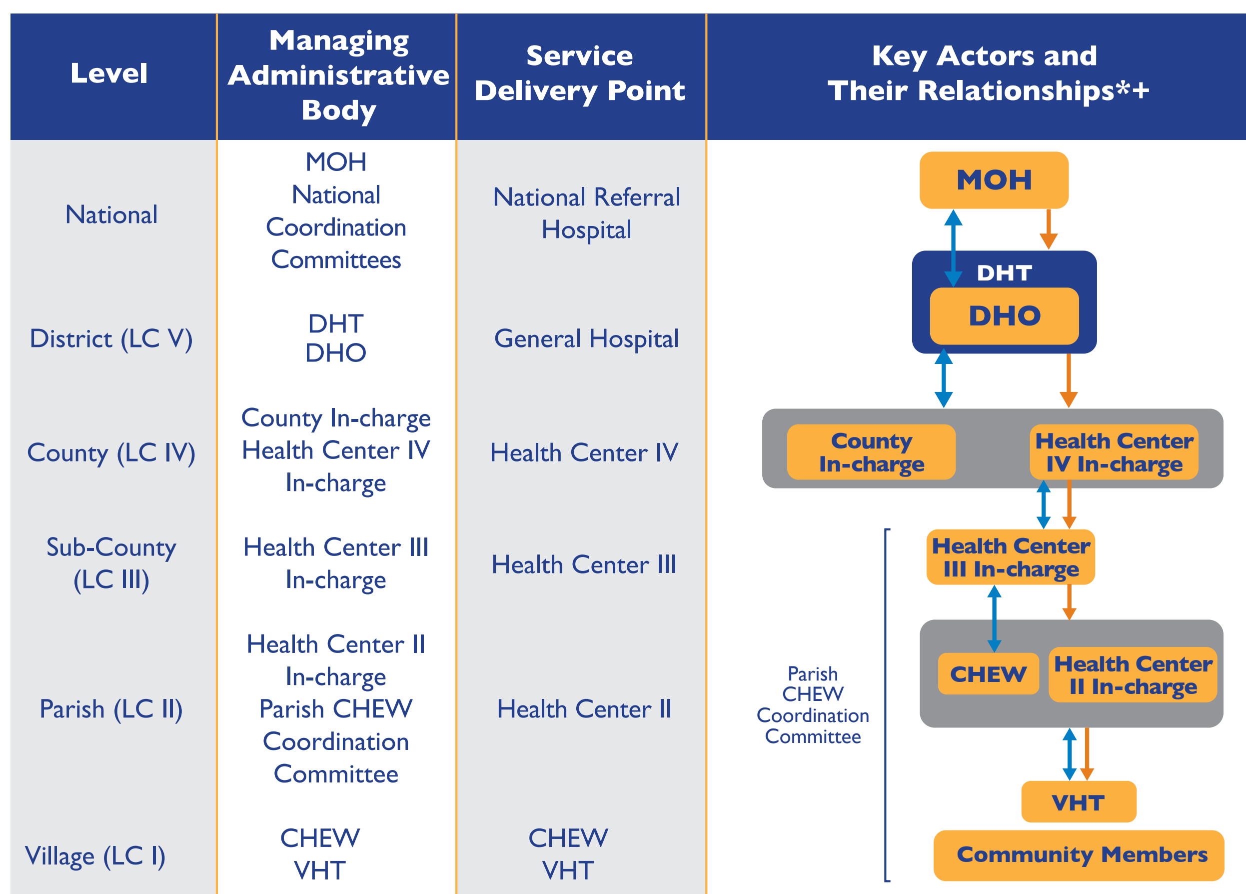
LEADERSHIP AND GOVERNANCE

Community-level service delivery in Uganda is managed and coordinated at the national level and throughout the local government (LC) system, which comprise the district, county, sub-county, parish, and village levels. Figure 1 shows the different LC levels, which are numbered I-V. Nongovernmental organizations (NGOs) provide financial and technical support at all levels of the health system. A coordination committee at each level supports CHEW program implementation and documents and disseminates successes.

- The MOH provides coordination, strategic leadership, and guidance for the health system at the **national level**. It also builds the district capacity, mobilizes resources, monitors and evaluates programs, and collaborates with development stakeholders. The MOH will develop the remaining aspects of the CHEW program, including standards and implementation guides, curricula, and a framework for integrating CHEW data into the health management information system (HMIS). A separate national coordination committee advises the MOH on the VHT and CHEW programs. The committees assist in developing frameworks, strategies, M&E plans, and workplans, and coordinate CHEW and VHT program stakeholders.
- The **district level** is the top tier of the LC system. The district health team (DHT) oversees and monitors program implementation, develops action plans, mobilizes resources, trains district trainers, and provides technical support to the lower levels. A district health officer (DHO), who is part of the DHT, coordinates the CHEW selection process.
- The **county** in-charge oversees health programs. The health center IV in-charge provides supportive supervision, technical support, and capacity building for health center staff at the lower levels.
- At the **sub-county level**, the health center III in-charge oversees the implementation of health programs and supervises health center staff at the parish level. He or she also supervises CHEWs.
- The health center II in-charge at the **parish level** oversees health program implementation, including supporting VHT selection, training, and supervision. CHEWs spend some of their time at the health center II and manage health priorities, develop annual action plans, and supervise VHTs. The parish CHEW coordination committee monitors the CHEW program, mobilizes community resources, and provides administrative oversight to CHEWs. This committee comprises representatives from local government and the community, parish chiefs, CHEWs, and the health center III in-charge. CHEWs also provide services in **villages**, along with VHTs.

Figure 1 summarizes Uganda's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure



Level	Managing Administrative Body	Service Delivery Point
National	MOH National Coordination Committees	National Referral Hospital
District (LC V)	DHT DHO	General Hospital
County (LC IV)	County In-charge Health Center IV In-charge	Health Center IV
Sub-County (LC III)	Health Center III In-charge	Health Center III
Parish (LC II)	Health Center II In-charge Parish CHEW Coordination Committee	Health Center II
Village (LC I)	CHEW VHT	CHEW VHT

*NGOs and development partners provide support at all levels and work in close collaboration with the government in community health planning and implementation.
+A CHEW coordination committee at each level supports the implementation of the CHEW program, and documents and disseminates best practices.

HUMAN RESOURCES FOR HEALTH

CHEWs and VHTs are the entry point for village-level health services in Uganda. CHEWs spend 40 percent of their time at health facilities and the remaining time in the village conducting home visits, disease surveillance, and service delivery for nutrition, RMNCH, FP, iCCM, and WASH.

VHTs are volunteers who conduct home visits and community mobilization in teams of approximately five. They provide similar services to CHEWs but with a stronger focus on health education and promotion.

CHEWs and VHTs train and support model households, which are well-respected families and early adopters of essential health and sanitation practices.

CHEWs and VHTs also support 'model' households, which are respected households and early adopters of essential health practices. The households demonstrate healthy behaviors related to FP and reproductive health, maternal and child health, HIV and AIDS, disease prevention, and hygiene and sanitation and encourage other households to follow their lead. With the support of VHTs, teams of two CHEWs train these households over four days on a package of model behaviors, after which the household "graduates" and receives a certificate. Each team is expected to train approximately 60 model households per year. Table 3 provides an overview of CHEWs and VHTs.

Table 3. Community Health Provider Overview

	CHEW	VHT
Number in country	1,500[1]	179,175[2]
Target number	15,000	*Information not available*
Coverage ratios and areas	1 CHEW : 500 households or 2,500 people Operate in urban, rural, and peri-urban areas.	1 VHT : 25–30 households or 5 VHTs : 1 village Operate in urban, rural and peri-urban areas.
Health system linkage	CHEWs are employed by the MOH, are linked to the health center, and serve as an entry point into the health system.	VHTs serve as an entry point into the health system in collaboration with CHEW and health center staff. They provide integrated health services on behalf of the government.
Supervision	The health center III in-charge provides technical supervision to CHEWs, while the parish CHEW coordination committee provides administrative oversight.	CHEWs and the health center II in-charge supervise VHTs.
Accessing clients	On foot Bicycle Public transport Clients travel to them	On foot Bicycle Public transport Clients travel to them
Selection criteria	Citizen of Uganda Resident of the parish Willing to work in that parish 18–35 years old Minimum of Uganda Certificate of Education (O level) Able to communicate in the local language and English	18 years old Approximately one-third should be female Resident of the village Literate in the local language Good community mobilizer and communicator Dependable and trustworthy Interested in health and development Willingness to work for the good of the community Not a political leader
Selection process	The community recommends two CHEW candidates—1 male and 1 female. The DHO conducts final selection and approval.	VHT selection is by popular vote during a community meeting.
Training	CHEWs undergo 12 months of training, with half of the training period devoted to theoretical sessions and the rest to practical sessions. A series of one-month refresher courses are conducted every two years.	Initial VHT training is 5–7 days. VHTs who will be engaged in more specialized activities (e.g., provision of injectable contraceptives) receive additional training. VHTs undergo regular refresher trainings, the duration of which is determined by the program conducting the training. Typically, a refresher training lasts 2-5 days.

Table 3. Community Health Provider Overview

	CHEW	VHT
Curriculum	The curriculum and training materials for CHEWs have yet to be developed, but policy indicates that they should be trained on human anatomy and physiology; family and reproductive health services; hygiene and environmental health; communicable disease prevention and control; NCD prevention and control; health promotion, education, and communication; community health service management; first aid; disaster and risk management; and vital statistics and data management.	*VHT Participant Manual* (no date); *Village Health Team Members - A handbook to improve health in communities* (no date); *Guidelines for community based provision of injectable contraception* (no date). Topics include recording and monitoring health data; home visits; referrals; community mobilization; communicable and non-communicable disease prevention; RMNCH; nutrition; iCCM; and sanitation.
Incentives and remuneration	CHEWs receive a salary, funded by the MOH and NGOs. The MOH and implementation partners are in the process of developing a standardized package of financial and non-financial incentives.	While VHTs are considered volunteers, the MOH suggests that they receive a minimum monthly stipend of 10,000 Ugandan shillings, equivalent to approximately $5 US, as well as per diems. They receive a variety of non-financial incentives, including t-shirts; umbrellas; bicycles; formal social recognition; certificates; job aides; registers; bags; apprenticeship training at the health facility; engagement and training for different health programs; preferential treatment at the health facility; study tours; and exchange visits with other districts.

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

HEALTH INFORMATION SYSTEMS

VHTs record data in a register on a variety of indicators, disaggregated by age and sex, including births, deaths, vaccinations, FP, home deliveries, and sanitation. They also maintain a village map to track where clients live and identify vulnerable populations. VHTs consolidate data into a summary form and submit it to their CHEW supervisor and the health center II.

Though standardized reporting forms and procedures for CHEWs have yet to be developed, policy indicates that CHEWs should document the services they provide. CHEWs should combine their reports with those from the VHTs and health center II and submit them to the health center III.

Health center III staff compile reports from the lower levels and enter the data electronically into the HMIS. The DHO reviews the data and submits periodic reports to the MOH. The MOH intends to expand the data collection system at the community level to provide more comprehensive data for decision-making.

Health centers at all levels of the system review data from the lower levels, and use them to address problems, improve services, and conduct supervision.

The flow of data through Uganda's health system is represented by blue arrows in Figure 1.

Table 4. Selected Medicines and Products Included in the *Essential Medicines and Health Supplies List for Uganda* (2016)

Category		Medicine / Product
FP	☑	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☑	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☑	Ready-to-use therapeutic food
	☑	Vitamin A

HEALTH SUPPLY MANAGEMENT

VHTs receive a standard kit of supplies that includes a bag, badge, register, health promotion flip charts, IEC materials, job aids, and a copy of the *VHT Participant Manual.* A standard kit of iCCM commodities and supplies, including medicines for malaria, pneumonia, and diarrhea, and diagnostic tools such as a respiratory timer and growth monitoring tape, is also provided.

Commodities for VHTs and CHEWs are supplied through a combined push and pull system. VHTs and CHEWs replenish materials and commodities at the health center II to which they are linked during supervision meetings and as needed.

In the case of stockouts, VHTs can borrow supplies and commodities from VHTs linked to other health centers.

Certain NGOs support VHTs to use a mobile reporting platform called mTrac to collect and submit data about stockouts. However, this mobile health system is limited to a few pilot sites.

Policy directs VHTs and CHEWs to bring medical waste to the health center II, where it is burned, buried, or transported for proper disposal.

The full list of commodities that CHEWs and VHTs provide is not available but Table 4 shows selected medicines and products included in the *Essential Medicines and Health Supplies List for Uganda* (2016).

SERVICE DELIVERY

The UNMHCP comprises essential health services at all levels of the system and is intended for use by both the public and private sectors. With the introduction of the CHEW program, a health extension package detailing the UNMHCP services that CHEWs would provide across a range of health areas was introduced and includes communicable and NCD prevention; FP and reproductive health; hygiene and environmental sanitation; health promotion, education and communication; first aid; and disaster and risk management.

Table 5 summarizes the various channels that CHEWs and VHTs use to mobilize communities, provide health education, and deliver clinical services.

VHTs routinely refer clients to CHEWs, and both cadres can refer clients in need of higher-level care to the health center II or III. The health center II counter-refers clients to VHTs and CHEWs for follow-up.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Health development army and one-to-five networks
Community mobilization	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
	Public gatherings

Using FP as an example, CHEWs and VHTs can provide condoms, oral contraceptive pills, injectable contraceptives, emergency contraceptive pills, CycleBeads®, and information on the Standard Days Method, lactational amenorrhea and other fertility awareness methods. They can refer clients to the health center II or III for the same methods they provide, as well as implants, intrauterine devices (IUDs), and permanent methods.

Table 6 details selected interventions delivered by CHEWs and VHTs according to policy in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	CycleBeads®	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	Emergency contraceptive pills	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	Implants	CHEW, VHT	No	CHEW, VHT	CHEW, VHT
	Injectable contraceptives	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	IUDs	CHEW, VHT	No	CHEW, VHT	No
	Lactational amenorrhea method	CHEW, VHT		CHEW, VHT	CHEW, VHT
	Oral contraceptive pills	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	Other fertility awareness methods	CHEW, VHT		CHEW, VHT	CHEW, VHT
	Permanent methods	CHEW, VHT	No	CHEW, VHT	No
	Standard Days Method	CHEW, VHT		CHEW, VHT	CHEW, VHT
Maternal health	Birth preparedness plan	Unspecified	Unspecified	Unspecified	Unspecified
	Iron/folate for pregnant women[i]	CHEW	CHEW	CHEW	CHEW
	Nutrition/dietary practices during pregnancy	CHEW, VHT		CHEW, VHT	CHEW, VHT
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Unspecified	Unspecified	Unspecified
	Recognition of danger signs during pregnancy	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	Recognition of danger signs in mothers during postnatal period	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
Newborn care	Care seeking based on signs of illness	CHEW, VHT			CHEW, VHT
	Chlorhexidine use	Unspecified	Unspecified	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	CHEW, VHT		CHEW, VHT	CHEW, VHT
	Nutrition/dietary practices during lactation	CHEW, VHT		CHEW, VHT	CHEW, VHT
	Postnatal care	CHEW, VHT	No	CHEW, VHT	CHEW, VHT
	Recognition of danger signs in newborns	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[2]	VHT	Unspecified	VHT	VHT
	Exclusive breastfeeding for first 6 months	CHEW, VHT		CHEW, VHT	CHEW, VHT
	Immunization of children[3]	CHEW, VHT	CHEW	CHEW, VHT	CHEW, VHT
	Vitamin A supplementation for children 6–59 months	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
HIV and TB	Community treatment adherence support, including directly observed therapy	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	Contact tracing of people suspected of being exposed to TB	CHEW, VHT	CHEW	CHEW, VHT	CHEW, VHT
	HIV testing	CHEW, VHT	No	CHEW, VHT	CHEW, VHT
	HIV treatment support	CHEW, VHT	VHT	CHEW, VHT	CHEW, VHT
Malaria	Artemisinin combination therapy	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
	Long-lasting insecticide-treated nets	CHEW, VHT	VHT	CHEW, VHT	CHEW, VHT
	Rapid diagnostic testing for malaria	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT
WASH	Community-led total sanitation	CHEW, VHT	CHEW, VHT		
	Hand washing with soap	CHEW, VHT			
	Household point-of-use water treatment	CHEW, VHT			
	Oral rehydration salts	CHEW, VHT	CHEW, VHT	CHEW, VHT	CHEW, VHT

[1] CHEWs can also provide iron/folate to non-pregnant women and adolescent girls.
[2] VHTs also provide the same de-worming interventions for the general population.
[3] VHTs provide education on and mobilize communities for immunization services. CHEWs administer immunizations to newborns and children, specifically BCG, polio, DPT+HebB+Hib, PCV, rotavirus, and measles.

KEY POLICIES AND STRATEGIES

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