THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

NATIONAL COMMUNITY HEALTH STRATEGY

April 2022

FOREWORD

The government of Uganda is committed to improving community health and people's livelihoods through the provision of basic health services in both rural and urban communities with the participation of the people that live in these areas. Historically, improved community health has significantly contributed to improvements in Uganda's health outcomes, in particular attainment of Millennium Development Goal 4, which was concerned with the reduction of child mortality.

Primary Health Care (PHC) systems are the most effective and efficient approaches to achieving the goals for Universal Health Coverage (UHC).

PHC requires building of strong and resilient systems from the community to national levels, with specific investments towards Community Health. These systems should lead to social accountability and improved health-seeking behaviors.

Recognizing the importance of community health and the need to address its related challenges, the Ministry of Health (MoH) has developed the first-ever National Community Health Strategy (NCHS) for the period of 2021/22-2025/26. This strategy is anchored in the Parish Development Model as well as other national frameworks. It is also intended to ensure that health services are accessible and that a person-centered approach in the provision of healthcare is implemented to achieve significant impact in the short and longer term.

With a stronger community health system, we can all contribute to improved health for all people in Uganda. I therefore, call upon all stakeholders across government ministries departments and agencies, districts, development and implementing partners to take this strategy as the core reference to guide planning, implementing, and evaluating community health services. It is also fundamental in mobilizing resources, as it reflects the MoH's aspiration for attainment of overall health goals in Uganda.

Hon. Jane Ruth Aceng Ocero
Minister of Health

PREFACE

Uganda's community health approach is anchored on the primary healthcare concept and the principles of community empowerment and participation, multi-stakeholder collaboration, and ensuring equitable access to healthcare services. The goal of community health services is to assure improved preventive, promotive, and rehabilitative health services closer to local communities.

The core business of Uganda's first-ever National Community Health Strategy is to guide multiple players towards the delivery of quality, integrated community health services that are affordable, culturally acceptable, scientifically appropriate, and accessible to every household. NCHS will guide the development of an effective community health system that can bring about the attainment of national and international goals, in particular, Sustainable Development Goals (SDGs) 3 of Universal Health Coverage.

This NCHS document will provide much needed guidance to the community health players in different government sectors at the national and district levels in strengthening and scaling up health services within Ugandan communities.

Dr. Diana Atwiine

Permanent Secretary

ACKNOWLEDGMENTS

Uganda's Community Health Strategy 2021/22-2025/26 has been developed through concerted efforts involving many stakeholders that are actively involved with the delivery of community health services across the country.

Our sincere appreciation goes to individuals that participated on behalf of other national stakeholders as Key Informants. In the same vein, we wish to extend our appreciation to representatives from regions and districts around the country who participated in the consultative workshops. Your combined insights helped in the identification of priority actions the country needs to undertake as we strive to improve the health outcomes of Ugandan communities.

In a special way, the MoH wishes to acknowledge USAID - Uganda who provided financial support towards the engagement of a consultant; and UNICEF who supplemented USAID - UHSS to support regional consultation workshops. Special appreciation is extended to other development partners such as Living Goods, Medical Teams International - Uganda, Nama Wellness, and Last Mile Health who contributed both financial and technical resources to support this national effort. Our gratitude also goes to the consultants, Assoc. Prof. Denis Akankunda Bwesigye and Mr. Julius Mukobe who led the process of development and costing of this strategy.

Our appreciation also goes to the officials in the MOH Community Health Department that spearheaded the development and finalization of this important document, and to the entire MoH leadership who provided an enabling environment. MOH constituted a Technical Review Committee that validated this document whose efforts we greatly appreciate. Let me also extend our thanks to the different Heads of Departments and Divisions (Planning, Finance and Policy; Health Information Management; Health Infrastructure; Human Resource Development; Health Promotion, Education and Communication; Directorate of Public Health; Reproductive and Child Health; Environmental Health; AIDS Control; Malaria Control; Tuberculosis; Communicable Diseases, Uganda National Expanded Program on Immunization/ Vaccines and Immunization, among others) who actively participation from inception to eventual completion of this National Community Health Strategy.

Dr. Henry G. Mwebesa
Director General of Health Services

DEFINITIONS OF KEY TERMS

Access: The ability of an individual or a defined population to obtain or receive appropriate health care. This involves the availability of programmes, services, facilities, and records. Access can be influenced by factors such as finances (insufficient monetary resources); geography (distance to providers); education (lack of knowledge of services available); appropriateness and acceptability of service to individuals and the population; and sociological factors (discrimination, language, or cultural barriers) etc.

Advocacy for health: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme. Advocacy also has a role in creating awareness in the minds of the community.

Affordable health services: Health care is considered affordable if, on individual coverage, the cost of the individual's coverage does not exceed 8 percent of the individual's household income.

Community Health: A medical specialty that focuses on the physical and mental well-being/ health status of a defined group of people, or community, and the actions and conditions that protect and improve the health of the community.

Community Health Workers: Frontline public health workers and aides selected, trained, and working in the communities from which they come through a variety of tasks such as home visits, sanitation, first aid, MNCH and family planning activities, TB and HIV/AIDS care etc.

Community: Specific group of people, usually living in a defined geographical area, who share common values, norms, culture, and customs, and are arranged in a social structure according to relationships which the community has collectively developed over a period of time.

Curative care: Medical treatment and care that cures a disease or relieves pain and promotes recovery.

Cadres: Group of people who can lead, organize and train within an organization.

Coordination: Coordination is the unification, integration, synchronization of the efforts of group members so as to provide unity of action in the pursuit of common goals. It is a hidden force which binds all the other functions of management.

e-health: An emerging field in the intersection of medical informatics, public health, and business, referring to health services and information delivered or enhanced through the Internet and related technologies

Equitable health services: Equitable care means delivering care that does not differ in quality according to characteristics of the patient or patient group such as their age, gender, geographical location, cultural background, ethnicity, religion, and socioeconomic status.

Health: The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social wellbeing. Health is not merely the absence of disease or infirmity.

Health for All: The attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life.

Health promotion: Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. It is also the process of enabling people to increase control over the determinants of health and thereby improve their health. Health promotion represents a comprehensive social and political process, which embraces actions directed at strengthening the skills and capabilities of individuals, and actions directed towards changing social, environmental, and economic conditions so as to alleviate their impact on public and individual health.

Health behavior: Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting, or maintaining health, whether or not such behavior is objectively effective towards that end

Health sector Building Blocks: These are the key pillars that operate together to meet the health care needs of the people being served. The six building blocks include: Leadership and governance, Health workforce, Health financing, service delivery system, Health Information Systems, and Supply chain/ medical products.

Health Policy: A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures.

Primary Health Care: Essential health care based on practical, scientifically sound, and socially acceptable methods and technologies made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Management information system: A system of databases designed to process and exchange information to support decision-making as well as implementation, monitoring and evaluation of programmes, activities, and projects.

Medical record: A file kept for each patient, maintained by the hospital (medical practitioners also maintain medical records in their own practices), which documents the patient's problems, diagnostic procedures, treatment, and outcome. Related documents, such as written consent for surgery and other procedures, are also included in the record. In addition to facts about a patient's illness, medical records nearly always contain other information such as clinical, demographic, sociocultural, sociological, economic, administrative, and behavioral data. The record may be on paper or computerized.

Preventive care: Care that has the aim of preventing disease or its consequences. It includes health care programmes aimed at warding off illnesses, early detection of disease, and inhibiting further deterioration of the body.

Quality of Care: The degree to which delivered health services meet established professional standards and are judged to be of value to the consumer. Quality of care is also the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge. This definition of quality-of-care spans promotion, prevention, treatment, rehabilitation, and palliation, and implies that quality of care can be measured and continuously improved through the provision of evidence-based care that takes into consideration the needs and preferences of service users – patients, families and communities (WHO).

Quality Assurance (QA): Standardized procedures, methods, or philosophy for collecting, processing or analyzing data, which is performed on an ongoing basis and aimed at maintaining or improving the appropriateness and reliability of health care services.

Rehabilitation: Defined by WHO as a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment".

Referral: The direction of people to an appropriate facility, institution, or specialist in a health system, such as a health Center or a hospital, when health workers at a given level cannot diagnose or treat certain individuals by themselves, or face health or social problems they cannot solve by themselves.

Strategy: Strategy is a high-level plan of action to achieve short, middle, and long-term desired goals within the context of given constraints and limited resources. Strategies often include a framework of how and when the strategy will be implemented.

Social Determinants of Health: The conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.

LIST OF ABBREVIATIONS/ ACRONYMS

ANC	Antenatal Care
AloS	Average Length of Stay
BOR	Bed Occupancy Rate
CBD	Community Based Distribution
CBOs	Community Based Organizations
CHEWs	Community Health Extension Workers
CHWs	Community Health Workers
CPBF	Community Performance Based Financing
DHIS2	District Health Information System2
DHO	District Health Officer
DHT	District Health Team
e-CHIS	Electronic Community Health Information Systems
EMHS	Essential Medicines and Health Supplies
EmONC	Emergency Obstetric and New-born Care
F-B	Facility-Based
FBO	Faith Based Organizations
FP	Family Planning
FY	Financial Year
HC	Health Center
HEWs	Health Extension Workers
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
HSPR	Health Sector Performance Report
HSSP	Health Sector Strategic Plan
HRH	Human Resources for Health
iCCM	Integrated Community Case Management
LC	Local Council
LLINs	Long Lasting Insecticide treated Nets
MDGs	Millennium Development Goals
MoH	Ministry of Health
M&E	Monitoring and Evaluation
NCHS	National Community Health Strategy
NDP	National Development Plan
NHP	National Health Policy
NHSDP	National Health Sector Development Plan
NCD	Non- Communicable Diseases
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PHP	Private Health Practitioners

PFP	private-for-profit
PNFP	private-not-for-profit
RMNCH	Reproductive, Maternal, Newborn and Child Health
STD	Sexually Transmitted Diseases
SDH	Social Determinants of Health
SDG	Sustainable Development Goals
TVET	Technical and Vocational Education and Training
TCMP	Traditional and Complementary Medicine Practitioners
TBAs	Traditional Birth Attendants
TB	Tuberculosis
UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UNMHCP	Uganda National Minimum Health Care Package
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UHC	Universal Health Coverage
VHTs	Village Health Teams
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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EXECUTIVE SUMMARY

This document is the first National Community Health Strategy (NCHS) 2021/22 – 2025/26, which is one of the initiatives by the Government of Uganda to improve access to primary, promotive, curative, preventive and rehabilitative health care services through a multi-sectoral collaboration. This strategy underscores the importance of community health on economic growth and development and was developed through wide consultations with stakeholders at national, regional and district levels. The opportunities to address Uganda's community health gaps and challenges across the six health building blocks have been mapped, and stakeholders' views on ways to improve on overall health outcomes incorporated in this document. The National Community Health Strategy was also informed by a detailed SWOT analysis of the context of Uganda's Community Health Structure, and the document is strongly aligned to key national health documents such as the third National Health Policy (NHP III) and The Ministry of Health (MoH) Strategic Plan (SP) 2020/21 – 2024/25.

The vision of the NCHS is to increase access to quality, affordable and equitable health services to all and the Mission is to ensure quality, integrated community health services are affordable, culturally acceptable, scientifically appropriate, and accessible to every household through community participation. To achieve these overall goals, the strategy is anchored on strategic objectives/ outcomes guided by the 6 priorities in the National Community Health Acceleration Roadmap that is also aligned to the health systems building blocks. These include:

Outcome 1.1: Increase availability and access to equitable Community health services
Outcome 1.2: Increase coverage of community health services
Outcome 1.3: Strengthen referral and linkages between the Community and health facilities
Outcome 1.4: Increase demand and utilization of community health services
Outcome 1.5: Standardize recruitment, and Terms of Engagement of VHTs
Outcome 1.6: Develop a performance management framework for CHWs
Outcome 1.7: Enhance retention and facilitate a career path for the community health workforce, including nursing, clinical and other health service professional areas
Outcome 1.8: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities
Outcome 1.9: Strengthen MoH leadership and coordination role of MoH
Outcome 2.0: Improve community level logistics management procedures
Outcome 2.1: Strengthen capacity for community supply chain system management
Outcome 2.2: Strengthen logistics information, reporting and utilization of community supply chain data at all levels.
Outcome 2.3: Improve financial planning for community level commodities
Outcome 2.4: Establishing strong stakeholder and political goodwill and alignment of community health to existing health strategies and policies
Outcome 2.5: Increased prioritization of Community health needs at national level.
Outcome 2.6: Strengthen multi-sectoral coordination, planning and implementation.
Outcome 2.7: Enhance capacity of Leaders for effective program planning, implementation, and accountability for improved CH outcomes
Outcome 2.8: Strengthen data utilization for effective decision making to improve

leadership and governance for community health programming
Outcome 2.9: Enhance the capacity of community health workforce to effectively collect, collate and report quality community health data
Outcome 3.0: Develop and implement a harmonized eCHIS
Outcome 3.1: Increase utilization of Community Health Data for decision-making in the community health system
Outcome 3.2: Establish Community-Based Surveillance system
Outcome 3.3: Encourage multi- stakeholder involvement in Monitoring, evaluation and learning to facilitate improvement in community health service delivery
Outcome 3.4: Develop and implement a harmonized eCHIS
Outcome 3.5: Increase utilization of Community Health Data for decision-making in the community health system
Outcome 3.6: Establish Community-Based Surveillance system health system
Outcome 3.7: To enhance effective mobilization of families, communities and citizens for community engagement and participation
Outcome 3.8: To strengthen institutional capacity of state and non-state actors for effective community engagement and participation
Outcome 3.9: To improve Community participation in governance, coordination, collaboration, planning and implementation of community health interventions
Outcome 4.0: To improve health knowledge, attitudes, practices and behavior among all population groups
Outcome 4.1: Manage information ecosystem in the community

The five-year implementation plan contained in this document also provides in-depth information on all recommended activities for each of the identified outcomes. The implementation plan for the National Community Health strategy is dependent on a combined coordination structure of all stakeholders, at national, regional, district and parish level as well as the role of different leaders and development actors. Implementation of this strategy will be integrated in the existing government initiatives like the Parish Development Model to capitalize on existing investments. At National level, the MoH will mainly play a stewardship, coordination and advocacy role, while the district levels will oversee and monitor the different programs and projects being implemented. The community level cadres will provide the actual linkage of communities and health facilities. To achieve the highlighted objectives, within the five-year period, the National Community Health Strategy has been costed following a three scenario (Ideal, Average, and Nominal) with budget totals covering 2021/2022-2025/2026 following the implementation framework. The range of annual costs is between 4 billion to six billion Uganda Shillings. Overall, the NCHS will transform the community health system and create enormous returns on investment for Uganda.

The NCHS document is structured as follows: Chapter 1 introduces community health in Uganda and provides a brief background that informs the development of this document. Chapter 2 summarizes the context analysis at global and national levels and presents key learnings from Community Health strategies of other countries. Chapter 3 presents the Situation analysis and the processes involved to conduct the various stakeholder consultations and Chapter 4 highlights the overall strategies and objectives. This chapter includes the vision, mission, guiding principles, strategic objectives, and their tailored interventions. Chapter 5 offers the implementation framework of the NCHS. Chapter 6

describes the Monitoring and Evaluation and systems for tracking progress towards key objectives. Chapter 7 provides a costed plan for implementation. Chapter 8 enlists the Annexes.

CHAPTER ONE
INTRODUCTION

1.1 BACKGROUND TO THE COMMUNITY HEALTH SYSTEM IN UGANDA

1.1.1 Demographic and health indices

Figure 1: Administrative Map of Uganda

Uganda, a landlocked country in East Africa and has a total area of 241,551 square kilometers, of which the land area covers 200,523 square kilometers with an estimated population of just over 43.7 million people as at mid-2020 (UBOS), with 44% of this population aged 14 years or younger, a sex ratio of 97 females to 100 males, and 74% residing in rural locations (UBOS, 2020) often needing a strong community health system for better health.

The country is divided into 135 districts and 15 cities. which are further sub-divided into lower administrative units namely sub-counties, parishes, and villages. The local government system is formed by a five-tier pyramidal structure, which consists of the village (LC1), parish (LC2), sub-county (LC3), county (LC4), and district (LC5) in rural areas. In the urban areas, the structure includes the cell or village (LC1), ward or parish (LC2), division (LC3), (municipal division, town, or city division (LC3),) municipality (LC4), and city (LC5).

Between 1990 and 2015 (the Millennium Development Goal - MDG era), some critical health indicators showed progress, such as reductions in child mortality, maternal mortality, access to HIV treatment, reduction of malaria incidence and increasing life expectancy, setting stage for attainment of the succeeding Sustainable Development Goal (SDG) targets for 2030.

Table 2 summarizes current health indices in comparison to MDG benchmarks

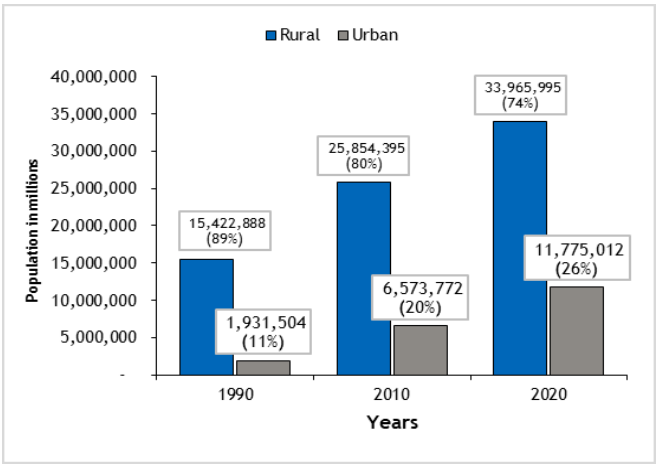
Table 1 Uganda population indicators 2020, and rural urban distribution (UBOS, 2020)

Table 1: Uganda Demographics

Demographic Indicators	Population	(%)
Total population	45,741,000	100%
Males	21,145,259	49.1%
Females	21,920,442	50.9%
Children <1 year	1,593,431	3.7%
Children <5 year	7,450,366	17.3%
Children <18 years	22,867,887	53.1%
Adolescents and youth (10–24	15,116,061	35.1%
Expected pregnancies	2,153,285	5%
Women of reproductive age	20,800,734	48.3%

Source: https://www.worldometers.info/demographics/uganda-

Figure 2: Urban rural distribution



1.1.2 Mortality and morbidity patterns

As indicated in Figure 3, the leading causes of death in Uganda among all ages in FY 2020/21 was malaria (10.9% down from 13.3% in 2019), pneumonia (6.4% in 2021 down from 7.4% in 2019), other neonatal conditions (5.3% in 2021 up from 5.1% in 2019) and anaemia (4.5% in 2021 down from 6.2% in 2019). The concerning digressing trend was noted around the category for "others" (HIV/AIDS, Lower Respiratory Infections, tuberculosis, diarrhea diseases, ischemic heart disease, congenital defects, stroke, road injuries) with notable increase from 64.2% in 2019 to 69.8% in 2021 (MoH - Annual Health Sector Performance report 2020/2021).

Table 2 summarizes mortality indices in Uganda, showing declining trends since 1990. Overall, it is estimated that about 75% of the country's disease burden is preventable and can be addressed through health promotion and disease prevention interventions. Further, the major determinants of health in Uganda include inequalities in levels of income, education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviors, and access to quality health services. As an example, more than half (56%) of children (0-14 years) in Uganda suffer from multiple deprivations (GoU and UNICEF, 2019), including a lack of adequate basics such as, health care and education, social and family life, clean and safe drinking water, proper housing, clothing, and regular meals with sufficient and nutritious food (GoU and UNICEF, 2019).

Table 2: Summary of Health Care indicators for Uganda

Indicator	1990	1995	2000	2005	2010	2015	2020
Population (in millions)	17.3	20.4	23.6	27.7	32.4	38.2	45.7
Neonatal mortality rate/ 1,000 live births	35	29.5	27.9	25.5	23.4	20.8	19.2
Infant mortality rate/ 1000 live births	107.1	97.3	87.1	65.6	49.5	38.9	31.9
Under-five mortality rate/ 1,000 live births	183.1	165.4	146.1	107.1	76.3	55.7	43.3
Maternal mortality rate / 1000 live births	550	520	502	491	438	336	
Life expectancy, years (Male, Female)	49.1	47.4	49.3	53.8	58.7	63.3	65.6

Source: *Uganda Demographic and Health Surveys, 1994, 2001, 2006, 2011, 2016, UNICEF 2020 State of the World's Children report*

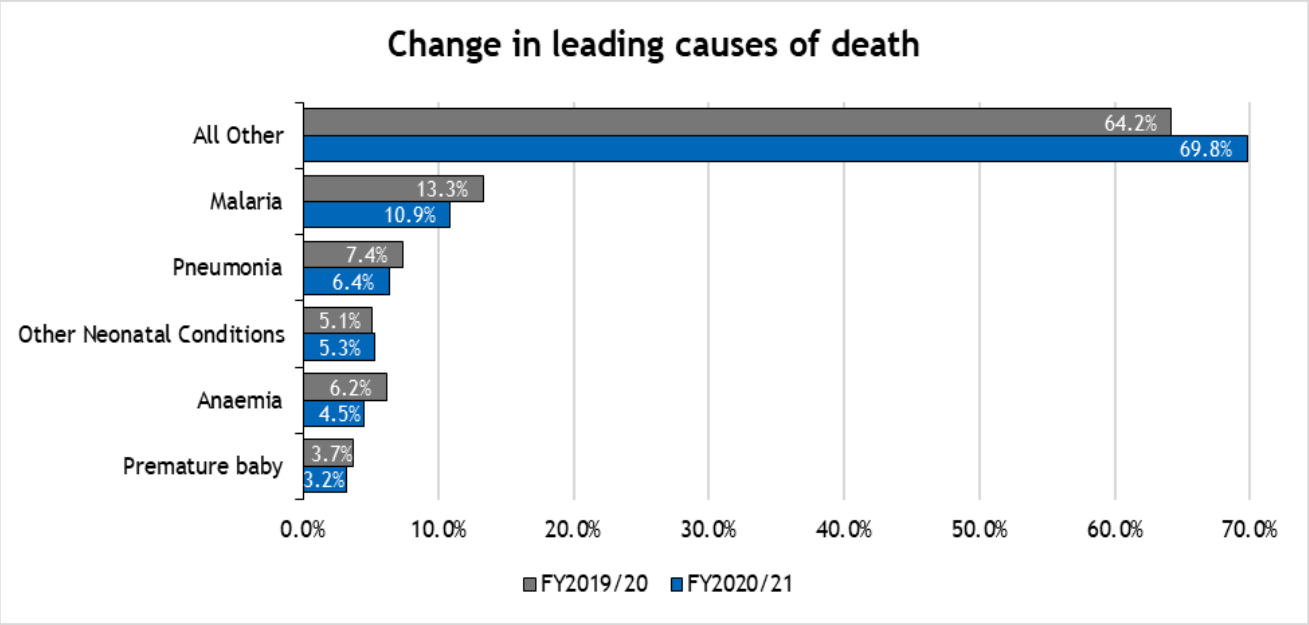


Figure 3: Change in Top Five leading causes of death

Source: *Ministry of Health's Annual Health Sector Performance report 2020/2021*

1.2 LEGAL AND POLICY FRAMEWORK FOR COMMUNITY HEALTH

The 1995 Constitution of the Republic of Uganda provides for all people in Uganda to enjoy equal rights and opportunities, to have access to health services, clean and safe water and education, among many others. The Public Health Act Cap 281 was enacted in 1935 with an overriding objective of ensuring protection of Public Health in Uganda.

The Local Government Act 1997 (sec 97) provides for the role of line ministries as monitoring, supervision and coordination of government initiatives, policies and projects as well as provision of technical assistance to Local Governments (LGs). The government of Uganda strives to improve access to primary, promotive, preventive and rehabilitative health care services through a multi-sectoral approach.

Uganda Vision 2040 identifies human capital development as one of the fundamentals that needs to be strengthened in order to accelerate the country's transformation and harness her demographic dividend. The NDP III places emphasis on human capital development with a focus on increasing the stock of a skilled and healthy workforce the country needs to steer economic growth and development. To achieve Vision 2040, NDP sets out the goal, "Increase household income and improve quality of life through increasing productivity, inclusiveness and well-being of the population" which echoes strongly on health.

The National Health Policy III (2021) and the National Health Strategic Plan (2020/21 – 2024/25) clearly stipulate community health as an important prerequisite and emphasize the importance of the health sector to engage in community-based preventive and promotive healthcare for realizing the goals of the country's Visions 2040.

The development of the country's first ever National Community Health Strategy (NCHS) 2021/22 – 2025/26, is therefore a landmark for the Ministry of Health (MoH) and her stakeholders in their efforts to;

- Align the contribution of key players towards the delivery of health services at community level.
- Strengthen community health systems.

Harness existing policies, guidelines, and experiences of multiple actors and implementers in the community health space for defining and improving community health. The National Community Health Strategy will leverage on the Community Health Acceleration Roadmap of 2019 which identified six priority areas to prioritize for community health programming in Uganda. These include the following:

i) Community health service delivery,
ii) Community health workforce,
iii) Community health information systems,
iv) Community Health supply chain/ medical products,
v) Community health financing, and
vi) Community health leadership and governance.

1.3 THE RATIONALE FOR DEVELOPING A NATIONAL COMMUNITY HEALTH STRATEGY

In 2001, Uganda institutionalized a national community health worker (CHW) programme at the Health Center I level called the Village Health Teams (VHTs). Led primarily by decentralized mechanisms, VHTs have steered health care service delivery at the household level for decades playing the role of a vital conduit between health facilities and households and delivering high quality and equitable health services to vulnerable communities. However, the system to manage and support community health workers has not been well established leading to fragmented geographic coverage, inconsistent functionality and intermittent assistance from partners and NGOs. There is also a vacuum in the policy frameworks and guidance for implementation of concerted community health strategies.

In the absence of an official policy for community health, the MOH and partners released a Community Health Acceleration Roadmap (NCHAR) in 2019 – which prioritized the development of a comprehensive, costed community health strategy that includes all CHW cadres and other system components and that would inform strategic actions by MoH, local government, and partners.

It is for the above reasons therefore that the MOH developed the NCHS as a concrete step to respond to the challenges associated with achieving the UHC. It also demonstrates the integration of community health within the Parish Development Model. The costed strategy will inform implementation of the CHEW Policy and facilitate advocacy efforts for increased financing for community health interventions in Uganda.

CHAPTER TWO
SITUATIONAL ANALYSIS OF UGANDA'S COMMUNITY HEALTH PROGRAMMING

2.1. BACKGROUND

This situation analysis assessed the progress made over the previous decades to-date (2022) in Uganda's community health system to inform the development of this National Community Health Strategy (NCHS), 2021 - 2026. The process followed was guided by a desk review, Key Informant Interviews with strategic stakeholders, national and regional consultation workshops, and focus group discussions within regional health districts including other government ministries such as MOGLSD among others.

2.2. HISTORICAL PERSPECTIVE OF COMMUNITY HEALTH PROGRAMMING IN UGANDA

In 1999, the Primary Health Care (PHC) concept was adopted in Uganda following the 1978 Alma-Ata Declaration, enacting national health policies and strategies, and subsequently, community empowerment for the development of health structures and systems that promised the delivery of community health. However, over the last decades, community health has not received much policy and practice attention. In addition, the community worker cadres, agents for health services delivery have not been formalized to-date. **Figure 5** shows historical landmarks for community health programming in Uganda.

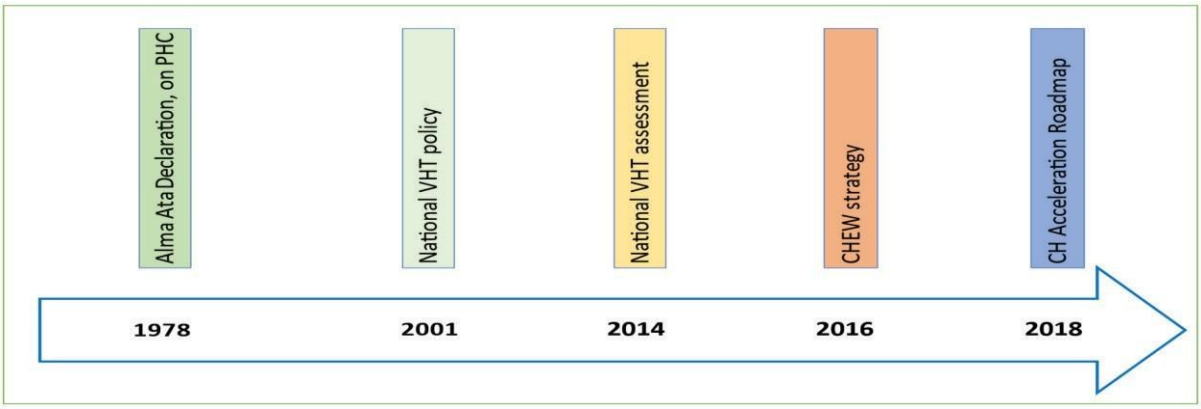


Figure 4: Historical landmarks for Community Health Programming in Uganda

The 2001 Village Health Teams (VHTs) Strategy was a foundational landmark for community health systems, aimed at harmonizing the effective delivery of health programs at the village level (JSI Research and Training Institute, 2017). The Village Health Teams are Community Health Workers (CHWs), defined by the WHO as "members of the community who are selected by, and accountable to the communities where they work; are supported by the health system; and receive less training than formally trained health workers."

The 2014 VHT assessment conducted by the Ministry of Health, and related smaller scale research conspicuously found a reduction in VHTs' effectiveness. VHT programs were found lacking in training, supplies and transportation, in part because the program was designed to operate on pure volunteerism (Mays, et al., n.d.). (Kimbugwe, et al., 2014).

Consequently, 30% of the 179,000 VHTs trained countrywide in 2001 had left their positions by 2014 (MoH, 2014). In 2016, following benchmarking from various countries the Community Health Extension Workers (CHEWs) strategy was developed (Musoke et al, 2020) to strengthen delivery of community health services with a well-trained and renumerated community health workforce. To-date, evidence is being generated from pilot studies to inform approval of the CHEWs policy as recommended by the President of the Republic of Uganda.

In 2018, following WHO guidelines on health policy and systems support for optimizing the community health workforce acknowledging severe shortfalls in the skilled health workforce, particularly in low- and middle- income countries (Workforce 2030 strategy).

Ministry of Health with support from UNICEF and USAID partners developed Uganda's Roadmap for Accelerating Community Health, identifying 6 priorities (Figure 6), which directly contribute to this National Community Health Strategy. The product of these national milestones aimed at delivering effective community health services is summarized in Figure 6 which illustrates the existing community health structure, its inter-linkages with the formal health system, and expected or functional roles.

2.3. THE STRUCTURE OF UGANDA'S COMMUNITY HEALTH SYSTEM

Figure 6 below illustrates Uganda's proposed community health system and shows the interplay among different levels of health establishments and the health service players within local contexts nationally. There are two main levels for the Primary health care delivery namely the health facility level and the community (village) level each with distinct synergistic functions. The facilities are mainly concerned with curative and rehabilitative services while the community health systems ideally tackle health promotion, disease prevention for some disease programs identification of cases and provision of first aid treatment to avert disease progression to more severe forms and referral of cases to the facilities. Within the District health system structure are the district health team, health sub districts, sub counties, parishes, and village structures to deliver community health services. The health center III (present at the health sub- County level) are responsible for supervising lower health facility levels (Health Center II's at parish levels, and Health Center I at the village levels). The HC II's are impending upgrades that will elevate them to HC III's. If this happens without approval of the CHEWs policy, it leaves the community level intervention without a competent cadre to coordinate service delivery, and the VHT system at HC II and I. The DHTs will equally be overstretched, and community health data collection will be a challenge.

The other alternative community health delivery structures include the private sector composed of traditional and complementary medicine practitioners, private health professionals, the non-facility based non-governmental organizations who offer preventive, curative and rehabilitative health services, social enterprises offering subsidized health services and lay community workers who are the beneficiary targets by all the players.

2.2.1 The Structure of Uganda's Community Health System

The development of this strategy deployed a conceptual framework (Figure 5) Community health system structure and service delivery channels) and chronologically unpacks critical dimensions of the health system that impacts community health outcomes in the country.

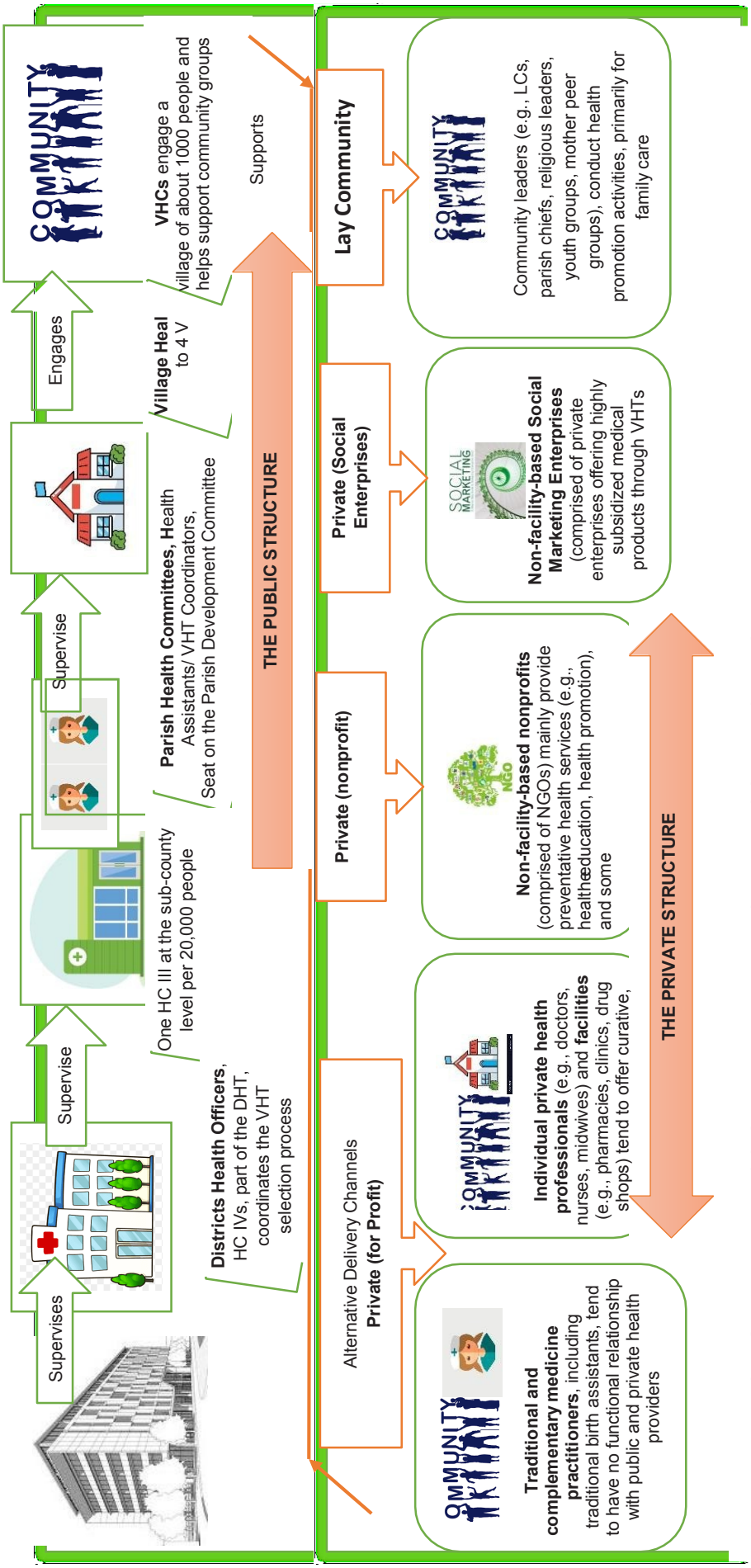


Figure 5: Uganda's Community Health System structure and service delivery channels

Source: *WHO, UNICEF and Rockefeller Foundation — Community Health Acceleration Roadmap, 2018*

2.2.2 Synthesizing community health priorities from the health system building blocks

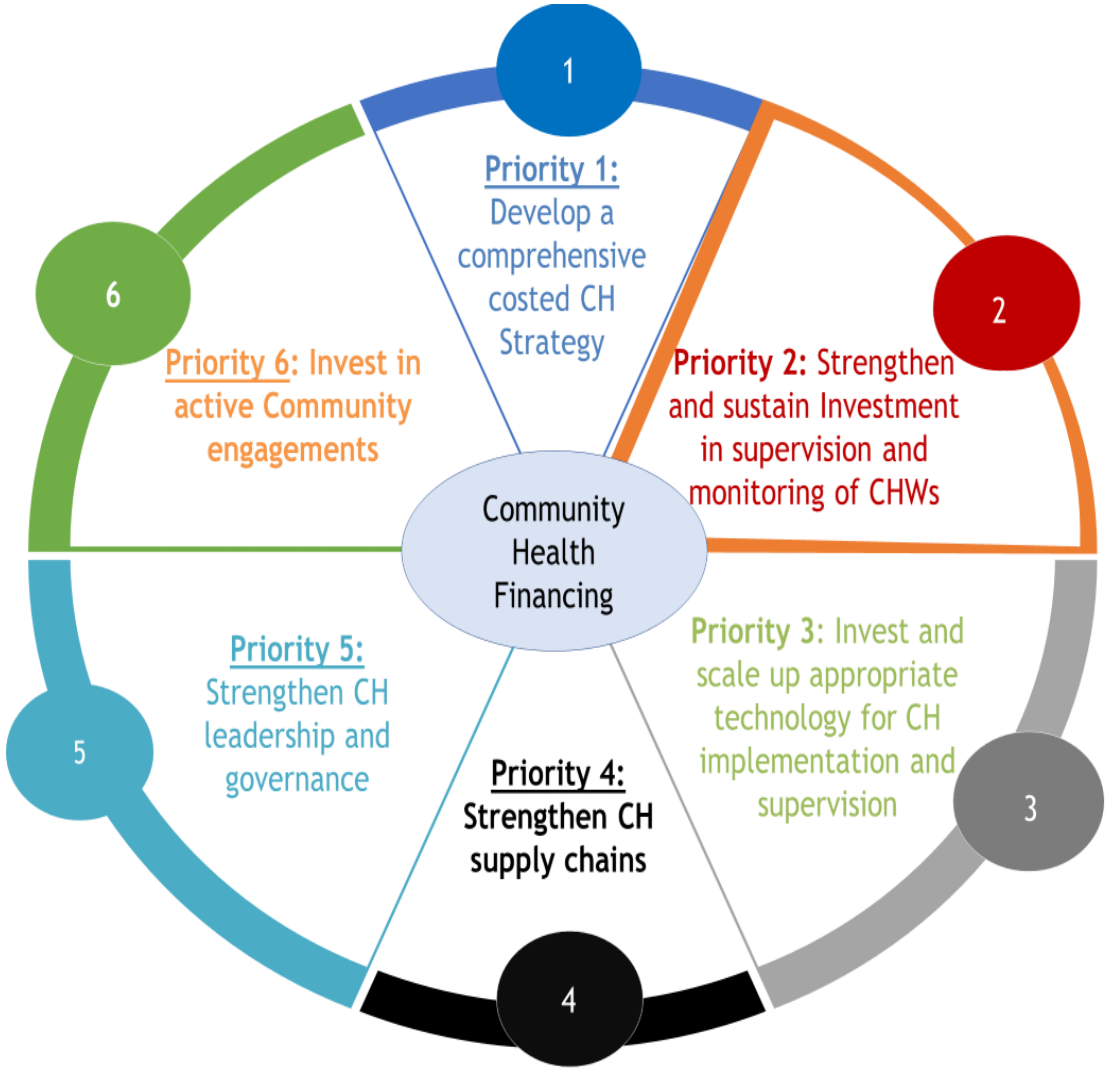


Figure 6: Priorities for improving Community Health (WHO adaptation) Figure 7 WHO Health System Building Blocks

2.3. HEALTH CARE SYSTEM LINKAGE TO THE COMMUNITY HEALTH SYSTEM

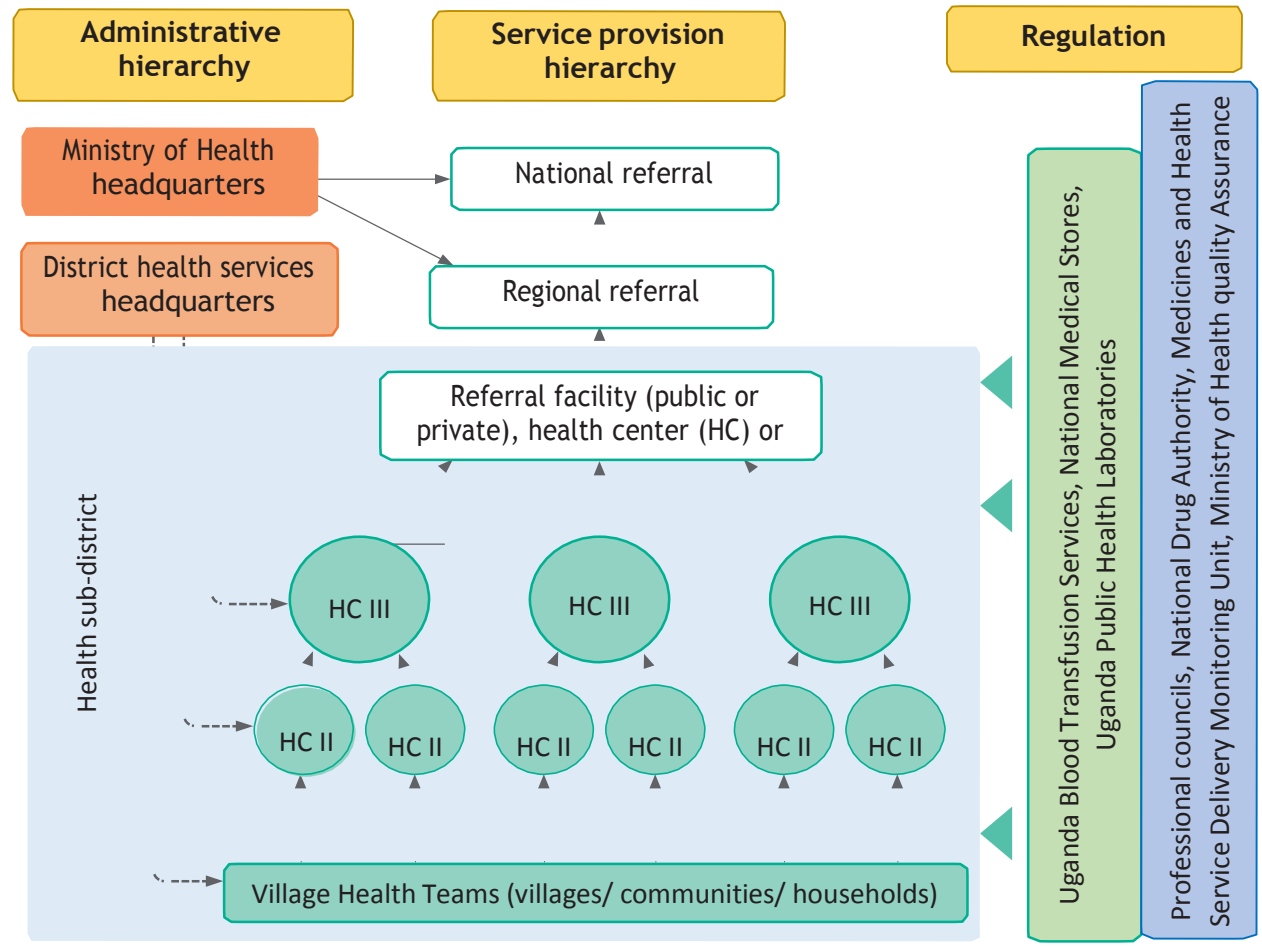
The vision for Community Health Acceleration Roadmap 2018 is to establish an effective and sustainable community health structure that empowers communities to take responsibility for improving their own health. To attain this vision, mutual partnerships are vital between the formal health system, the skilled health workforce, CHWs and the communities they serve. The use of appropriate technologies, with access to integrated care and information from community-based health care providers linked to the formal health system is paramount.

Primary health care is a whole-of-society approach to health that aims to equitably distribute health and well-being focusing on people's needs (both as individuals and communities) as early as possible along the continuum of care, involving health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment (UNICEF – Community Health Acceleration Roadmap, 2019). To assess this, the situational analysis explored the health system's strengths, and opportunities for direct linkages to strengthen the community health system.

2.3.1 Leadership and Governance

The leadership and governance of the health system directly incorporates the community health system, as shown in the Ministry of Health system governance pathways **(Figure 7)**. And while we have a clear structure in place, the current state of community health Leadership, Governance and Coordination, remains weak. There is no structured and formal way to engage with other government structures/ line ministries on community health; and the different players in the community arena use different and fragmented approaches to community health interventions.

Additionally, community participation beyond HUMC is also weak with most communities or households hardly involved in making decisions for their own health. Furthermore, collaboration with other line ministries and Local governments (Ministry of Gender, Education, Local Government) through a multisectoral approach is one major area for improvement as well as coordination of CSO at the grassroot level. All these efforts need to leverage on the MOH strategic shift to regionalization of the health care system with RRH repositioned as CoE along with the Community Health Department playing a pivotal coordination role in strengthening support to the districts and health facilities in their catchment areas.



Status quo

Strengths

- A well governed multisectrol health system exists in Uganda with decentralization permitting devolution of decision-making for context specific health needs.
- Diverse development and implementing partners supporting community health.
- A Community Health Accelerated Roadmap was adapted for Uganda.

Weaknesses

- A lack of institutionalization of CHWs
- Inadequate coordination, joint planning, and implementation of community interventions at all levels

Opportunity for CH programming

- Alignment of existing policies (NDP III), Health Sector Policy and Strategy III, UHC strategy - for disease prevention through community health platforms.
- Regionalization of health services with the CHD at the RRH playing the supervisory role at the decentralized

Figure 7: Governance and Management structures for Uganda's Health System

2.3.2 Health Services Delivery

According to the National Health Facility master list 2018, Uganda has 6937 health facilities (GOU, PFP & PNFPs) each established under an administrative unit that could be a region, district, health sub-district, sub-county etc. and tiered across 6 levels of care. These tiers range from the highest level of care - the National referral hospital, to regional referral hospital, General hospitals to HC IV, III, II, and HC I level where community or primary healthcare services are offered. Service delivery at the community level cuts across multiple services and disease areas in both the public and private sector with health facilities acting as referral points for all community health interventions and working with the community health workers, especially for follow-up of cases.

Currently, there are over 150,000 Community Health Workers that provide selected lifesaving interventions at the community level. However, with the few numbers of CHWs trained and updated, healthcare services at that level are suboptimal in terms of quality and quantity. Moreover, supervision and mentorship for these service providers is often lacking. And while the MOH has defined a package of services to be offered at the community level in the Comprehensive service standards manual (CSSM), the majority of the existing community health workers do not have the required knowledge, skills, supplies and tools to offer the full range of community health services. Worse still, the referral between the community and health facilities remains weak across the entire country and this strategy needs to strengthen the referral systems for better outcomes from referrals made from the community levels.

Status quo

Strengths

- A wide range of community health interventions are being provided at the community level
- PHC prioritizes the Essential Medical and Health Services (EMHS) at facility, and at community level

Weaknesses

- There is limited technical knowledge and skills among CHW service providers including in DHIS2 data use for community actions

Opportunity for CH programming

- Financing for PHC has taken a performance-based approach, thus rewarding CH interventions with high promise
- New needs such as NCDs offer opportunities to re-think chronic care support in communities

Figure 8:Snapshot of Uganda's Health Services Delivery Strengths and Opportunities (Annex I)

2.3.3 Health Workforce

The Ministry of Health's Human Resources for Health strategic plan (2020 – 2030), identifies the non-achievement of the target for filling 80% of established staffing norms by 2020 (MoH, 2020) as an area for improvement. By 2021, staffing norms for the skilled health workforce remained suboptimal as shown in Table 3, coupled with a projected shortfall of over 40% globally for LMICS (WHO, 2018, Sidibe 2018; Campbell, 2017). This, therefore, necessitates a strategic strengthening of the community health workforce.

Table 3: Health Workforce staffing gaps in Uganda

Cadre	Active licensed workforce	Total norms in 2020	Positions filled	Gap (%)
Specialist doctors/ dentists	1,300	1,143	342	801 (70.0%)
General doctors/ dentists	3,124	1,885	1,379	506 (26.8%)
Nurses	33,420	22,484	15,762	6,722 (30.0%)
Midwives	14,961	8,485	7,237	1,248 (14.7%)
Allied Health Professionals	12,884	18,712	11,718	6,994 (33.4%)
TOTAL	**66,589**	**52,899**	**36,543**	**16,356 (30.9%)**
Disaggregated community health workforce (AHPs)				
Public health nurses		300	76	(25.3)
Health assistants		3,304	1,665	(50.4)
Health inspectors		594	477	(80.3)

Source: *Ministry of Health, Human Resources for Health Strategic Plan, 2020 – 2030; iHRIS accessed 18th Feb 2022*

For this reason, in 2001, the MOH established the VHTs to outspread health services to households within a village and mobilize and empower communities to take part in their own healthcare. Each village was to be served by five VHT members, with an average of 25 - 30 households. This means that with the 70,626 villages in the country (https://molg.go.ug/), Uganda would need 353,130 VHTs for the aspirations of the VHT strategy to be realized. However, by the year 2020, of the 179,000 VHTs trained countrywide, only 142,000 were still actively involved in the current community health system (MOH, 2014) leaving a huge gap of 211,130. Several of the existing VHTs were supported through fragmented vertical programs (72,000 VHTs through the iCCM program in the public and private sector while a few other HIV-specific community health workers have been supported by AIDS development partners, FP actors etc).

A number of the trained VHTs remain inactive due to challenges of poor motivation, lack of facilitation and incentives/salaries, lack of equipment, training supervision. And while the VHT strategy clearly stipulates the facilitation of 10,000 Uganda shillings for transport for this voluntary service, this cost is often not covered except where implementing partners who depend on the VHTs to implement project driven work, pay the VHTs. This approach is however not sustainable and concerted efforts are required to ensure the GoU incentivizes the CHWs.

There is a great opportunity to institutionalize the incentives with the current discussions in the parliament of Uganda for these critical community health workers to receive a stipend to not only motivate but also facilitate them to do their work.

The government envisions to establish a well-trained community level cadre - the CHEW, that is motivated and remunerated to supervise and work alongside the VHTs to provide better quality services at the community level.

To further ensure the effectiveness of the community-level workforce, the DESC strategy would be appropriate to **Digitize** – to ease and lighten the burden of reporting but also reduce costs in terms of time and money used to print paper tools and transport reports **Equip** with knowledge, skills as well as health supplies delivered through a reliable robust supply chain mechanism; **Supervise** to enhance competence and update on emerging/ new knowledge; **Compensate**/Remuneration – important in ensuring they remain motivated and valued for their efforts.

The other important opportunity is the introduction and rollout of the community health worker registry (CHWR) which is linked to the iHRIS as an inventory of the Community health worker footprint in the country. This CHWR provides an understanding of the CHW footprint and informs managers and stakeholders about the number and distribution of CHWs, the training that these CHWs have received, incentives and tools received, types of services being offered; all critical information for better planning, decision making and efficient deployment. Several fragmented vertical programs have supported CHW forces with a total of 72,000 VHTs supported through the iCCM program in the public and private sector while a few other HIV-specific community health workers have been supported by AIDS development partners among others.

Status quo

Strengths

- Governance structures exist, formal (E.g health inspectors and health assistants) and informal (CHW) health workforce are situated.
- A Community Health Accelerated Roadmap was adapted for Uganda.

Weaknesses

- The HRH strategic plan is silent on the CH Workforce

Opportunity for CH programming

- A variety of CHWs exist, GoU supported, development and implementing partner supported
- There are training modules and tools for various CHW related services
- There is a VHT workforce of approximately 142,000 nationally

2.3.4 The Health Management Information Systems (HMIS)

Currently the country uses the customized District Health Information System (DHIS2) as the primary data capture and reporting system and builds on existing paper based HMIS tools. A set of community health system data is generated from the VHT/ICCM register (which captures data from households and in the community), compiled into the Quarterly HMIS 097b report, submitted to the respective health facility where the VHTs are attached, and submitted to the district health office where the community data is entered into the DHIS2.

In general, reporting of community data has lagged behind facility reporting as shown by the low reporting rates (35%) of community data in DHIS2 in the FY 2020/21. The main challenge affecting community data reporting is the frequent stock-out of community data capture and reporting tools. Additionally, training in the revised tools for the CHWs has been limited. Oftentimes, community data does not find its way into the DHIS2 because implementers of community health interventions use parallel data capture and reporting tools or systems.

The quality of data reported is also a major challenge. Data quality is compromised by the largely paper-based system which poses a risk to the quality of data during the process of aggregation, transcription, and data entry. In line with the national development plan of digitization of service delivery, community digital technology innovations such as the Electronic Community Health Information System and the Open SRP have been introduced in pilot areas to ease community HMIS data collection, data reporting, data visualization and real-time data use for decision making.

The other e-Health approaches piloted and scaled up include the CHW Registry which is linked to the integrated Human Resource Information System (iHRIS). All these efforts present great opportunities for improvements in CHIS/HMIS reporting, ensuring that data gets reviewed and analyzed at the community level; and to complete the feedback loop shared back with the village LC's or communities by the VHTs to trigger community level response/actions to improve their health outcomes.

Similarly, data use at the district levels has been limited and needs to be strengthened. With the community dashboard now institutionalized into the national systems, corroboration of community data with facility-based data to visualize individual VHT efforts to health facility health outputs as well as understand the holistic health picture needs to happen through existing platforms such as performance review, baraza's etc. This way the community data becomes pivotal for holistic decision making and an avenue for sharing health information for local leadership participation, action, and ownership of health interventions. Also key in this area is the linkage of Community health information systems to other ministries like the MOGLSD and other relevant stakeholders particularly those linked to the implementation of the PDM where the social determinants of health can be identified and addressed jointly.

Status quo

Strengths

- Digital, web-based data capture systems exists nationally

Weaknesses

- A multiplicity and duplicity of CHW data collection and reporting tools and systems

Opportunity for CH programming

- There exists an online CHW registry
- E-Health initiatives/ pilots to ease community data capture and reporting with a potential to improve reporting rates, timeliness, and quality of reporting.

2.3.5. Logistics and Supply-Chain of Community Health Products

A functional health system ensures equitable and consistent access to quality essential medicines and health supplies (EMHS) to help save lives and improve health outcomes of

Status quo

Strengths

- Community supply chain strategy exists, 2016 - 2020
- Community supply chain tools exist (consumption log, summary form).
- Existence of a standardized supply list for VHTs
- About 50% of VHTs are trained on supply chain management.

Weaknesses

- High dependency on donor support challenging sustainability for commodities such as ICCM and NTD

Opportunity for CH programming

- Parish Development Model development - where monitoring and accountability of commodities and supplies at community can occur
- eHealth approaches / pilots
- Availability of development partner funding (Global Fund, USAID, UNICEF, UNFPA, UNHCR, CDC etc)

Figure 9: Snapshot of Community Health Supply Chain Strengths and Opportunities (Annex I)

any country's population. The USAID/ Management Sciences for Health (MSH) supported the Uganda Health Supply Chain (UHSC) project (2015 – 2018) which prioritized equitable access to medicines nationally, hence streamlining the National Medicines Policy – and instituting the EMHS at health facilities. Uganda currently uses a combined push and pull system to supply medicines to health facilities; Hospitals and HC IV have a "pull" (order-based) system, while lower-level health facilities (HC III and II and Clinics/HC Is) have a "push" (kit-based) system. VHTs offer referrals to health facilities and default tracking, they support health facility staff for community health education, promotion and mobilization for a range of primary health care services, such as RMNACH services including antenatal care, skilled birth attendance and immunization, and growth monitoring, increasing access to Antiretroviral (ART), Malaria and TB treatments for HIV and smear positive TB persons respectively among others, providing preventive advice to households for mitigating infectious conditions such as malaria, diarrhea, TB, and lifestyle changes required for NCD prevention. Commodity and medicines distribution in the community is supported by VHTs for ICCM, Family planning, Neglected Tropical Diseases such as Bilharzia, Onchocerciasis, and Schistosomiasis, Condoms for HIV prevention, Chlorine for bucket chlorination, screening and care or management for COVID-19 among others. All these supplies are provided by decentralized health care services. However, there is a gap of tracking the operationalization of the National Medicines Policy at the community level largely due to the absence of community health data.

2.3.6 Health Financing

Figure 15 summarizes the trends in health care financing in Uganda 2010/11 through 2018/19 as reported in the National Health Accounts.
By policy, public healthcare is free to access in Uganda, however, health financing realities show a mix of household, public and donor (external) financing as key. Public expenditure on the health sector remains low at approximately 7% of the GoU's National Budget- below the Abuja Declaration target (15%) of the national budget for health. The total health care expenditure by the GoU is $36 per capita, approximately $48 per capita lower than the recommended WHO minimum level of 84 US$ (National Health Accounts (NHA), 2018/ 2019; National Health Policy, 2021). Out- of-pocket (OOP) financing constitutes 41%, donor (external funding) 42%, and government funding (15%) (NHA, 2017).

One major concern for community health financing is that a large proportion of the national health budget continues to go to the hospitals which are mostly located in towns leaving out the peripheral units and HCs at the lower units. A 2020 MoH report intimated low financing of community health services highlighting that the percentage of health facilities having over 95% availability of a basket of commodities dropped to 46% in 2019/20 from 53% in 2018/19, a value that is far below the HSDP target of 75%. Regional consultative meetings revealed that these financial challenges have been coupled with delays in fund transfer by the center to the different implementation units with no cost centers earmarking community health interventions except for health facility outreaches at the local government level.

Table 4: Trends in Uganda's health sector allocations

Source: National Health Accounts, 2010/11 – 2018/19

Year	Health Budget (millions)	Growth	Total Gov't Budget (millions)	Growth	Health as % total budget
2010/11	660		7,377		8.9%
2011/12	799	21%	9,630	31%	8.3%
2012/13	829	4%	10,711	11%	7.7%
2013/14	1,128	36%	13,065	22%	8.6%
2014/15	1,281	14%	14,986	15%	8.5%
2015/16	1,271	-1%	18,311	22%	6.9%
2016/17	1,827	44%	20,431	12%	8.9%
2017/18	1,950	6.7%	29,000	42%	6.7%
2018/19	2,373	18%	32,700	13%	7.2%

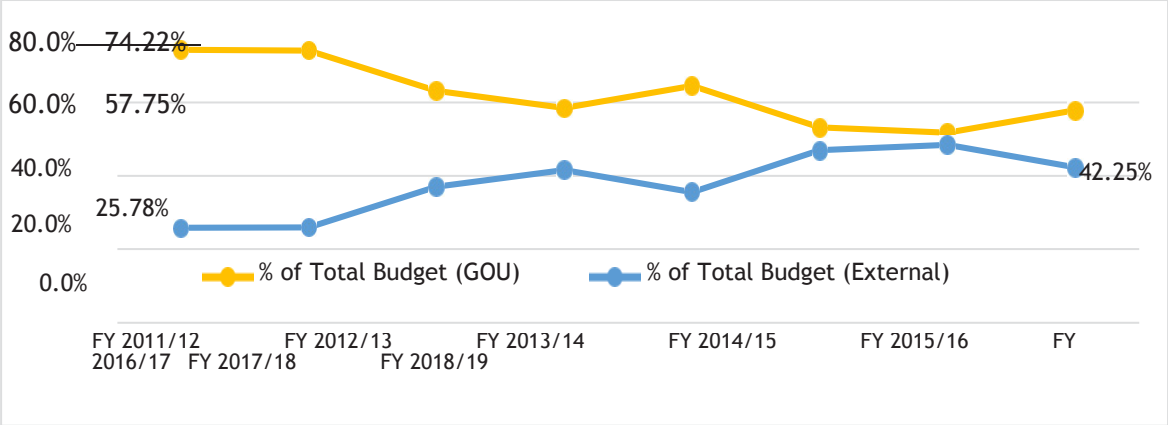


Figure 10: Trends in healthcare financing in Uganda (Annex I)

Status quo

Strengths

- The current health strategy delineates clinical and community health platforms, as avenues for programming and budgeting.

Weaknesses

- A fragmented funding mechanism between GoU and development partners

Opportunity for CH programming

- Community Insurance schemes exist and can be strengthened to reduced out-of-pocket expenditure.
- Parish development model could provide health care financing at community level
- Development partners could adopt the support social/ community health insurance financing mechanisms

2.3.7 Community Engagement and Participation

One of the priority areas for NDP III is to empower families, communities, and citizens to embrace national values and actively participate in sustainable development underscoring increasing the proportion of families, citizens and communities informed about national and community programmes from 30 to 90 percent; and increase the participation of families, communities and citizens in development initiatives including health by 80 percent.

On the other hand, the Parish Development Model 2022 aspires to take the government to the people which in the lens of health is to take health to the household level using the 'bottom-up' approach. This is aligned to the Community Health Agenda in NHP III policy objective 3 speaks to building household level and community level demand for services.

The aspiration of the community health program is to have communities placed at the center of Primary Health Care by ensuring that all people in Uganda are aware, empowered and are participating actively in the prevention, control and response to outbreak of disease and public health conditions both as a duty and a right, using existing structures, systems and resources as much as possible.

Engaging communities will create a health and safety net around individuals, families, and communities. The recent outbreak of Covid-19 reawakened the urgent need to place the communities at the center of their own health. This birthed the community engagement strategy for Covid-19 from which many lessons have been drawn. Community health programs like the ICCM and HIV/TB programs, Primary Health Care –Community Engagement initiative (PHC-CEI) have attempted to develop approaches to engage communities however all these have not been able to fully meet the Community Health aspiration of the community engagement agenda which emphasizes that individuals should have the primary responsibility for maintaining their own health and that of their households and communities at large.

Opportunity for CHprogramming

Strengths

- An allocation of 30% of PHC funding to community health
- VHT members that are leveraged for mobilizing communities for health-related activities

Weaknesses

- GoU prioritizing curative over community health financing.
- Insufficient Community engagement and participation
- Vertical programming
- No clear guidelines on the functions and reporting structures of different health committees
- No clear roles and responsibilities for the different structures and insufficient training of persons on their roles and responsibilities

Opportunity for CH programming

- COVID 19 Community Engagement and Social Protection (CESP) pillar, implements multi-sectoral collaboration
- Decentralized health services delivery

CHAPTER THREE:
STRATEGIC DIRECTION AND OBJECTIVES

3.1. INTRODUCTION

This section highlights the Vision, Mission and the thematic areas, objectives, recommendations, and activities of the NCHS strategy. The main objective of the National Community Health Strategy for Uganda is to ensure increased access to quality, affordable and equitable health services to all.

3.2. VISION AND MISSION OF THE NATIONAL COMMUNITY HEALTH STRATEGY FOR UGANDA

The vision

A responsive, resilient and people centered health system that protects and promotes the health and wellbeing of all the people in Uganda.

The Mission

To promote and ensure Universal Health Coverage in Uganda through evidence-based and technically sound policies, standards and strategies that are client centered.

The Goal:

To ensure accelerated programs towards UHC through provision of quality, evidence based and integrated community health services, strengthening community participation, referral and linkages.

Guiding principles

The Ministry of Health guiding principles aim at providing the highest affordable quality services and these principles include:

Effective Leadership

We believe that effective leadership should be structured, present and accessible. Our leadership strategy is based on a practice and overall management level support network which provides both personal and team motivation, direction and accountability.

Teamwork

The health sector is composed of a team from different professions. Therefore, we believe in teamwork to reinforce the services from different disciplines all aiming at improving the overall care-giving experience.

Partnerships

The private sector shall be complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided. The Ministry of Health will promote the Public-Private-Partnership-For-Health (PPPH) policy nationally and internationally.

Quality

We believe that consistency in standards, protocols and procedures are essential to maintaining and improving the quality of our services

Gender-sensitive and Responsive Health Care

A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.

Human rights approach

The Ministry of Health will ascertain that the rights to access quality health care and health information are respected by all categories of individuals of the society both within the public and private sector.

3.3. STRATEGIC DIRECTION

The following strategic directions have been earmarked for the National Community Health Strategy in line with the health system building blocks:

Strategic Direction 1: Increase availability and access (geographic and functional) to equitable and integrated Community Health services

Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce.

Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply chain system.

Strategic Direction 4: Ensure improved and sustainable financing for community health programs

Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions

Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in community health services

Strategic Direction 7: Engage and empower communities for better accountability and improved health outcome

Strategic Direction 1: I Increase availability and access (geographic and functional) to equitable integrated community health services

Strategic Objective 1.1: Deliver a standardized, integrated essential package of community health services.

Key interventions:

- *Review and operationalize an integrated community health service package that incorporates prevention, promotion, community case management, surveillance, referral, and rehabilitative services.*
- *Disseminate guidelines and regulatory frameworks for the integration of community health activities at all levels.*
- *Strengthen and streamline referral and follow up mechanisms to strengthen linkages between the community and health facilities.*
- *Provision of equitable community health services to include vulnerable populations.*
- *Map and operationalize local government coverage plan for community health services.*

Strategic Direction 2: Ensure an equipped, competent, committed and compensated Community Health Workforce.

Strategic Objective 2.1: Standardize recruitment of Community Health workers.

Key interventions:

- *Maintaining of an updated CHW database for use at community level*
- *Operationalize the roles and responsibilities for the cadres of community health workers (CHW)*
- *Operationalize the standards for CHW recruitment.*
- *Review and consolidate a master training curriculum for CHW.*
- *Strengthen the CHW registry to aid evidenced based planning, health information exchanges and communication.*

Strategic objective 2.2: Operationalize a performance management framework for CHW using the **DESC** approach

Key interventions:

- ***D**igitize: Develop and utilize mobile technology in an integrated way to drive greater program performance and to enable strong performance management processes.*
- ***E**quip: Train CHW and equip them with tools and supplies to effectively serve their communities.*
- ***S**upervise: Build capacity of supervisors, and strengthen supervision, coaching, and mentorship of CHW to meet pre-determined performance targets.*
- ***C**ompensate: Provide performance based monetary facilitation to ensure CHWs are motivated to deliver health services at the community level.*

Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply system

Strategic Objective 3.1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities in public and private sectors.

Interventions:

- *Review of medicines schedule as per Uganda's clinical guidelines for products being managed by CHW to address the existing disconnect between policy and regulation on medicines dispensed by trained CHW.*
- *Align the essential medicines and health supplies package for community health with the updated EMLSU.*

Strategic Objective 3.2: Strengthen capacity for community level logistics and supply chain system management in public and private sector.

Interventions:

- *Collaborate with the Pharmaceuticals and Natural Medicines to build capacity of implementers (DHT, IPs, PNFPs, PFPs, CHEWs and VHTs) of community health programs on community supply chain using the standardized national guidelines on medicine management and health supplies for community health program and related logistic management tools.*
- *Integrate community supply chain into existing community health programs to address gaps in program implementation targeting supply chain improvement at district, health facility and community level.*
- *Collaborate with the Department of Health Services, Pharmaceuticals and Natural Medicines to Scale up the implementation of community supply chain procedures at all levels through ensuring standardized frequency on ordering for supplies for the CHWs, and issuing supplies based on demand using the standardized tools).*

Strategic Direction 4: Ensure improved and sustainable financing for community health

Strategic objective 4.1: Institute harmonized and equitable financing by stakeholders

Key interventions:

- Design an advocacy strategy for increased financing and alignment of community health interventions.
- *Develop guidance for all stakeholders on coordination for CH financing and rationalizing resources.*
- *Advocate for increased MoH budgetary allocation for CH services and CH generated non-tax revenue.*
- *Advocate for Amendment of Legislation for CH financing (amendment of public health act/by-laws of local councils).*
- *Advocate for inclusion of community health indicators for compensation under RBF.*

- *Identify and scale public private partnerships models that have worked well elsewhere for sustained financing.*

Strategic objective 4.2: Improve resource mobilization for the delivery of integrated community health services

Key Interventions:

- *Create a community health cost center at the district level to earmark funding for implementing community health services.*
- *Quantify and include CHW needs at the community level into the general health facility procurement planning for all community programs.*

Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions

Strategic objective 5.1: Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data.

Key interventions:

- *Review and functionalize a Harmonized comprehensive community data collection and reporting tool for an integrated community health service delivery.*
- *Build the capacity of CHW in microplanning, data use, community feedback and reporting*
- *Review and update indicators for assessing logistics data on community health programs as per the integrated community health service package.*
- *Develop a data use manual for VHTs to enhance data utilization at community level.*
- *Develop indicator compendium for CH data reporting.*
- *Build capacity of CHW in data use and reporting for timely and informed community health interventions through routine trainings, supportive supervision and mentorship*
- *Quantify, procure and distribute all relevant community health data collection and reporting tools including community supply chain tools for all districts.*
- *Strengthen community health data quality audits at all levels.*

Strategic Objective 5.2: Digitize community health service delivery platforms

Key interventions:

- *Map, evaluate and adopt appropriate innovations (OCR, Apps) for CH service delivery.*
- *Develop and disseminate a roadmap for scaling up digital community health service delivery.*
- *Develop and disseminate training manuals for community health workforce on digital community health systems.*
- *Build capacity of community health workforce on basic ICT.*
- *Equip CHW with digital tools for service delivery.*

Strategic Objective 5.3: Increase utilization of Community Health Data for decision-making in the community health system

Key interventions:

- *Improve community health data visualization and analytics at all levels- national, sub national, facility and community Level.*
- *Develop and integrate key community health indicators on the district league table for effective monitoring and evaluation of community health programs.*
- *Strengthen capacity of health facility, district, and national level to use community level*

logistics data for planning and decision-making including replenishment of medicines for CHW's.

Strategic objective 5.4: Coordinate Community-Based Surveillance systems (CBDS).

Key interventions:

- *Coordinate and Implement active CBDS in line with IDSR.*
- *Build capacity and tooling of community health workforce to implement CBDS*

Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector of the community health services

Strategic objective 6.1: Strengthen leadership and multi-sectoral coordination, planning and implementation of Community Health programs.

Key interventions:

- *Map all community health stakeholders, funding flows and intervention areas at the national and district/sub-county level.*
- *Strengthen partnerships and meaningful engagements with stakeholders to encourage cross-sectoral synergies in implementation of community health programs.*
- *Identify opportunities and establish mechanisms for public-private partnerships across all levels to address social determinants of health.*

Strategic Direction 7: Engage and empower communities for better accountability and improved health outcome

Strategic Objective 7.1: Enhance effective mobilization of families, communities and citizens for community engagement and participation.

Key interventions:

- *Operationalize community engagement, empowerment and participation strategy for health security and health emergency preparedness.*
- *Implement activities aimed at promoting community empowerment and participation in community-based programming at all levels.*
- *Establish community activities that improve health knowledge, attitudes, practices, and behavior among all population groups.*
- *Conduct community dialogues to identify barriers of utilization and issues faced by the communities in respect to their causality, differentiation of needs and demands of the various social strata.*
- *Promote health education activities and awareness raising campaigns to improve health seeking behavior and empower communities with information.*

Strategic objective 7.2: To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions.

Key interventions:

- *Strengthen advocacy at national, district and community level for community participation in governance, planning and implementation of essential health services.*
- *Enhance participation of community stakeholders in technical working group meetings.*

CHAPTER FOUR:
COORDINATION FRAMEWORK FOR COMMUNITY HEALTH

PROGRAMMING

4.1. INTRODUCTION

The coordination of implementation of the National Community Health Strategy will leverage the multi-sectoral stakeholders, Community Health Structure and the Parish Development Model (PDM) stipulated hereunder.

4.2. MULTI-SECTORAL STAKEHOLDERS AND LINKAGES

The Ministry of Health is mandated to coordinate and lead periodic reviews with the Uganda Community Health Stakeholders including other Ministries, departments, and Agencies, HDPs, NGOs and CSOs, private sector, social enterprises, academia, donor organizations among others. These platforms, as well as other available channels like the Technical Working Group meetings, will also form ground for advocacy and standardization of community health practices.

4.2.1 Roles and responsibilities of various structures to support implementation of the NCHS

4.2.1.1 Ministry of Health and line ministries

i. Provide policy framework for the establishment, functioning, monitoring and evaluation of the CH services.
ii. Define minimum package of services and standards to be provided by CH workforce.
iii. Ensure availability of medicines and supplies as provided for in the package
iv. Take lead in resource mobilization for CH services.
v. Provide overall coordination and supervision in VHT implementation.
vi. Link up/liaise with relevant ministries to harmonize policy frameworks in support of VCH services.
vii. Provide strategic leadership, coordination and guidance.
viii. Play advocacy roles for all policies and needs of Uganda's Community Health system to all stakeholder groups.
ix. Standardize terms of engagement of the CHWs, through development of a framework, and ensuring that all stakeholders adopt and implement through these guidelines.
x. Allocate the necessary resources to ensure that there is integration of nationwide data collected, into one database.
xi. Undertake Monitoring and Evaluation function for overall Community Health System in Uganda.

4.2.1.2 Local Governments

i. To integrate NCHS into their development and operational workplans.
ii. To allocate and avail resources for implementation of community health activities.
iii. To formulate, pass and enforce by-laws in support of CH workforce functions.
iv. To promote intersectoral collaboration in the local government.
v. To ensure harmonized and integrated implementation of health activities at community level using CHW force.
vi. To ensure harmonized and well-coordinated IP support.
vii. Empowerment of community leaders.
viii. To ensure that all those delivering community-based health care interventions do so through VHTs and avoid creating other parallel structures.

4.2.1.3 Health Development Partners

i. To contribute to policy development and resource mobilization.
ii. To provide technical, financial and logistical support for the operationalization of the NCHS strategy.
iii. To support monitoring, evaluation documentation and sharing of best practices.
iv. To contribute towards bridging the existing implementation gaps through provision of services to achieve national community health indicators, intensive supervision, and advocacy to the government and non-state actors for improved policies guidelines.

4.2.1.4 Non-Government Organization and Civil Society Organizations

These include the semi-autonomous institutions in the health sector such as the National Chemotherapeutics, research institutions such as Uganda National Health Research Organization, Uganda Virus Research Institute and Joint Clinic Research Center, National Drug Authority, National Medical Stores, among others.

i. Participate in joint planning with Government Health planning authority at all levels
ii. Facilitate functioning of CH services in accordance with the National Health Strategy/Policy.
iii. Integrate their community-based health programmes into the district annual operational plan.
iv. Promote advocacy and raise the profile of the NCH strategy and CH programmes
v. Sensitize communities on the roles of CH structures and workforce and empowerment of community leaders.

4.2.1.5 Health Facilities

i. Take overall responsibility for all CH activities within their areas of responsibility.
ii. Conduct training and supervision of CHEWs.
iii. Support management of logistics and supplies for CH/HBC services.
iv. Regularly organize planning, review meetings and refresher programmes with CH workforce/VHTs in their catchment areas.
v. Receive, analyze, utilize CH data and provide feedback.
vi. Select CHEWs/VHTs to work with in their catchment areas.

4.2.1.6 Community Leaders

The success of the Community Health Strategy hinges a lot on the empowerment of the community to take lead in making decisions about their own health. As such Community Leaders (such as elders, religious leaders, village chiefs, cultural leaders among others) will be empowered to utilize the available platforms in order to support the processes towards the achievement of health indicators and targets. The roles of Community leaders will include, but not limited to:

i. Mobilization of the community to access available health services
ii. Creation of awareness to enhance behavioral change
iii. Support advocacy through identification of the community health needs and supporting members to demand for quality and equitable health services.
iv. Being the linkage to the people for CH services.
v. Work with the CHWs to track indicators within their respective communities.
vi. Participate in the development of bylaws and customization of MOH community health guidelines for increased ownership and uptake.

4.2.1.7 Local Council I Executive

i. To advocate for CH services
ii. Sensitize communities on the roles of CH workforce.
iii. Provide time for the CH workforce to conduct health education at community meetings and other public gatherings.
iv. Enforce implementation of laws, by-laws, regulations and recommendations on community health.
v. Initiate and implement motivation schemes for the CH workforce.
vi. Take lead in the mobilization of communities to engage in CH activities.

4.2.1.8 Local Communities

i. Volunteer for community health activities
ii. Nominate CHEWs/VHTs/Caretakers according to the national guidelines
iii. Seek and utilize the CH services available.
iv. Recognize and appreciate the services of CHWs.
v. Support CHWs to collect medicines and supplies from health centers
vi. Report health incidences in the community to CHEWs
vii. Respond to the call for community activities initiated by CHEWs and local council leaders.
viii. Responsible for their own health and observance of health-related laws and regulations.
ix. Actively engage in community advocacy and social accountability initiatives for better health outcomes

4.3. THE COMMUNITY HEALTH STRUCTURE

4.3.1 Coordination Mechanisms

The National Community Health Strategy defines coordination as efforts to ensure that community health programme activities are implemented in a consistent, integrated, and resource-efficient manner. Efficient coordination will be achieved through consistent communication, joint planning, implementation, and monitoring of activities.

The National CH Steering Committee serves as the primary forum for coordination at the National level – supported by the Community Health Technical Working Group (CH TWG) under the Ministry of Health.

4.3.1.1 Conducting day-to-day business

The Community Health TWG will be meeting monthly as prescribed by the guidelines in each district to ensure efficient and coordinated health service programing. Health sub-District teams will make recommendations to the District Health Management Teams that include the Extended district management team, the District Technical Planning Committee, and the District Executive Committee. The District Council will make the final approval.

Districts will have a dedicated CH TWG under DHT led by the Community Health Officer at the DHO's Office. These district coordination structures will provide technical support including but not limited to advocacy and resource mobilization.

Parish level will have the Community Health Team (CHT) and Parish Development Committee (PDC) and the Social Services sub-committee whose role will be to provide advisory and to coordinate activities within each of the villages under the Village Health Committees (VHCs).

Village level will have the Community Health Team (CHT) who will work as the primary vehicle for community leadership, mobilization, empowerment, engagement, and participation. The CHT and the VHC will meet monthly to ensure efficient coordination, both upwards with the PDC and DHT and downwards with the VHTs and Community members.

4.3.2 Linking key stakeholders for community health with the VHTs

The VHT strategy and operational guidelines outline a few stakeholders under the stakeholders' forum, however, there are a number of stakeholders that are critical in implementation of community health and key in VHTs' work. The stakeholders include, Ministry Health, Development Partners, Implementing Partners, Local Government, District Health Office, Health Facility and Sub County and Local Councils at Village level. To ensure proper coordination and effective program implementation during the implementation of the NCHS, VHTs will be linked to all stakeholders in the following ways:

4.3.2.1District level: The District Health Officer (DHO) shall hold quarterly meetings with the VHTs and implementing partners to jointly develop quarterly implementation and Monitoring plans and discuss any challenges encountered during the previous quarter. The DHO will work as liaison with the CAO. Through the Chief Administrative Officer, all other departments will be required to utilize and support the VHT structure to implement their health-related community activities. This is intended to offer support to these VHTs and keep them motivated (VHT Strategy, 2021).

4.3.2.2Health Sub-District: The in-charge of the Health Sub-District with the assistance of the Assistant Health Educator shall be responsible for overall planning and coordination VHT activities at the Health Sub-District level. VHT activities shall be integrated into the Health Sub-District work plan which is developed from Health Center level. The in-charge shall be responsible for sensitization of sub-county leaders.

4.3.2.3Sub-County: The In-charge of HCIII with assistance of other sub county VHT Trainers will be responsible for planning, implementation and monitoring of VHT activities in the sub county. The In-charge may delegate some of the responsibilities to an active and competent Health worker in-charge of the sub-county. The in- charge in collaboration with the sub-county chief shall ensure that the health activities of NGO's are implemented through the VHTs. Health Facilities of all levels shall be responsible for coordination, implementation, monitoring and evaluation of VHT activities within their areas of responsibility. Health Centers shall provide technical guidance to the VHTs, replenish commodities and health supplies, hold regular meetings with VHT members, encourage them to participate in health unit activities and give them support supervision and mentorship.

4.3.2.4Community (Parish and LC 1 Levels): This is the implementation level of VHT activities. The Community leaders (LC1 and Parish chief) will be responsible for coordination, overseeing and administrative (nontechnical) supervision of VHT activities in their areas. The VHTs will be accountable to the community leaders.

4.3.2.5Village level: VHTs will work with Village task teams and Home-based Care teams to ensure proper coordination and division of responsibilities.

4.3.2 The Community Health Coordination and Governance Structure

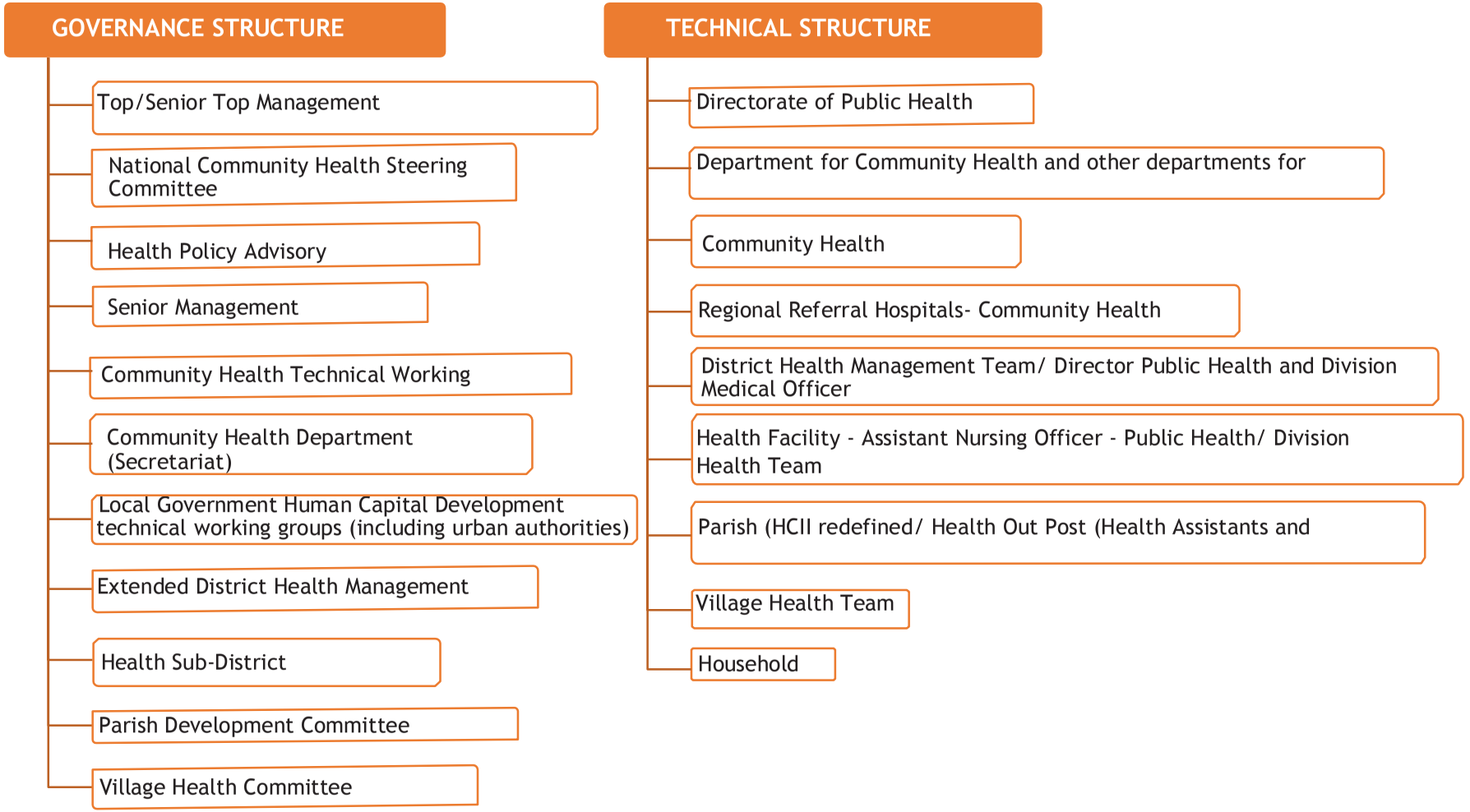


Figure 11: Structure for the implementation of the Community Health Programs

Figure 12 Structure for the implementation of the Community Health Programs

4.3.2.1 Governance Structure

Table 5: Governance role across the Community Health Structure

#	Structure	Roles	Chair	Composition
1	National CH Steering Committee	i. Strategic governance, Leadership and stewardship ii. Strategic Policy direction iii. Initiate strategies for community Health financing.	Minister of Health	Representatives from line MDAs, HDPs, IPs, (On request for nomination by Minister of Health)
2	MOH CH TWG	i. Develop, review, adopt, and present the SMC on technical aspects to the development, implementation, and monitoring of Community Health-related regulations, policies, standards, guidelines. ii. Review and ensure that all discussions on CH related policies, regulations, strategic plans, standards, and guidelines are informed by scientific evidence and data. iii. Review, adopt, and recommend to the SMC specific recommendations from the monitoringand evaluation of the CH programmes. iv. Review, adopt, and advise the health sector/stakeholders on operational research agenda related to community health for the country. v. Review, adopt, and present SMC on the development, implementation, and monitoring	Director PH,	Commissioners/Reps from relevant Depts, Program Managers, and Technical Advisors, Academia, DHO representative, Representatives from HDP, IPs, NGOs, PHPs, Registrars of professional councils, Professional Associations, Semi-autonomous Institutions, Health Consumers, CSOs, Private sectors.

		of guidelines for the management of CH programmes. vi. Review, adopt, and present SMC on the new interventions and projects in community health programming vii. Review and advise on the monitoring and evaluating health sector performance on interventions in community health activities.		
3	CH Dept	i. NCHS Secretariat. ii. To coordinate implementation of the community health programs. iii. To monitor and ensure alignment of implementation of CH programmes to iv. the NCHS framework v. To mobilize the finances and ensure that programmes appropriate resources for Community health.	CHS CHD	CHS Core Team / Heads of Departments, Divisions, Units and Sections
4	RRH/CH Department	i. Coordination office for CH; Coordinate CH advocacy and resource mobilization activities. ii. Overall planning, implementation and monitoring of CH activities in the region.	CH Dept	CH related all departments, IPs, CSOs.
5	LG Human Capital Dev't Working Group	i. Ensure that all line departments utilise and support the CH structures to implement theirhealth-related community activities. ii. Ensure full integration of CH activities into the District Health Development and Operational Plans- the guiding document for community- level health interventions in the district.	CAO	Representatives from Relevant depts- Health, Labour, Education, Water, community development, Production, Planning
6	HSD Mgt	i. Coordinate All stakeholders and implementers	Chair	AHE, HI, CDO,

	Committee	of CH activities in the HSD. ii. Ensure proper coordination of community level health interventions in the HSD.	HUMC	
7	HC III Mgt Committee/ Division Healthteam	i. 1.Coordination, implementation, monitoring and evaluation of CHW force activities within their catchment areas. ii. Sensitization of sub-county leaders at regular meetings on CH and ensure that activities of partners working at sub-county level are included in the sub-county and health facilitywork plans. iii. Be the custodians of supplies and commoditiesthat are used by the CH workforce. iv. 4.Oversees and supervises the implementationof CH programmes in the sub-county.	Chair HUMC	I/C, Committee Members
8	Parish Health Committee	i. This is the implementation level of CH activities-essential health services atcommunity level. ii. Responsible for the coordination, overseeing and administrative supervision (non-technical)of CH activities in their areas. iii. Provides the actual linkage of the Communitiesto the health facility	PC/PDC Chair	PC, Committee members, PHNurse, H/Asst, CHEW
9	Village/cell Health Committee	i. Formation of Bye laws ii. Community based surveillance and case detection including deaths, iii. Community case management including supporting self-isolation, community-based drug distribution and referrals as appropriate iv. Community contact tracing and reporting v. Community shielding of vulnerable members vi. Strategic Communication, creating awareness,	C/Man LCI	LC1 Chairperson and Council with the Village Health Team of five or more members, one of whom will be a fulltime paid Community Health Worker, Parish Chief, CDOs, Religious and Cultural leaders, Schoolrepresentatives, Health facility representatives, CSOs and Volunteers, private sector

		information and education to gain and hold trust of the communities vii. Maintaining the Village Health Register on households, data management and reporting viii. Responding to other health needs as appropriate		
10	Households	i. Guide/educate the household members on the tools provided by healthcare personnel without increasing fear. ii. Be attentive to the presence of alarming signalsor those indicating deterioration. iii. Maintain constant communication (as far as possible) with health authorities. iv. maintain the patient's mental well-being and reduce anxiety and stress. v. Support the patients on treatment and other measures vi. Maintain Infection prevention and control at household level	Head of family	Family members

4.3.2.2 Technical Structure

Table 6: Technical structure of the Community Health Structure

#	Structure	MOH	Roles
1	Directorate ofPublic Health	Director Public Health	i. Provide policy direction and coordinate line MDAs and relevant stakeholders in the Community Health programming. ii. Coordinate the development of Community Health Policies, Standards and Guidelines. iii. Monitor development and implementation of Community Health Work plans and Strategies across programmes. iv. Provide technical guidance and ensure coordination of community health system for the management of endemic andepidemic emergencies. v. Regularly assess the Key performance indicators (KPIs) of the Community health players across programmes. vi. Promote adherence to public health standards, protocol and guidelines
2	CH Department	CHS/CHD, Other relevant Depts. in MDAs and IPs	i. Carry out advisory role on the coordination, planning, and implementation of Community Health programmes. ii. Participate in the development of policies and strategies for improving Community health outcomes. iii. Support and participate in the formulation of national CH guidelines and standards. iv. Advocacy and resource mobilization for CH. v. Participate in building the capacity of health workers in the implementation of CH interventions. vi. Participate in M and E performance reviews and

			implementation of CH interventions in the health sector including developing a CH data base and receiving reportsfrom Regional CH Committees. vii. Conduct quarterly National Secretariat Committee meetings
3	Community Health Programmes	Heads of CH line programmes/ Depts/ Divisions /Sections: CH initiatives, Nutrition, Disability and Rehabilitation, Env'tal Health, Malaria Control, RMCH, UNEPI, NTB/LP, HIV/AIDS, NCDs, CDs, NTDs, Integrated Epi and Surveillance, National Lab and Diagnostics.	i. Coordinate advocacy and resource mobilization for CH activities ii. Ensure effective interventions are selected at national. regionaland district levels according to the local needs in conformity with national policies. iii. Support and coordinate implementation of CH programmes
4	DHO/ Public Health Officer	DHT	i. Overall planning, implementation and monitoring of CH activities in the district. ii. Delegate/assign a member of the district health team (CH Coordinator) to be responsible for the CH activities iii. Oversee and monitor the different CH programmes and projects being implemented; reporting to the central level to facilitate planning. Build the capacity of the CH workforce through provision of required technical support to the lowercadres.
5	Health Facilities/ Facility Health Team	HF in-charge	i. Take overall technical responsibility for all CH activities within their catchment areas. ii. Conduct training and supervision of Health Assistants iii. Support management of medicines and supplies for CHEWs iv. Regularly organize planning, review meetings and refresher programmes with VHTs in their catchment areas. v. Receive, analyze, utilize VH data and provide feedback

6	Parish/ HCII (Redefined)- HEALTH OUTPOST	Parish Chief/ Community leaders, Health Assistant, PH Nurse and CHEWs	i. Provide Community-based essential health services. ii. Coordinate, supervise and mentor the VHTs iii. Monitor, assess and ensure quality assurance of the supplied commodities and products for use at the community level
7	Village	Village Health Team	i. Provide Community-based essential health services as guided by qualified health care workers. ii. The VHTs will be accountable to the community leaders.
8	Households/ individuals	Heads of families	i. Provide the resources required for their families' health care ii. Seek and utilize and the services of the CH workers and VHTs iii. Report health incidences in the community to CH personneland VHTs

4.3.3 Specific Roles and Responsibilities of Key Community Health Structures

A) RURAL SETTING

1. Sub-County Level/HCIII/ Health Inspectors

- In-charge of community health services at Sub- County level/HCIII
- Oversee of all community health activities; preventive and promotive health, Home-based Care, Immunization, and Outreach services, including health reporting.
- Coordination and Supervision of Health Assistants/Community health activities at parish level
- Mobilize and link Parish communities to HCIII
- Perform other relevant duties as per public health career.

2. Parish Level: PH Nurse/Health Assistant/CHEWs

- In-charge of health affairs on Parish Development Committee, under Parish development model
- Oversee of all community health activities; health promotion, Home-based Care, Immunization, and Outreach services, including health reporting.
- Coordination and Supervision of the VHT/CHW activities/services at village level
- Mobilization and linking village communities to HCIII services,
- Perform other relevant duties as per public health career.

3. Village Health Committee/Local Council

- Oversight, leadership and ownership of CH activities/services, including supervising VHTs/CHWs.
- Support mobilization of the community to access available health services and enforcement of government health directives/policies
- Community based surveillance and case detection including deaths
- Strategic communication, awareness creation, information and education on health-related issues and services
- Maintain village health register on households and reporting on health issues
- Respond/act on any other health needs of their villages as appropriate.

4. VHTs/Village health Teams

- Perform functions equivalent to HC1: Basic health promotion, preventive and curative services-first aid, malaria, pneumonia, and diarrhea, etc.
- Community case management including case identification, home-based care, community-based drug distribution, and referral services
- Creation of awareness to enhance behavioral change, identification of the community health needs
- Collect health data and reporting, including deaths
- Link the community/households to healthcare system

5. Households/Individuals

- Family heads/caretakers responsible for the health of their members
- Household heads/caretakers and members to carry out prevention and control health activities

- Household heads/caretakers and members to offer care and psychosocial support to their sick members in homes
- Household heads/caretakers and members to support needs/case identification, surveillance, neighborhood watch and reporting
- Households to participate in the cascade of the model household approach.
- Household heads/caretakers and members to alert/inform VHTs, LCs/VHC, HCWs, and/ or para-social workers of any health concerns that need redress.

B) URBAN SETTING (CITIES, MUNICIPALITIES AND TOWN COUNCILS)

B.1 Directorates of Public Health

- Overall planning, implementation and monitoring of CH activities in the city/urban town.
- Delegate/assign a member as CH Coordinator/Officer to be responsible for the CH activities
- Oversee progress, monitor and report on the different CH programmes and projects
- Build the capacity of the CH workforce through technical support to the lower cadres.

B.2 Division/Sub- County level: Division Health Officers/ teams

- Oversee all community health activities; preventive and promotive health, Home-based Care, Immunization, and Outreach services, including health reporting.
- Coordination and Supervision of Community health activities at parish level
- Mobilize and link Communities/individuals to Health facilities
- Perform other relevant duties as per public health career.

B.3 Ward /Parish Level: PH Nurse/Health Assistant/CHEWs

- Form Community health teams, heads health affairs on Parish Development Committee/Social services sub-committee
- Oversee of all community health activities; health promotion, Home-based Care, Immunization, and Outreach services, including health reporting.
- Coordination and Supervision of the VHT/CHEW activities/services at village level
- Mobilization and linking village communities to HCIII services,
- Perform other relevant duties as per public health career.

B.4a Village Health Committee/Local Council

- Oversight, leadership and ownership of CH activities/services, including supervising VHTs/CHEWs.
- Support mobilization of the community to access available health services and enforcement of government health directives/policies
- Community based surveillance and case detection including deaths
- Strategic communication, awareness creation, information and education on health-related issues and services
- Maintain village health register on households and reporting on health issues
- Respond/act on any other health needs of their villages as appropriate.

B.4b Cell/Village Level- Formal Settlements: Public Health Nurse/Health Assistant

- Perform functions equivalent to HC1: Basic health promotion, preventive and curative services-first aid, malaria, pneumonia, and diarrhea, etc.
- Community case management including case identification, home-based care, community-based drug distribution, and referral services
- Creation of awareness to enhance behavioral change, identification of the community health needs
- Collect health data and reporting, including deaths
- Link the community/households to healthcare system

B.5 Cell/Village Level-Peri-urban /Informal settlements/Slums: VHTs

- Community case management including case identification, home-based care, community-based drug distribution, and referral services
- Creation of awareness to enhance behavioral change, identification of the community health needs
- Collect health data and reporting, including deaths
- Link the community/households to healthcare system

B.6 Households/Individuals

- Family heads/caretakers mobilize resources for the health of their members
- Household heads/caretakers and members to carry out environmental health and sanitation activities
- Household heads/caretakers and members to offer home-based care and psychosocial support to their sick members in homes
- Household heads/caretakers and members to support needs/case identification, surveillance, neighborhood watch and reporting
- Households to participate in the cascade of the model household approach.
- Household heads/caretakers and members to alert/inform VHTs, LCs/VHC, CHEWs, and/ or para-social workers of any health concerns that need redress.

4.3.2.1 Leveraging the Parish Development Model (PDM)

The PDM among its seven sector pillars, incorporates a focus on impacting improvements in health care services under Pillar 4 – Social Services. The parish model is further supported by the community information system which is a Parish-based Management Information System (PBMIS) that seeks to support community profiling, data collection, analysis, tabulation, storage, and dissemination at all levels. Pillar 4 of the PDM provides for improvements in primary health care, education, access to clean water, transport and communication that constitute basic social services, and these are the enablers in the attainment of better quality of life for households and communities.

The National Community Health Strategy shall consolidate delivery of these services at the grassroots level. Under Pillar 4, relevant stakeholders in the health sector shall identify and transfer resources to Local Governments in line with article 176(2)(e) of the 1995 constitution of Republic of Uganda to enable the local government to establish the best social services envisaged through the implementation of this constitutional provision.
The resources transferred will be appropriately planned for by the local governments to carry out the following:

a) Construct and equip health centers (HCIII)

b) Recruit critical staff as well as Community health workers needed.

c) Strengthen community health infrastructure /facilities management

d) Provide and maintain safe and accessible water points

e) Support functional CH structures/Workforce

f) Construct/upgrade community primary schools

g) Provide logistics and equipment for institutions (schools, Hospitals, Health centers)

h) The PDC shall be critical in identifying and prioritizing social services required at that level and share the priorities for approval and consolidation at the sub-county and district level. The PDM approach is tailored to the third National Development Plan 2020/21 – 2024/25, and it positions the "Parish" as the epicenter of multi-sectoral community development, planning, implementation, supervision and accountability.

4.3.3 Essential CH healthcare services / package

The CH services scales down to the Village level with the CH workers and other community support groups. Their main role is to provide the necessary services to the community with regards to prevention, health promotion, curative services, rehabilitation, and referrals. They will also be responsible for supporting the community to demand for quality health services, and access those that are available at the necessary facilities.
Key community health services will include, but not limited to, the following:

i. Health promotion and education about common disease
ii. Environmental health and sanitation
iii. Immunization/vaccination services
iv. Malaria prevention and control
v. Prevention and control of CDs/NCDs including Disability and rehabilitation
vi. Nutrition and supplementation
vii. Home-based and School health services
viii. HIV/AIDS and palliative care services including TB
ix. Occupational health and safety
x. Integrated community case management/ICCM of common diseases
xi. Sexual and reproductive health services and rights including FP and gender-based violence
xii. Community disease surveillance and reporting
xiii. Emerging health problems including disasters, climate change and pollution

CHAPTER FIVE:
IMPLEMENTATION FRAMEWORK

The Ministry of Health will be the overall party in charge of implementation of the National Community Health Strategy, through the Department of Community Health in collaboration with other departments. The previous chapter described the main outcomes, objectives, and strategies of community health in Uganda. This section enumerates the phases of the NCHS implementation along a five-year (2021/2022 – 2025/2026) period. It further specifies the Pillars, strategies and activities that will be implemented for an effective community health strategy.

5.1. IMPLEMENTATION FRAMEWORK

Table 7: Implementation Framework of Uganda's Community Health Strategy

No:	**Strategic Direction 1: Increase availability and access (geographic and functional) to equitable Community Health services**						
	Strategic Objective 1.1: Deliver a standardized integrated essential healthcare package of community level services						
	Key Interventions						
1.1.1	*Fast-track the MoH technical working group efforts to reconcile work on community service delivery and training curriculum guide to be used by allactors*	*National*	X				
1.1.2	*Review and develop an integrated community health service package that incorporates prevention, promotion, community case management,surveillance, referral, and rehabilitative services*	National level	X				
1.1.3	*Launch and operationalize the integrated community health service package*	All levels	X	X	X	X	X
1.1.4	*Disseminate guideline and regulatory frameworks for integration of community health activities at all levels*	All levels	X	X	X	X	X
1.1.5	*Review and consolidate a training curriculum for integrated community*	National	X				

	health services						
1.1.6	*Map and support districts to develop local government coverage plan for delivery community health services including vulnerable populations*	District level	X	X	X		
1.1.7	*Conduct mapping of implementing partners (private and public) by district and capabilities to assess existing capabilities potential partners/actors.*	All levels	X	X	X		
1.1.8	*Develop a community referral and follow up protocol to strengthen and streamline linkages between the community and health facilities*	National level	X				
1.1.9	*Develop a guideline for community homebased care of public health conditions*	National Level	X				
1.1.10	*Revise and disseminated guidelines for community homebased care of public health conditions.*	All levels	X	X	X	X	X
1.1.11	*Scale up ICCM strategy in the whole country*	District level, Health facility, Community	X	X	X	X	X
1.1.12	*Conduct community level wellness campaigns including regular medical camps, community wellness groups and clubs to prevent non- communicable diseases and community led home improvementcampaigns*	*Sub county, ParishVillage*	X	X	X	X	X
1.1.13	*Conduct Integrated outreaches to underserved and disadvantaged communities (geographical features, hard to reach)*	*Village*	X	X	X	X	X
1.1.14	*Procure and distribute ambulances to the respective regions based on District coverage plan*	*National Regional*	X	X			
1.1.15	*Equip Health Assistants and Assistant Public Health Nurse with motorcycles (District) and double cabins (Cities)*	*Health Facility*	X	X			
1.1.16	*Conduct Performance review meetings done quarterly (District) and monthly (facility), bi-annual (National) involving key stake holders likecommunity structures and partners*	*All levels*	X	X	X	X	X
1.1.17	*Revive Parish Development Committees to participate in community health promotion and disease prevention*	*Parish*	X	X	X	X	X

	Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce						
	Strategic Objective 2.1: Standardize recruitment of Community Health workers						
	Key Interventions:						
2.1.1	*Operationalize the cadres of Community health workforce*	National	X				
2.1.2	*Operationalize the roles and responsibilities for the cadres of community health workers (CHW)*	National level	X				
2.1.3	*Develop and operationalize the standards for CHW recruitment (that contains policies and guidelines on (Selection, with a gender sensitivemethodology, job description, education, certification, recruitment, deployment and remuneration of CHW)*	National level	X				
2.1.4	*Review and consolidate a master training curriculum for CHWs*	National level	X				
2.1.5	*Recruit up to 2 VHTs /Village based on population density and disease burden (1 VHT to cover between 60 to 100 households)*	Parish; Village					
2.1.5	*Strengthen the CHW registry to aid evidenced based planning, health information exchanges and communication. (Provide Support to biostatistician and HMIS focal persons to register VHTs in regions)*	District, health facility level	X	X	X	X	X
	Strategic Objective 2.2: Operationalize performance management framework for CHWs using the DESC approach						
	Key Interventions:						
2.2.1	*Develop and operationalize a remuneration and motivation framework for community health workers e.g., mobilize resources for communityhealth workers for both monetary and non- monetary incentive and reward packages*	National	X				
2.2.2	*Develop and disseminate CHW coordination structure.*	All Levels	X	X	X	X	X
2.2.3	*Procure and provide ID cards and visibility vests to CHWs for identification*	National; District		X	X	X	X
2.2.4	*Routinely Update CHW registry*	National; District	X	X	X	X	X

2.2.5	*Equip CHWs with basic kits (bicycle, Medicine bag, medicine box, T-shirt, Apron, gumboots, raincoat, torches, phone, thermometer, masks, Sickchild job aid, VHT/ICCM register, consumption logbooks MUAC tape, HMIS 001(Referral booklet, KFC practices, bicycle)*	National; District	X	X	X	X	X
2.2.6	*Provide Allowance of 100,000 per month per VHT (2 VHTs per village, 71,000 villages)*	National; District	X	X	X	X	X
2.2.8	*Train CHW supervisors on basic integrated package for delivery of community health interventions*	District level		X	X	X	X
2.2.9	*Train CHWs on basic integrated package for delivery of community health interventions*	community level		X	X	X	X
2.2.10	*Conduct refresher trainings of community health workers on integrated package for delivery of community health programs (3-day course)*	Health facility/ community level		X		X	
2.2.11	*Conduct training of CHW peer supervisors on supervisory role and reporting*	Health facility		X			
2.2.12	*Conduct quarterly CHW meetings (VHTs to meet at the health facility (Transport facilitation of 20,000 UGX per quarter per VHT) and SDA of20,000 for 2 health facility staff*	Health facility, community level	X	X	X	X	X
2.2.13	*Conduct home visits by HF staff/ Health assistant in communities*	Health facility/ Community	X	X	X	X	X
2.2.14	*Organize periodic CHW review meetings/ at district, that feeds to facilitate health facility sharing and learning*	District level		X	X	X	X
2.2.15	*Organize Periodic CHW meetings/ review workshops at regional level workshop to facilitate cross district sharing and learning*	Regional		X	X	X	X
2.2.16	*Organizing Periodic CHW meetings at national level facilitate cross district sharing and learning*	National		X	X	X	X
2.2.17	*Create CHW cooperatives that implement periodic saving and investment activities*	Parish	X	X	X	X	X

	Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply system						
	Strategic Objective 3.1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities in public and private sectors.						
	Key Interventions:						
3.1.1	*Participate in the review of Uganda's clinical guidelines to include products being managed by CHW to address the existing disconnect between policy and regulation on medicines dispensed by trained CHW*	National level	X				
3.1.2	*Participate in updating of essential medicines and health supplies list of Uganda to include integrated package for community health*	National level	X				
	Strategic Objective 3.2: Strengthen capacity for community level logistics and supply chain system management in public and private sector						
	Key Interventions:						
3.2.1	*Build capacity of implementers (DHT, IPs, PNFPs, PFPs, CHEWs and VHTs) of community health programs on community supply chain usingthe standardized national guidelines on medicine management and health supplies for community health program and related logistic management tools. (2-day training)*	All levels	X	X	X	X	X
3.2.2	*Integrate community supply chain into existing community health programs involved with use of health commodities to address gaps in program implementation targeting supply chain improvement at district,health facility and community level*	National level	X	X	X	X	X
3.2.3	*Collaborate with the Department of Health Services, Pharmaceutials and Natural Medicines to Scale up the implementation of community supply chain procedures at all levels through ensuring standardized frequency onordering for supplies for the CHWs, and issuing supplies based on demand using the standardized tools).*	All levels	X	X	X	X	X
3.3.6	*Quantify, procure and procure community supply chain tools to be used at the health facility and parish level. (I summary form for consumptionand requisition at parish and facility level, 2 product issue log for each health facility per year)*	National level	X	X	X	X	X

	Strategic Direction 4: Create improved and sustainable financing for community health programs						
	Strategic Objective 4.1: Institute harmonized and equitable financing by a stakeholder						
	Key Interventions:						
4.1.1	*Engage stakeholders to advocate for increased financing and alignment of community health interventions*	All Levels	X	X	X	X	X
4.1.2	*Develop guidance for all stakeholders for coordination for CH financing and rationalizing resources and operationalize/monitor adherence to theguidance through regular TWG monitoring*	National	X				
4.1.3	*Identify and evaluate effective and sustainable public private partnerships models and partner models, and develop a strategy to incorporate andscale them in implementation of the CHS*	All levels	X	X	X	X	X
4.1.4	*Conduct a review of Provider Payment Mechanisms for primary health care to identify linkages between the health facilities and communityhealth framework*	National		X			
4.1.5	*Develop an investment case for the inclusion of community health indicators under the Results Based Framework to strengthen healthoutcomes*	National		X	X		
4.1.6	*Conduct a gap analysis and develop an investment case for increased MoH budgetary allocation to Community Health services and CHgenerated non-tax revenue*	National		X			
4.1.7	*Advocate for the alignment, harmonization and coordination of external funding and resources and for more financial resources to flow throughthe Government account for funding predictability*	All levels	X	X	X	X	X
	Strategic Objective 4.2: Improve resource mobilization for the delivery of integrated community health services						
	Key Interventions:						
4.2.1	*Analyze the sufficiency and public management practices of PHC funds which contribute towards CH*	National		X			
4.2.2	*Quantify and include CHW needs at the community level into the general health facility procurement planning for all community programs andadvocate for increased financing*	National; District	X	X	X	X	X
4.2.3	*Create a community health cost center at the district level to ear mark*	District	X				

	funding for implementing community health services						
4.2.4	*Develop strategy to consolidate the community health workforce financing strategies through the TWF to be able to define and consolidatea strong CH workforce in the medium term and long term*	National	X				
4.2.5	*Strengthen the incentive mechanisms for CHW programme, through cooperatives, community PBF and in partnership with hospitals IGRprograms and ensure sustainable quality service provision*	All levels	X	X	X	X	X
4.2.6	*Identify and review existing community health insurance schemes to evaluate their effectiveness in providing social protection and financingCH at sub national levels*	District	X				
	Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions						
	Strategic Objective 5.1: Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data						
5.1.1	*Collaborate with DHI to map and review existing community data collection and reporting tools*	National, District, Sub-County, Parish	X				
5.1.2	*Review and update indicators as per the integrated community health service package including supply and logistics data for delivery ofcommunity health programs*	National	X				
5.1.3	*Develop a standardized comprehensive community data collection and reporting tool for an integrated community health service delivery*	National	X	X			
5.1.4	*Strengthen vital registration (Births and deaths registration) at community level*	Facility; Village	X	X	X	X	X
5.1.5	*Develop a data use manual for VHTs to enable decision making and timely interventions*	National	X				
5.1.6	*Quantify, procure and distribute all relevant community health data collection and reporting tools including community supply chain tools forall districts (2 Registers, 2 Referral books, 2 Consumption Logbooks/VHT/Year)*	National, District, Sub-County	X	X	X	X	X
5.1.7	*Quantify, and procure community supply chain tools to be used at the health facility and parish level. (I summary form for consumption and*	National level	X	X	X	X	X

	requisition at parish and facility level, 2 product issue log for each health facility per year)						
5.1.8	*Launch and operationalize a comprehensive and integrated community data collection and reporting tool for community health interventions*	National, District, Sub-County, Parish		X	X	X	X
5.1.9	*Routinely train CHWs in reporting indicators and data use for timely and informed community health interventions*	District, Sub-County, Parish		X	X	X	X
5.1.10	*Provide supportive supervision and mentorship to CHWs in data collection and reporting*	Parish, Village		X	X	X	X
5.1.11	*Conduct monthly community health data quality audits at all levels*	National, District, Sub-County, Parish, Village	X	X	X	X	X
	Strategic Objective 5.2: Digitize community health service delivery						
5.2.1	*Collaborate with DHI to Map and evaluate digital innovations (OCR, Apps) for CH service delivery*	National	X				
5.2.2	*Develop and disseminate a roadmap for adopting and scaling up digital community health service delivery*	National	X	X			
5.2.3	*Develop and disseminate training manuals for community health workforce on digital community health systems*	National	X	X			
5.2.4	*Adopt and Scale appropriate innovations (OCR, Apps) for CH service delivery*	Sub-County, Parish, Village	X	X	X	X	X
5.2.5	*Routinely train community health workforce on basic ICT and digital community health systems*	Sub-County, Parish, Village	X	X	X	X	X
5.2.6	*Equip CHWs with appropriate digital tools for community health service delivery*	Sub-County, Parish, Village	X	X	X	X	X
5.2.7	*Integrate community supply chain into available community digital platform and link it to DHIS2 and pharmaceutical information portal.*	National level	X	X			
	Strategic Objective 5.3: Increase utilization of Community Health Data for decision-making in the community health system						
5.3.1	*Collaborate with DHI to develop the indicator compendium/KPIs for CH data reporting.*	National	X				

5.3.2	*Integrate key community heath indicators on the district league table for effective monitoring and evaluation of community health programs*	National	X				
5.3.3	*Strengthen capacity of health facility, district, and national level to use community level logistic data for planning and decision-making includingreplenishment of medicines for CHW's.*	All Levels	X	X	X	X	X
5.3.4	*Build improved community health data visualization and analytics at all levels- national, sub national, facility and community Level*	All Levels	X	X	X	X	X
5.3.5	*Conduct performance review meetings monthly (facility); quarterly (District) and bi-annual (National) involving key stake holders such ascommunity structures and stakeholders*	All Levels	X	X	X	X	X
	Strategic Objective 5.4: Strengthen Community-Based Disease Surveillance systems (CBDS)						
5.4.1	*Coordinate and harmonize active CBDS in line with IDSR*	National	X	X			
5.4.2	*Build capacity of Community health workforce to implement active CBDS*	District/ Subcounty/ Village	X	X	X	X	X
5.4.3	*Equip community health workforce with appropriate tools to implement CBDS*	District/ Subcounty/ Village	X	X	X	X	X
	Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in delivery community health services.						
	Strategic Objective 6.1: Strengthen multi-sectoral coordination, planning and implementation of Community Health programs						
	Key Interventions:						
6.1.1	*Institute and support functionality of community health technical working group (TWG) and steering committee at national and sub-national/district levels.*	National/ District	X	X	X	X	X
6.1.2	*Map all community health stakeholders, funding flows and intervention areas at the national and district/sub-county level*	National/ District	X				
6.1.3	*Strengthen partnerships and meaningful engagements with stakeholders to encourage cross-sectoral synergies in implementation of community*	All Levels	X	X	X	X	X

	health programs						
6.1.4	*Identify opportunities and establish mechanisms for public-private partnerships across all levels to address social determinants of health*	National/ District	X	X			
6.1.5	*Strengthen Village Health communities' capacity to develop contextualized measure to public health*	Parish/Village level	X	X	X	X	X
6.1.6	*Increase capacity of the community Health Department at Ministry of Health to oversee and coordinate the community Health service deliveryPlatform*	National level	X	X	X	X	X
	Strategic Direction 7: Engage and empower communities for effective accountability and improved health outcomes.						
	Strategic Objective 7.1: Enhance effective mobilization of families, communities and citizens for community engagement and participation						
	Key Interventions:						
7.1.1	*Conduct consultative meetings with community members and community leaders to identify barriers of utilization and issues faced by the communities in respect to their causality, differentiation of needs anddemands of the various social strata.*	Parish/ Village	X	X	X	X	X
7.1.2	*Identify and support participatory methods in the production of Community Radio shows, TV, Print media, Bodaboda talk; communitydrama that promote health seeking behaviour and empower communities with information*	Parish/Village/ Community	X	X	X	X	X
7.1.3	*Support activities at the community level that are aimed towards health knowledge, attitudes, practices and behavior among all population groups*	Parish/Village/ Community	X	X	X	X	X
7.1.4	*Conduct awareness raising campaigns through gatherings; focus group discussions and media channels on the importance of health services andactivities*	Parish/Village/ Community	X	X	X	X	X
7.1.6	*Routinely conduct health information needs assessment of communities*	All Levels	X	X	X	X	X
7.1.5	*Disseminate IEC s at the community level based on information needs of communities*	Parish/Village/ Community	X	X	X	X	X
7.1.6	*Establish a misinformation tracking and response mechanism to address knowledge-damaging messages for community health*	All Levels	X	X	X	X	X

	Strategic objective 7.2: To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions						
	Key interventions:						
7.2.1	*Strengthen advocacy at national, district and community level for community participation in governance, planning and implementation ofessential health services*	All Levels	X	X	X	X	X
7.2.3	*Involve community, leaders and representatives in the selection of community health workers, as key role models in society*	Village	X	X	X	X	X
7.2.4	*Identify and support local innovations to enhance community health services*	District/ Parish/ Village	X	X	X	X	X
7.2.2	*Enhance participation of community stakeholders in technical working group meetings*	All Levels	X	X	X	X	X
7.2.3	*Establish a feedback mechanism to facilitate a two-way communication bottom top approach*	All Levels	X	X	X	X	X
7.2.4	*Build capacity of local health structures to effectively participate in monitoring community-based activities*		X	X	X	X	X
7.2.5	*Involve HUMCs in planning and budget and promoting of community-based health services*	Sub County; Parish; Village	X	X	X	X	X
7.2.6	*Identify and reward community change agents as role models*	Parish, Village	X	X	X	X	X

CHAPTER SIX:
MONITORING AND EVALUATION FRAMEWORK

This section specifies the Goals and objectives of a national community health strategy, the Short-term, Mid-term and Long-term targets of a national community health strategy, Indicators of measurement and means of verification, Data Collection methods, tools and timelines as well as the persons responsible and reporting.

6.1. M&E AND RESULTS FRAMEWORK

Table 8: Monitoring and Evaluation Framework

Interventions	Measurement Indicators	Targets
PILLAR 1: HEALTH SERVICE DELIVERY		
Objective 1: To deliver a standardized integrated essential health care package of community level services		
-Define the scope of the community health services to include MDT -Advocacy for improved community health services -Support community health teams to conduct integrated outreaches tounderserved populations. - Organize integrated and specialized medical camps -Increase the geographical coverage of community health services - Mainstreaming and integrating health promotion in all program andproject activities being implemented - Setting up a regional Emergency Medical Services system to cater for	Number of Consultative meetings held Number of writing workshops held Number of outreaches done Number of medical campsorganized Number of materialsdeveloped Number of implemented programs that cover the component of Communityhealth	90% of the community report involvement and participation 20 writing workshops held 90% of the outreaches conducted Medical camps are organized bi-annually Material developed and revised annually At least 90% of implemented programs include component ofcommunity health At least three per village

emergency situations - Conducting community level wellness campaigns including regular medicalcamps, community wellness groups and clubs to prevent non-communicablediseases and community led home improvement campaigns	Number of Emergency Medical Services Systems setup Number of wellness campaigns conducted	Wellness campaigns are conducted at least bi-annually
Objective 2: To strengthen referral and linkages between the community and health facilities		
-Increase scope of Home- based care in the community - Procure and distribute ambulances to the respective regions - Equipping Environmental Health Staff and health educators with motorcycles (District) and double cabins (Cities) - Performance review meetings done quarterly (District) and monthly (facility), bi-annual (National) involving key stake holders like community structures and partners	Number of community health workers mentored Number of ambulancesprocured Percentage of staff supported with motorcycles Number of meetingsconducted	75% of the health workers mentored At least five ambulances procuredper region 80% of the staff are supported At least two meetings conducted monthly
Objective 3: To increase demand and utilization for community services		
-Enhance initiatives to ensure demand and utilization of community health services - Conducting community level wellness campaigns including regular medical camps, community wellness groups and clubs to prevent non-communicable diseases and community led home improvement campaigns - Carry out integrated outreaches to underserved and disadvantagedcommunities (geographical features, hard to reach)	Number of districts with documented community diagnosis Number of wellness campaigns conducted Number of outreaches done	Review of the community diagnosis. (Can be updated quarterly for emerging epidemic Wellness campaigns are conducted at least bi-annually 90% of the outreaches areconducted
PILLAR 2: HEALTH WORKFORCE		
Objective1: To standardize recruitment, and terms of engagement of VHTs		
-Create ToRs for VHTs	Number of VHTs certified in a given year	142,000 (2 per village)

-Develop a 2-week basic training and certification program for VHTs -Deploy VHTs -Functionalize the CHW/VHT Registry at parish and district level	A final approved National VHT training curriculum in place % VHTs with a fully equipped work toolkit An updated CHW registry updated annually at each district	2022 developed curriculum 2022 revised edition Guidelines developed to be followed at district level in 2022
Objective 2: Develop performance management framework for CHWs		
-Develop a performance plan for VHTs - Review the training materials and curriculum for CHWs - Fast-track the MoH technical working group efforts to reconcile work on community training curriculum and guide to be used by all actors	Percentage of timeliness of VHT reports Training materials reviewed A harmonized guide for all partners is developed	50% VHT reports received per district 100% of all training materials reviewed Presence of a harmonized guidefor all partners
Objective 3: To enhance retention and facilitate a career path for the community health workforce, including nursing, clinical and other health service professional areas		
-Determine an optimal CHW: Population ratio -Equip the CHWs with basic kits (PPEs, reporting tools) - Carrying out routine skills assessments, training, mentorships, orientationand refreshers of CHWs, so as to improve capacity. Trainings must be streamlined across projects, partners and districts	Rapid assessment for contextualization conducted Number of CHWs supported with the necessary tools Number of CHW supported	Once every year At least 90% of the CHWs At least 90% of the CHWs
PILLAR 3: SUPPLY CHAIN		
Objective 1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities		
-Update the community supply chain strategy 2016-2020.	-Copy of updated community	Monthly

	supply chain strategy 2022-2026. -Number of medicines and health supplies updated in the EMLS. -Number of storage facilities developed for supply -Number of stakeholderswith capacity built	Quarterly Bi-annually Annually 90% of the storage facilities are developed 75% of the stakeholders havetheir capacity built
- Improvement of storage structures at all levels especially village andparish levels e.g. expansion of stores - Capacity building of stakeholders and supply chain/medical product management and monitoring		
Objective 2: Strengthen capacity for community level logistics and management in public and private sector		
-Functionalize and streamline the MoH coordination task team to steer implementation of the community supply chain - Introduce e-ordering of medical supplies through digital innovations - Normalization and recruiting qualified staffs in supply chain management atall levels -Map and identify gaps in the availability of community supply chaintools - Conduct needs assessment prior to supply for the streamlining of implementation and allocation of drugs to prevent shortages in some placesand wastage in other	Presence of a supply chain system in place for trackingof supply Developed e-ordering system Percentage of staff that are qualified Presence of supply chain system in place Number of needs assessments conducted	1 supply chain system in place E ordering system in place 90% of the staff are qualified 1 supply chain system in place 90% of distributions have prior needs assessments
PILLAR 4: COMMUNITY HEALTH FINANCING		
Objective 1: Institute harmonized and equitable financing by stakeholders		
-Develop guidance on coordination for CH financing & CH generated non-tax revenue	Number of community health strategies included in long term financing plans	At least 5 community health strategic activities included in long term financing plans

-Investment on advocacy to ensure leadership is brought in and the will of national actors and partners to own the strategy is escalated	Number of advocacy activities carried out	Advocacy activities implementedat least bi-annually
Objective 2: Improve resource mobilization for the delivery of integrated community health services		
-Develop guidance on financing activities at community level - Organize initiatives on financing activities at community level	Number of community mobilization initiativesorganized	5 National community mobilization initiatives organized
PILLAR 5: LEADERSHIP AND COOPERATION		
Objective 1: Strengthen multi-sectoral coordination, planning and implementation of CH program		
-Strengthen Legal and Regulatory Frameworks for CH Programming -Supporting the development of community health ordinances and bye-laws toensure community compliance.	Number of meetings held Number of community health ordinances and bye-laws formulated	Twice every year Once a year
Objective 2: Enhance capacity for effective program planning, implementation and accountability for improved CH outcomes		
-Carry out leadership training workshops to enhance capacity of leaders	Percentage of leaders trained.	Once every year
Objective 3: Strengthen data utilization for effective decision making to improve leadership and governance for community health programming		
-Provide data recording tools with community health information	% Of CH information digitized	70% of the information digitized
PILLAR 6: INFORMATION MANAGEMENT		
Objective 1: Enhance the capacity of community health workforce to effectively collect, collate and report quality community health data		
-Develop an integrated reporting tool for an integrated service delivery of community health interventions	Percentage CHW trained on reporting	90% of the community report involvement and participation
Objective 2: Establish Community-Based Disease Surveillance system such as a harmonized eCHIS		
-Map, evaluate and adopt appropriate innovations (OCR, Apps) ineCHIS	-% CHW trained on eCHIS Percentage of facilities with	90% of the community leaders around the country report involvement in identification of

-Strengthen Monitoring and Evaluation (M&E) unit at the community health division of MoH for timely and informed community healthinterventions -Develop and disseminate community-based surveillance guidelines and integrate into the national diseases surveillance system	Community Score Card Percentage of VHT equippedto perform CBDS	community health needs National community mobilization initiatives organized Community innovations arefunded
PILLAR 7: COMMUNITY ENGAGEMENT AND PARTICIPATION		
Objective 1: Enhance effective mobilization of families and communities for community engagement and participation		
-Develop and implement a comprehensive community engagement and participation strategy -Streamline the role of community groups such local leaders, women and youth groups	Strategy developed Number of community groups actively involved in community health service delivery	2022 Quarterly
Objective 2: Strengthen institutional capacity of state and non-state actors for effective community engagement and participation		
-Strengthen advocacy at national, district and community level for community participation, governance, planning and implementation	Write ups made	2022
Objective 3: Improve Community participation in governance, coordination, collaboration, planning and implementation of community health interventions		
-Enhance participation of stakeholder in technical working group meetings	Percentage of community members that meet regularly and plan	70% of community leaders mobilized to participate inplanning

CHAPTER SEVEN:
COSTING OF THE NATIONAL COMMUNITY HEALTHSTRATEGY

7.1. INTRODUCTION

To support strategic planning and to link the programs to the funding, a costing model was developed and used to estimate the resources required for the NCHS strategy. The costing model is anchored on the seven pillars of the NCHS that are illustrated in the table below.

Table 9: Pillars, Strategic Direction and Strategic objectives for the NCHS

Strategic Direction	Strategic Objectives
Pillar 1: Community Health Service Delivery	
Strategic Direction 1: Increase availability and access (geographic and functional) to equitable Community Health services	**Strategic Objective 1.1**: Deliver a standardized integrated essential healthcare package of community level services **Strategic Objective 1.2**: Strengthen referral and linkages between the community and the health facilities **Strategic Objective 1.3**: Increase demand and utilization of community health services
Pillar 2: Community Health Workforce	
Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce.	**Strategic Objective 2.1**: Standardize recruitment of Community Health workers **Strategic Objective 2.2**: Operationalize performance management framework for CHEWs using the DESC approach **Strategic Objective 2.3**: Facilitate career path for the community health workforce
Pillar 3: Health Supply Chain and medical products	
Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply system	**Strategic Objective 3.1:** Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities in public and private sectors. **Strategic Objective 3.2:** Strengthen capacity for community level logistics and supply chain system management in public and private sector
Pillar 4: Community Health Financing	
Strategic Direction 4: Create improved and sustainable financing for community health programs	**Strategic Objective 4.1:** Institute harmonized and equitable financing by stakeholders **Strategic Objective 4.2**: Improve resource mobilization for the delivery of integrated community health services

Strategic Direction	Strategic Objectives
Pillar 5: Leadership, Governance and Coordination	
Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions	**Strategic Objective 5.1:** Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data **Strategic Objective 5.2:** Digitize community health service delivery **Strategic Objective 5.3:** Increase utilization of Community Health Data for decision-making in the community health system
Pillar 6: Community Health Management Information Systems	
Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in delivery community health services.	**Strategic Objective 6.1:** Strengthen multi-sectoral coordination, planning and implementation of Community Health programs **Strategic Objective 6.2:** Strengthen Community-Based Disease Surveillance systems (CBDS)
Pillar 7: Community Engagement and Participation	
Strategic Direction 7: Engage and empower communities for effective accountability and improved health outcomes.	**Strategic Objective 7.1: E**nhance effective mobilization of families, communities and citizens for community engagement and participation **Strategic objective 7.2:** To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions

7.2. COSTING METHODOLOGY

Costing was undertaken through a participatory and consultative approach including all key sectors and other stakeholders. The process involved engagements with the stakeholders including the technical wing from the Ministry of Health, the Civil society Organizations and representatives of the Implementing partners and the other mechanisms across the national and sub-national levels. The stakeholders identified, developed, and prioritized key interventions to be drawn from the respective sectors that were included in the strategy. Key interventions were selected based on the effectiveness and level of their impact in achieving the objectives of the NCHS.

The stakeholders further identified additional resources needed for implementation which included health products and equipment, human resources, capacity building monitoring, evaluation, and other services. Finally, an ingredient costing approach was used to complete the analysis, where key inputs for each activity are identified, quantified, and then costed.

This ensured all aspects of an activity were monetized to facilitate resource allocation, utilization, and tracking.

Specifically, the two-layered analysis was done as follows:

a) The specific interventions layer was used to estimate the resources for all programmatic interventions. This used the formula below:

Intervention Cost = Target Populations X Service Coverage X Unit Costs

This involved the identification of the populations, and /or communities for whom the services were intended for thus the Target population; the population in need; the portion of the population in need that can feasibly be reached. The component of the unit costs used were derived with inputs and guidance from the Government of Uganda Civil service standing orders; Domestic and international indicative price indices for medicines drugs and all supplies used in the NHCS Strategy. The Annexes attached (**Annex 4**) illustrated the key assumptions that were used in estimating the programmatic needs for the health and non-health supplies.

b) Program Overhead were calculated by estimating the quantities of activities, the scope of coverage and the cost of services as guided by the relevant payment mechanisms including the GoU standing payments orders, project costings, and the UN payment systems where applicable.

7.2.1 Data

The datasets used for the costing exercise were drawn from the MoH reports, the GoU administrative structures, program reports and the demographic projections using the Spectrum software. Unit cost data was based on Government of Uganda Public service standing order regulations, International Indicative prices for health products and supplies and also indicative expenditure trends obtained through detailed reviews of project expenditures from various funding agencies as well as consultations with key MDAs and implementing agencies.

7.2.2 Scenario

The assignment was guided by the use of the scenarios which were developed to inform the policy and key decision making with regard to the financing of the plan. The major cost driver for this strategy is the Human resource element. This is composed for the Village Health Teams and the Community Health Extension Workers anchored at the village and the parish levels respectively. The Human resources component was identified a basis for the scenario development as it had a significant influence on the implementation of the plan.

Three scenarios were developed based on the following assumptions.

Scenario 1: Base case scenario.

This scenario assumed that the GoU will remunerate **one VHT** per village and **one CHEW** per parish in the first two year, and later funds an extra VHT and CHEW for the remaining period of the plan.

Table 10: VHTS and CHEWS planned for GoU support

CHEWS and VHTS	Year 1	Year 2	Year 3	Year 4	Year 5
CHEWS- (10590 Parishes)	10,590	10,590	21,180	21,180	21,180
VHTs- (70,630 Villages	70,630	70,630	141,260	141,260	141,260

Scenario 2: Moderate case

This scenario was based on the assumption that GoU will remunerate **one VHT and one CHEWs** in the first year of strategy implementation. GoU will thereafter renumerate the 2 CHEWS from the second year till the end of the plan. An additional VHT will be picked up making five VHTS remunerated by GoU by the fifth year of the plan.

Table 11: VHTS and CHEWS planned for GoU support

CHEWS and VHTS	Year 1	Year 2	Year 3	Year 4	Year 5
CHEWS- (10590 Parishes)	10,590	21,180	21,180	21,180	21,180
VHTs- (70,630 Villages	70,630	141,260	211,890	282,520	353,150

Scenario 3: Full scale case

This scenario was based on the assumption that GoU will remunerate all the **five VHTs** and **two CHEWs** throughout the period pf the plan.

Table 12:VHTS and CHEWS planned for GoU support

CHEWS and VHTS	Year 1	Year 2	Year 3	Year 4	Year 5
CHEWS- (10590 Parishes)	21,180	21,180	21,180	21,180	21,180
VHTs- (70,630 Villages)	353,150	353,150	353,150	353,150	353,150

The other key attendant cost that will vary with the numbers of the VHTs and CHEWS will include the VHT filed packages, trainings, and mentorships.

A quick comparison of estimated resources for the three scenarios reflected a gradual increase in funding under scenarios one and two across the five years, while there are peak costs in the first and second years under scenario 3. The peak years are attributed to huge costs of recruitment and equipping all the required VHTs and the CHEWs in the initial years.

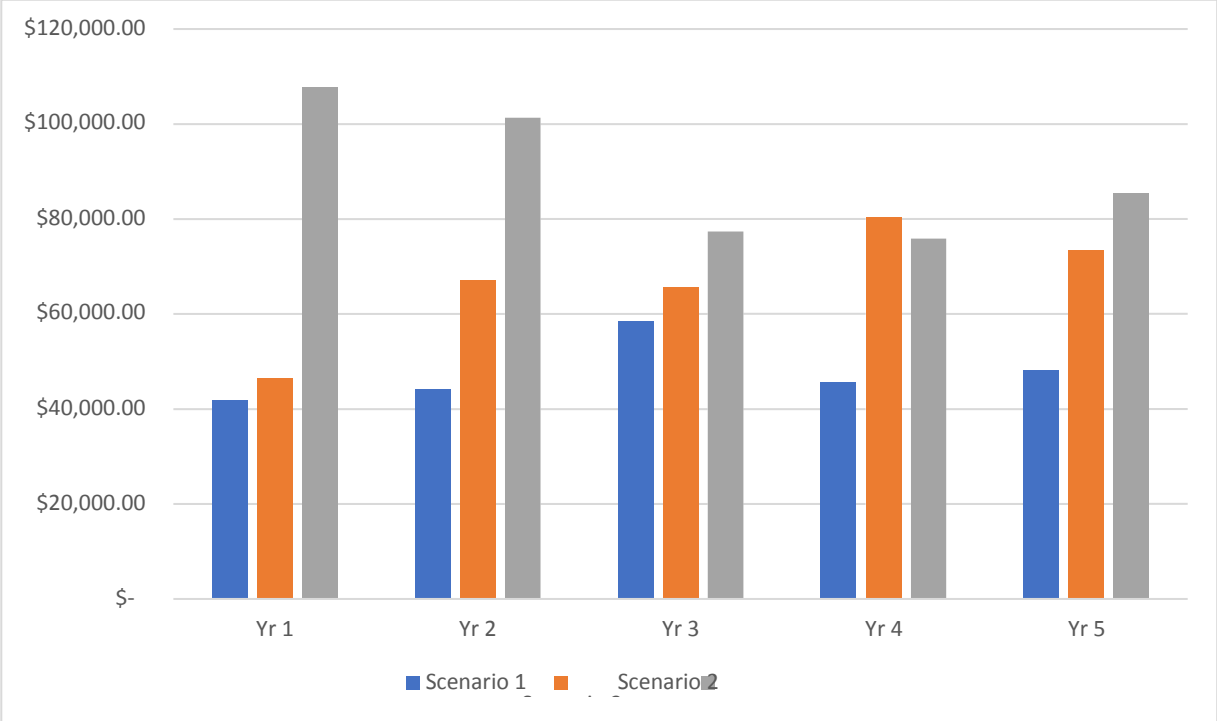


Figure 12: Comparison of Resource requirements in USD '000" for the three Scenarios

Based on the above assumptions and the resource constraints, the Moderate scale scenario was proposed for recommendation as the suitable scenario for implementation during the planned period. This scenario was deemed more feasible as it provided ample time in a resource constraint environment to lay the necessary infrastructure and build capacity of health workers at the service delivery levels before full implementation.

Key Assumptions for the Proposed Scenario.

a) The Scenario assumes at least one CHEW per Parish in the first year and additional recruited in the second year

b) At least one VHT per village supported by GoU in the first year, with additional VHT recruited and supported per year to attain the target of 5 VHTs per village in the fifth year.

7.2.3 Results

The resource estimate for the planned period 2021/22-2025/26 was estimated at US Dollars 332.185 million over the five-year period. The resources for the plan period would gradually increase from US$ 45.465 million in the first-year peaking US $ 81.638 million and US $ 74.479 million in the fourth and fifth years respectively. The peaks are reflective of the need to ensure all the required VHT are recruited and fully equipped for service delivery.

Table 13: Summary of the costing of the NCHS by Cost categorized

Cost Categories	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5	Total	%age
	USD "000"						
Advocacy	3,174.50	3,298.47	3,269.73	3,269.73	3,269.73	16,282.17	5%
Community Outreaches	4,763.43	4,906.33	5,740.00	5,952.57	5,952.57	27,314.89	8%
Equipment	2,730.00	2,811.90	-	-	-	5,541.90	2%
Financing	598.77	582.70	560.61	560.61	560.61	2,863.31	1%
Health information system	1,366.38	1,346.64	-	-	-	2,713.02	1%
Human Resources	14,255.78	27,886.63	36,200.79	44,514.95	52,829.11	175,687.25	53%
Information Education and Communication	215.86	207.04	207.04	207.04	207.04	1,044.01	0%
Monitoring Evaluation and Learning	6,187.17	6,776.54	6,729.40	6,729.40	6,746.58	33,169.08	10%
Governance	1,315.12	1,327.80	1,327.80	732.86	1,006.96	5,710.55	2%
Policy Issues	143.74	-	-	-	-	143.74	0%
Program Support	9,689.79	15,843.62	9,942.05	17,537.34	2,067.42	55,080.21	17%
Trainings	1,998.40	1,981.68	1,660.89	845.84	779.97	7,266.77	2%
Totals	**46,438.94**	**66,969.34**	**65,638.31**	**80,350.33**	**73,419.99**	**332,816.90**	

Sector Wide Approach Mechanism.

A multi-sectoral approach will be used to implement the National Community Health strategy. The interventions in the strategy will be implemented across different sectors, including: Health; Education Gender, Labour, and Social Development and the Local Government, with the Ministry of Finance, Planning and Economic Development, playing a key role of mobilizing and allocating resources to the respective sectors and implementers.

Cost Categories of the Strategy.

The resource estimates for the NCHS under scenario 2 are split among the various categories as illustrated in the figure below. The cost categories taking up the majority of the resources is the Human resources with 53% of the total resources followed by the program support and the Monitoring evaluations and Learning components with 16% and 10% respectively. The key drivers under the Human resources are the costs for the VHTs and the CHEWs cadres at thevarious service delivery levels.

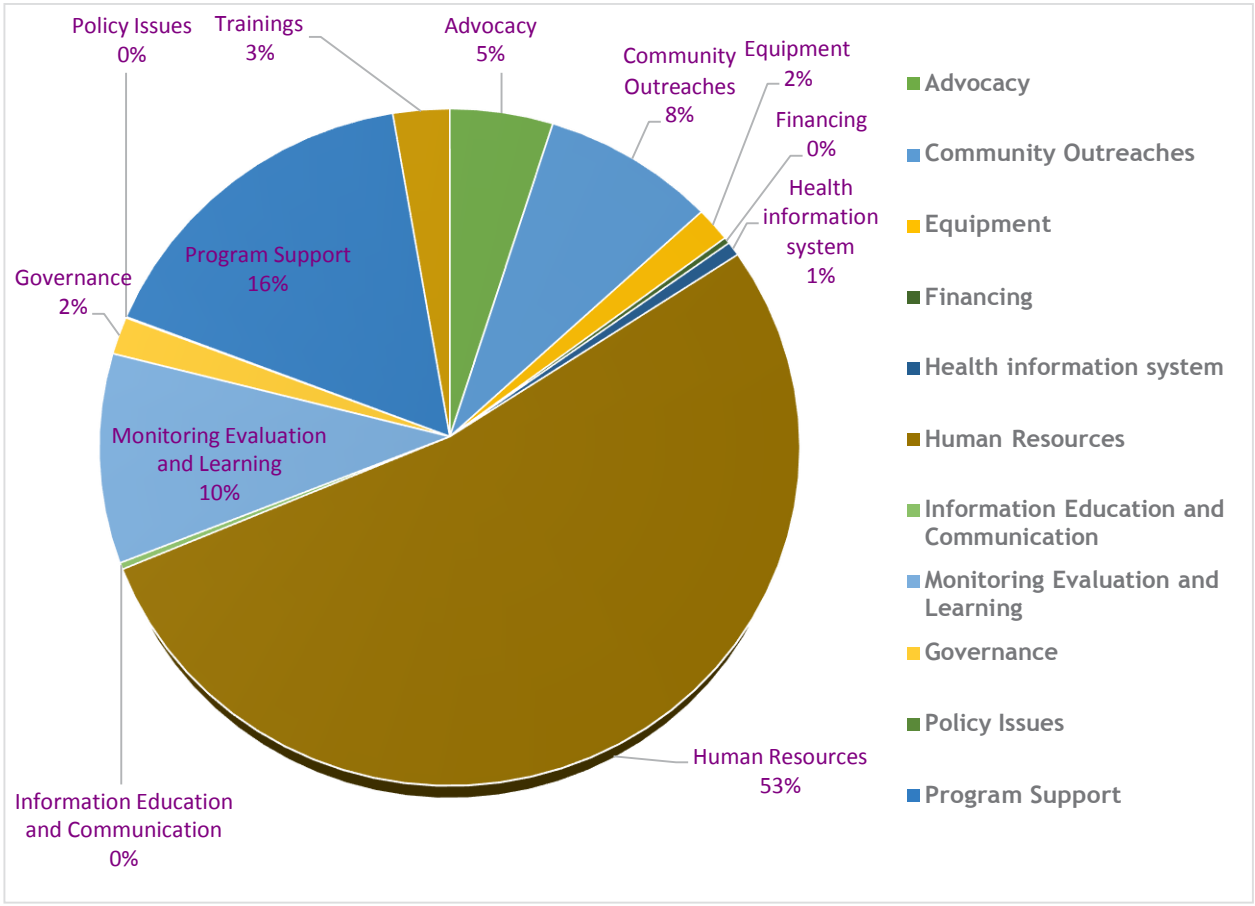


Figure 13: NCHS resources as categorized by the Cost classifications

7.3. FINANCING OF THE STRATEGY

Contributions from the GoU, the development partners, and contributions through key interventions with the private sector will finance the NCHS strategy. The GoU will fund the Community program using budget support to the sectors. The funding covers wage, nonwage bill, and development and transitional expenditures. Development partners' contribution will be through the budget and off-budget support. The off-budget support is primarily project based; and funded directly from the donor Agencies.

The private sector and individual households will continue to play a role in filling in gaps not financed by the GoU and the development partners. This will be largely through out-of-pocket expenditures and in-kind contributions from the communities. The private sector, out-of-pocket, and community contributions, however, cannot be accurately quantified because of lack of reliable and verifiable data and information. A funding gap analysis revealed a funding gap to a tune of USD 320,705.93 million as shown in the table below.

Table 14: Funding Gap Table for the NCHS

	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5	Totals
		US $ "000"				
Resource estimates for the strategy	46,438.94	66,969.34	65,638.31	80,350.33	73,419.99	332,816.90
Committed resources						
Government of Uganda	2,191.78	2,301.37	2,416.44	2,537.26	2,664.12	12,110.97
External Resources						-
UNICEF						-
GFATM						-
WHO						-
USG						-
KoFIH						-
Private sector contributions						-
Total Projected resources	2191.7808	2301.3699	2416.4384	2537.2603	2664.1233	12110.9726
Funding Gap.	44,247.15	64,667.97	63,221.87	77,813.07	70,755.86	320,705.93

Efforts to raise adequate resources for the NHCS will require among others lobbying for GoU budget allocations to the Human capital development thematic areas under which the Health, Education and Gender sectors are premised. Additional budget allocations and release are vital step in ensuring the strategy implementation can draw resources from the domestics funding.

Other Key mobilization strategies will include the following:

a) Deepening and further consolidations of relationships with the current and potential partners. Over 60% of the current resources for the implementation of the strategy is provided by the external funding sources. It is critical for their continued support and commitments in the short and medium terms.
b) There urgent need to ensure efficient and optimum utilization of resources at hand. Increasing program integrations will results into synergetic process with more resultants outputs, as well as minimizing program duplications and resource wastes.
c) There is need to diversify into new and innovative mechanism of raising additional resources. These include increasing collaborations with the Private sector players, community initiatives and rolling out of the national and community insurance schemes among others.

CHAPTER EIGHT:
ANNEXES

8.1 ANNEX 1: STRENGTHS WEAKNESSES OPPORTUNITIES AND THREAT (SWOT) ANALYSIS

Table 15: SWOT analysis: Community Health Service Delivery

A- Community health service delivery			
Strengths	**Weaknesses**	**Opportunities**	**Threats**
i. Community based programs are available in the communities (ICCM, WASH, MCH, TB/HIV/OVC, Nutrition among others) ii. Partner support at all levels; national through to community, (including the private sector support, NGOs, CBOs, FBOs, etc.) iii. Readily available CHWs in the community who are equally committed to provide health services iv. There are existing leadership structures that can spearhead the success of the community health service delivery.	i. Disaggregated community health governance (mandate) at central level within MoH (departments of CH as well as HPE&C in addition to program specific departments who all have community-based interventions) ii. Unclear coordination structure for CH services across all levels. iii. Piece-meal implementation of community-based health services especially by partners who come with vested thematic interests (MCH, TB/HIV/OVC, among others). iv. A top-down approach instead of a bottom-up approach is used in planning and implementation v. Absence of Strong and streamlined linkages not only between the community and the health system, but also among the available health system. This also affects the functionality of referral pathways vi. Duplication of efforts due to too many donors and projects. There is absence of a streamlined structure for implementation.	i. There is large demand/ a need for community health services ii. CHWs as implementers live in the same communities served and hence relate with them well. iii. Acceptability of community health services by recipients (communities) iv. COVID-19 pandemic, which has led to realization of the importance of the community health system especially with disease prevention	i. Missed opportunities from the lack of multisectoral implementation and governance of CH service delivery and programing. ii. Community level data not used for decision making to inform CH services programing and implementation.

There are many challenges that affect the capacity of health workers and these include: Limited earmarked financing mechanism for supporting CHWs, High proportion of VHTs weakly functional in several districts evidenced by an average 19% reporting rate in 2021, absence of a clear coordination and reporting structure for CHWs which further results into a weakness in supervision of CHWs, Low or no remuneration of CHWs including absence of clear guidance (policy, strategy, guidelines) to guide CHW remuneration, limited clarity on reporting lines for VHTs undermines the role of CHWs system.

Table 16: SWOT Analysis: Community Health Workforce

Strengths	Weaknesses	Opportunities	Threats
i. Existence of CHWs governance structures at national and sub national levels ii. A variety of cadres of CHWs is in existence and can also be enhanced, including VHTs, Health Assistants, Health Inspectors, Health Educators, Para-Social Workers and other Community resource persons.	i. Limited ring-fenced/ earmarked financing mechanism for supporting CHWs ii. High attrition rates (check CHW assessment, 2014) iii. High proportion of VHTs weakly functional in several districts, evidenced by an average 19% reporting rate in 2021 iv. Absence of clears Terms of Engagement/ ToRs for CHWs. v. Absence of a clear coordination and reporting structure for CHWs which further results into a weakness in supervision of CHWs vi. Low or no remuneration of CHWs including absence of clear guidance (policy, strategy, guidelines) to guide CHW remuneration. vii. Limited clarity on reporting lines for VHTs undermines the role of CHWs	i. Existing policy, National Development Plan III and Health Sector Development Plan III prioritizing health prevention, and CH ii. Parish Development Model – to be leveraged for CH services delivery iii. Existing Results Based Financing mechanism for the PHC services iv. Existing, albeit fragmented financing sources for CHWs from Implementing Partners (US$50 from USG PEPFAR supported partners), and GoU UGX100,000/= for COVID-19 facilitation. v. The voluntary nature of the existing CHW workforce, permitting the testing of incentivization approaches for enhancing performance. vi. Existing COVID-19 Community Engagement Framework vii. Retired health care professionals living in the communities as well as the unemployed who can be leveraged upon.	i. CHWs more focused on curative service delivery and have neglected primary role of health promotion ii. Conflicting loyalty of CHWs from non- harmonized facilitation iii. Abuse of power by Community health workers due to the limited supervision and training. iv. Out migration to countries that pay health workers more attractive wages

Communication and information management is critical in assessing health outcomes and health coverage, managing the workforce, tracking the quality of care delivered, and ensuring effective integration of service. There are several challenges affecting the health information system which include: Low distribution rate for community tools, limited optimal knowledge and capacity of VHTs in use of available tools e.g., the revised HMIS tools, limited prioritization of National Health information systems.

Table 17: SWOT Analysis: Community Health Information System

Strengths	Weaknesses	Opportunities	Threats
i. Presence of platforms and teams in the HMIS (Digital and non-digital) including HIV, TB, ICCM, HBC register, VHT reporting tool. ii. Availability of VHTs as human resource iii. Availability of political will to support the Health Information systems.	i. Low distribution rate for community tools ii. Limited optimal knowledge and capacity of VHTs in use of available tools especially the revised HMIS tools iii. Limited prioritization of National Health information systems. Most of the tools and systems developed are project-based	i. Digitization of community tools ii. Presence of CSO participation in data collection iii. Increased coverage in smart technology	i. Low motivation of the team collecting data/generating the required information, information team ii. Migration of responsible person thus a gap in the HR to manage CHIS iii. Over reliance on development partners to develop and implement CHIS

Effective community health systems require basic infrastructure at the community level and well-functioning supply chains. Uganda's supply chain systems function poorly and face a myriad of challenges including but not limited to shortage of human resources, weak inventory management, low supply chain skills among health workers, and a lack of data visibility and utilization for sound decision making.

Table 18: SWOT Analysis: Community Health Supply Chain/ Medical products

Strengths	Weaknesses	Opportunities	Threats
i. Existence Community supply chain strategy 2016-2020. ii. Existence Community supply chain tools (consumption log, summary form iii. Existence of supply chain job aid on management of medicine and health supplies at community level iv. 50% of the health worker and VHTs have been trained on community supply chain management. v. Existence of integrated distribution of community medicine and health supplies through the NMS to health facilities. vi. Availability of funding from health development partners (GLOBAL FUND, USAID, UNICEF, UNFPA, UNHCR, CDC) vii. Existence of district medicine management supervisor who can support with medicine management including redistribution for the community health program.	i. Lack of adequate funding to support procurement ii. High donor dependency for medicines and health supplies used at community level which affects sustainability of community health programs iii. Requirements for community health program needs has not been fully integrated in the health facility needs which results into stock outs iv. Capacity gaps on use of the community supply chain tools at community, health facility and 60% at district level	i. Integrating quantification of community health worker needs with health facility requirements ii. Existence of demand and acceptance of health services at community level iii. A strong political will to support the community health work programs iv. The ongoing development of the parish development model which can support monitoring and advocacy of community programs	i. Expiries of medicines and health supplies at community level ii. Health emergencies like COVID 19 which affects the supply chain of medicines and health supplies iii. Pilferage of commodities and health supplies given to community health workers iv. Increasing demand for medicines and supplies to support the emerging needs of the population

Table 19: SWOT Analysis: Community Health Financing

Strengths	Weaknesses	Opportunities	Threats
i. There are Central & local government clear departments/sections for CH budgeting and earmarked support from partners. ii. CH is a priority for the majority of partners. iii. Public financial management (PFMA) guidelines in place & local government finance and accounting regulations.	i. No cost centers at the local government level ii. Fragmented funding mechanism between government and development partners iii. Weak coordination structures for resource mobilization (NGO forum, technical planning committees at the districts iv. The push funding system is hurting many health facilities that serve big population catchments	i. Parish development Model will provide possible financing ii. Village saving groups as some of them target their health. iii. Financing model. iv. COVID-19 has CH to the forefront	i. Integrated service delivery makes it difficult to delineate CH services (CH services are not prioritizing at all levels of implementation in the as the funds allocated to these activities are not utilized to serve their purpose). ii. Unharmonized coordination and networking especially between the MDAs & the NGO forum involving in CH.

In Uganda, community health programs are returning to favor as an integral part of primary health care systems, often on the back of pre- existing community-based initiatives. There are significant challenges to the integration and support of community health programmes, and they require coordination and stewardship at all levels of the health system. Strong leadership, good governance, and coordination underpin a well- functioning community health system and will determine the success of the Implementation of the NCHS

Table 20: SWOT Analysis: Community Health Leadership and Governance

Strengths	Weaknesses	Opportunities	Threats
i. Political will and strides from CES are creating renewed momentum ii. The development partners are willing and available to support the financing of community structure iii. Strong regional commitment and political goodwill iv. Available man power for health leadership and governance v. There are leadership structures in places	i. Multi-sectoral thinking is lacking ii. Lack of funding to sustain structures iii. Weak governance is that community programming is currently driven by the availability of donor funded project activities. iv. Lack of institutionalization and integration of CHWs into the formal structures v. Low political organization, leadership and systems to spearhead the health ministry (numbers, roles, structures, reporting lines etc). vi. Weak leadership system especially political leadership – In the mid and late 1990's the leadership was instrumental and came up with the concept of health centers (NC II, HC III etc.)	i. Strong political global will and momentum from C19 ii. Available policies and strategies such as National health strategy iii. Readily existing leadership structures for community health service delivery	i. Ongoing pandemics and need to foster continued preparedness that captures community levels ii. Non-prioritization of the community health activities iii. Too many donors driven engagements that sometimes come with conditions that need to be fulfilled

Strong community structures and community-level engagement are critical in ensuring successful community health programmes. The ultimate goal of Community engagement interventions is to empower individuals and communities to take responsibility and control of their own actions in relation to their health. The strategy seeks to enhance changes in knowledge, attitudes and practices and proactively educate the population about healthy behaviors, lifestyle choices and access to health care in order lead healthy lifestyles and productive lives.

Table 21: SWOT Analysis: Community Health Engagement and Participation

Strengths	Weaknesses	Opportunities	Threats
i. Social media ii. Allocation of 30% of PHC for community health services at local governments iii. Willingness of community members to gather for health-related programs. iv. A presence of community /Youth groups v. A presence of Village Health Team members to mobilize for communities; engagement and participation for health promotion	i. Prioritization of curative over preventive health services ii. Lack of framework or guidelines governing Community engagement and participation in the country. iii. Lack of KPIs for Community engagement and participation iv. Absence of community bi- laws to promote healthy food practices E.g., on nutrition as it relates to the use of the locally produced foods for better child and adult nutrition, v. Absence of district /sub county exchange visits for learning and adaptation of best practices for community health engagements vi. Absence of regulations on production of food products and beverages that are free from hazards	i. COVID-19 community engagement task force. ii. Decentralized service delivery allows decision-making to be close to the communities, providing an opportunity for participation at this level. iii. Parish development model iv. A presence of other national strategies for community health engagement such as the Covid-19 Engagement Strategy of 2020.	i. Budget reduction and instability in financing of community health ii. Limited appreciation of Community engagement by the public iii. Diverse interests of partners iv. Mobile communities v. Negative social media vi. Over duplication of activities vii. Higher expectations and of communities on community health services. viii. Demoralized Community health workers ix. Limited collaboration between stakeholders.

8.2 ANNEX 2: LIST OF KEY STAKEHOLDERS CONSULTED

Table 22: List of key stakeholders consulted

	Names	Gender	Organization	Designation
1	Dr. George Upenytho	Male	Ministry of Health	CHS – Community Health
2	Mr. Kabangi Moses	Male	Ministry of Health	ACHS – Environmental Health
3	Dr. Daniel Kyabayinza	Male	Ministry of Health	DHS – Public Health
4	Dr. Sarah Byakika	Female	Ministry of Health	CHS – Planning Financing & Policy
5	Dr. Jimmy Opigo	Male	Ministry of Health	ACHS – Malaria Control Division
6	Dr. Jessica Nsugwa S	Female	Ministry of Health	CHS – Reproductive & Child Health
7	Dr. Driwale Alfred	Male	Ministry of Health	ACHS – Vaccines & Immunization Division (UNEPI)
8	Mr. Paul Mbaka	Male	Ministry of Health	ACHS – Division of Health Information
9	Dr. Ayoo Akia	Male	Ministry of Health	CHS – Non-Communicable Diseases
10	Nampurira Rosen	Female	Ministry of Health	CESP Admin
11	Brenda Nakanwagi	Female	Ministry of Health	PHO-CH
12	Katto Edward	Male	MOH/ACP	Community Advisor
13	Jane Irene Nabakooza	Female	Ministry of Health	Pediatrician
14	Mubangizi Andrew	Male	Ministry of Health	Principal Occupational Therapist
15	Dr. Jimmy Ochorin	Male	Ministry of Health	Community Health Department
16	Nabwire Ruth	Female	Ministry of Health	ICCM Coordinator
17	Dr. Amutuhaire Maureen	Female	Ministry of Health	National ICCM Coordinator
18	Betty Atai Ngabirano	Female	USAID - UHSS	Deputy Chief of Party
19	Pauline Ketty Okello	Female	USAID - UHSS	Team Lead, Community Systems
20	Allen Nabanoba	Female	Ministry of Health	ICCM technical advisor RCH department
21	Sukanya Borthakur	Female	Medical Teams International	Community Health Advisor
22	Edward Zzimbe	Male	Living Goods - Uganda	Deputy Country Director
23	Namwanja Roland Wakiibi	Male		Senior Project Officer
24	Dr. Jessica Oyugi	Female	UNICEF	Community Health Specialist
25	Kirigwajjo Moses	Male	UHSS	Community Engagement Advisor
26	Tosca Terra	Female	HE	Program Manager
27	Dr. Meddy Rutaisire	Male	MoH	M&E Specialist
28	Ivan Ireeta Birungi	Male	Pathfinder	Partnership Manager
29	Kenneth Nyehoora Mugumya	Male	Last Mile Health International	Country Program Director
30	Kamusiime Nimrod	Male		Community Linkages Coordinator
31	Prossy Jonker Nakanjako	Female	UNFPA	Communications Specialist
32	Eyadu Bernard	Male	SNV	WASH Advisor
33	Kenneth Muhwezi	Male		Principal Economist
34	Nabunya Victoria	Female	World Vision Uganda	Health Specialist
35	Elizabeth Njoki Mwai	Female	World Health Organization	Risk Communication and Community Engagement Officer
36	Mayanja Bernard Dr.	Male		Director of Programs
37	Juliet Sentumbwe	Female		Ag. Director Animal Resources
38	Zzimula Patrick	Male	BRAC	Community Human Resources for

				Health Advisor
39	Amia Poni Deborah	Female	Consultant	Research Assistant
40	Jamiru Mpiima	Male	Last Mile Health	Technical Coordinator
41	Hasifa Naluyiga	Female	Living Goods	Deputy Director, Community Health Partnerships
42	Mary Ajwang	Female	UNAIDS	Program Officer
43	George Matete	Male	BRAC Uganda	Country Director
44	Rosemary Kindyomunda	Female	UNFPA	Program Specialist HIV/SRH
45	Priscillah Balirwa	Female	Living Goods	Digital Health consultant
46	Mary Achen	Female	USAID	UHSS/Team Lead Community Health System
47	Vicky Pros Abenakyo	Female	Family Strength for a Better Child	Executive Director
48	Magoba Abu Kassim	Male	Community Health Division- MoH	Behavior Scientist
49	Edward Basenge	Male	Ministry of Health	Program Officer
50	Richard Kintu	Male	Last Mile Health	Director Advocacy
51	Kavuma Prichard	Male	KOFIH	PM
52	Nagendi Grace	Female	UNFPA	Analyst
53	Bamuloba muzamiru	Male	MoH	Community Systems Technical Advisor
54	John Obicho	Male	EGPAF	supply Chain Advisor
55	Tagoya Adrian	Male	KOICA	Health M&E specialist
56	Kutamba Elizabeth	Female	Health Haven Clinic	Director and pediatrician
57	Suzie Albone	Female	UNICEF	CHW Consultant (Incentives and Motivation Study)
58	Thomas Maina	Male	USAID UHSS	Chief of Party
59	Omuudu Onyang Charles	Male	Moroto District Local Government	District Health Educator
60	Nabirye Betty	Female		Senior Technical Advisor Gender and Community Systems strengthening
61	Roy Asiku	Male	UNFPA- Yumbe	Program Coordinator
62	Catherine Kabahuma	Female	UNICEF	Health Information Systems Specialist
63	Morris Otim	Male	AVSI	HIV/AIDS Specialist
64	Victoria Kajja	Female	IOM	Migration Health Coordinator
65	Gloria Nyamungu	Female	AVSI Foundation	C4D & BCC
66	John Obicho	Male	EGPAF	Supply Chain Advisor
67	Ojok Francis	Male	AVSI Foundation	Health specialist
68	Pande Stephen Legesi	Male	Soroti RRH	Consultant
69	Dr. Obeti Richard	Male	BUNYANGABU DISTRICT	District Health Officer
70	Senteza Robert Augustine	Male		Public Health Specialist/ Senior Health Educator
71	Dr Mary Josephine Mbidde	Female	TASO	Senior Technical Advisor, Malaria
72	Agaroi David	Male		DLFP
73	Med Makumbi	Male	RHITES -N Lango	
74	Dickson Akankwatsa	Male	IDI	IPC TO
75	Edson Muhwezi	Male	UNFPA-Uganda Country Office	Assistant Representative
76	Pauline Picho Keronyai	Female	Nama Wellness Community Centre	Project lead
77	Steven Kikomeko	Male	UHSS	Snr MEL Advisor & Database Manager
78	Tino Salome	Female	DLG	DHO Abim
79	Deborah Oyella	Female	UN Human Rights	National Officer
80	Immaculate Ddumba	Female	USAID	PMS community systems
81	Chimwemwe Msukwa	Male	UNICEF	Health Specialist

Table 23: Key Informant Interviews Participants

#	Name	Designation	Organization	Date of Interview
1	Edson Muhwezi	Assistant Representative	UNFPA-Uganda	27th July 2021
2	Rose Okot Chono	Deputy Team Lead	USAID	27th July 2021
3	Humfrey Masaba	Senior Program Assistant	CDC	28th July 2021
4	Darinka Perisic	Advisor Health Systems Strengthening	WHO	28th July 2021
5	Sarah Murungi	Chief of Party	Health Partners - Uganda	28th July 2021
6	Allen Namagembe	Deputy Project Director	PATH	
7	Kumakech Sunday	Community Systems Strengthening Manager	Baylor Uganda	30th July 2021
8	Hasifa Naluyiga	Director Community Health Partnerships	Living Goods	4th August 2021
9	Dr. Elizabeth Ekirapa	Head of Department (HPPM)	Makerere SPH	30th July 2021
10	Dr. Jessica Oyugi	Community Health Specialist	UNICEF	29th July 2021
11	Denis Ahairwe	Chief Executive Officer	JSI	30th July 2021
12	Sharon Ajedra	Senior Technical Advisor – Community Engagement	JSI	30th July 2021

8.1 ANNEX 3: LIST OF KEY DOCUMENTS REVIEWED AND REFERENCES

Health policy and implementation document
a) Second National Health Policy
b) Health Sector Strategic and Investment Plan HSSIP (2010/11 – 2014/15) and related policies and strategic plans for the different programs
c) Health Sector Development Plan (2015/16 – 2019/20), related policies and strategic plans
d) Health Financing strategy 2015/16 – 2024/25
e) National Village Health Teams (VHTs) Assessment in Uganda
f) Annual health Sector Performance Report 2019/2020
g) Ministerial Policy Statement Financial Year 2020/2021
h) Compact Between Government of Uganda and Partners for Implementation of the Health Sector Development Plan 2015/16 – 2019/20
i) Mid-Term Review report for the Health Sector Development Plan 2015/16 - 2019/20.
j) Annual statistical abstracts and Household Surveys
k) Health facility assessment reports
l) Published research and evaluation studies
m) Third National Development Plan (NDPIII) 2020/21 – 2024/25.
n) Comprehensive Service Standards Manual
a) Uganda National Statistical Abstract
b) Uganda Demographic Health Surveys
a) The National Population and Housing Census 2014
b) Hospital and Health Centre IV Census Report - 2016
c) Uganda National household survey Reports:
d) National Health Accounts Reports

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8.2 ANNEX 4: COSTING SCENARIOS AND BUDGET SUMMARIES

Table 24: Scenario 1: Summary as per Cost Categories

	Activity	Year 1	Year 2	Year 3	Year 4	Year 5	TOTALS
		US D "000"					
	Strategic Direction 1: Increase availability and access (geographic and functional) to equitable Community Health services						
	Strategic Objective 1.1: Deliver a standardized integrated essential package of community level services	6,221,896	11,712,354	6,273,954	4,537,364	4,537,364	**33,282,932**
	Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce						
	Strategic Objective 2.1: Standardize recruitment of Community Health workers	898,165	199,723	199,723	199,723	199,723	**1,697,056**
	Strategic Objective 2.2: Operationalize performance management framework for CHWs using the DESC approach	19,187,824	19,954,086	37,755,337	30,238,055	30,090,228	**137,225,530**
	Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply system						
	Strategic Objective 3.1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities in public and private sectors.	31,475	-	-	-	-	**31,475**
	Strategic Objective 3.2: Strengthen capacity for community level logistics and supply chain system management in public and private sector	145,404	111,974	111,974	111,974	111,974	**593,300**
	Strategic Direction 4: Create improved and sustainable financing for community health program						
	Strategic Objective 4.1: Institute harmonized and equitable financing by a stake holder	90,927	90,162	74,297	43,440	60,621	**359,447**
	Strategic Objective 4.2: Improve resource mobilization for the delivery of integrated community health services	251,622	225,136	203,049	203,049	203,049	**1,085,904**
	Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions						
	Strategic Objective 5.1: Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data	2,334,561	2,310,690	2,180,332	2,711,017	2,792,976	**12,329,576**
	Strategic Objective 5.2: Digitize community health service delivery	2,340,406	1,072,424	1,308,924	-	-	**4,721,754**
	Strategic Objective 5.3: Increase utilization of Community Health Data for decision-making in the community health system	860,312	1,303,872	1,303,872	1,303,872	1,303,872	**6,075,802**
	Strategic Objective 5.4: Community-Based Surveillance systems (CBDS)	196,812	284,261	160,598	242,143	200,747	**1,084,560**
	Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in delivery community health						
	Strategic Objective 6.1: Strengthen multi-sectoral coordination, planning and implementation of Community Health programs	152,693	140,544	123,813	123,813	123,813	**664,676**
	Strategic Direction 7: Engage and empower communities for effective accountability and improved health outcomes.						
	Strategic Objective 7.1: Enhance effective mobilization of families, communities and citizens for community engagement and participation	7,293,004	5,112,540	7,496,492	5,112,540	7,496,492	**32,511,068**
	Strategic objective 7.2: To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions	1,830,506	1,574,699	1,361,203	766,266	1,040,369	**6,573,043**
	TOTALS	41,835,607	44,092,464	58,553,567	45,593,256	48,161,227	**238,236,122**

Key Assumptions.

a) The Scenario assumes GoU will support One CHEW per Parish in the first two years and then two CHEWS per parish in the last three years of the strategy.

b) One VHT per village supported by GoU in the first two years, with additional VHT recruited and supported from year

Table 25:Scenario 3 Summary as per Cost Categories

	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5	Total	
	US D "000"						
Advocacy	3,298.79	3,466.43	3,437.69	3,437.69	3,437.69	17,078.30	4%
Community Outreaches	6,625.40	4,793.09	6,824.16	4,825.81	6,856.88	29,925.33	7%
Equipment	5,460.00	-	-	-	-	5,460.00	1%
Financing	1,021.62	1,018.23	996.14	996.14	996.14	5,028.27	1%
Health information system	2,637.18	37.72	-	-	-	2,674.90	1%
Human Resources	51,990.06	52,829.11	52,829.11	52,829.11	52,829.11	263,306.49	60%
Information Education and Communication	1,683.54	1,718.74	1,718.74	1,718.74	1,718.74	8,558.51	2%
Monitoring Evaluation and Learning	6,243.37	6,834.43	6,787.29	6,787.29	6,804.47	33,456.85	8%
Governance	1,315.12	1,327.80	1,327.80	1,327.80	1,327.80	6,626.32	2%
Policy Issues	143.74	-	-	-	-	143.74	0%
Program Support	26,283.65	23,272.47	3,768.64	2,027.27	3,649.04	59,001.07	13%
Trainings	1,998.40	1,981.68	1,660.89	2,104.16	1,015.21	8,760.34	2%
Totals	**108,700.88**	**97,279.70**	**79,350.46**	**76,054.01**	**78,635.08**	**440,020.12**	

Key Assumptions.

a) The Scenario assumes GoU will support 2 CHEWs per Parish for each of the years of the strategy.

b) GoU supports 5 VHTS per village for each of the years of the strategy.

Table 26: Budget Summary as per Strategies. Scenario 1

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	TOTALS
	US D "000"					
Strategic Direction 1: Increase availability and access (geographic and functional) to equitable Community Health services						
Strategic Objective 1.1: Deliver a standardized integrated essential package of community level services	6,221,896	11,712,354	6,273,954	4,537,364	4,537,364	**33,282,932**
Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce						
Strategic Objective 2.1: Standardize recruitment of Community Health workers	898,165	199,723	199,723	199,723	199,723	**1,697,056**
Strategic Objective 2.2: Operationalize performance management framework for CHWs using the DESC approach	19,187,824	19,954,086	37,755,337	30,238,055	30,090,228	**137,225,530**
Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply system						
Strategic Objective 3.1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities	31,475	-	-	-	-	**31,475**
Strategic Objective 3.2: Strengthen capacity for community level logistics and supply chain system management in public and private sector	145,404	111,974	111,974	111,974	111,974	**593,300**
Strategic Direction 4: Create improved and sustainable financing for community health program						
Strategic Objective 4.1 : Institute harmonized and equitable financing by a stake holders	90,927	90,162	74,297	43,440	60,621	**359,447**
Strategic Objective 4.2: Improve resource mobilization for the delivery of integrated community health services	251,622	225,136	203,049	203,049	203,049	**1,085,904**
Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions						
Strategic Objective 5.1: Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data	2,334,561	2,310,690	2,180,332	2,711,017	2,792,976	**12,329,576**
Strategic Objective 5.2: Digitize community health service delivery	2,340,406	1,072,424	1,308,924	-	-	**4,721,754**
Strategic Objective 5.3: Increase utilization of Community Health Data for decision-making in the community health system	860,312	1,303,872	1,303,872	1,303,872	1,303,872	**6,075,802**
Strategic Objective 5.4: Community-Based Surveillance systems (CBDS)	196,812	284,261	160,598	242,143	200,747	**1,084,560**
Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in delivery community health						
Strategic Objective 6.1: Strengthen multi-sectoral coordination, planning and implementation of Community Health programs	152,693	140,544	123,813	123,813	123,813	**664,676**
Strategic Direction 7: Engage and empower communities for effective accountability and improved health outcomes.						
Strategic Objective 7.1: Enhance effective mobilization of families, communities and citizens for community engagement and participation	7,293,004	5,112,540	7,496,492	5,112,540	7,496,492	**32,511,068**
Strategic objective 7.2: To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions	1,830,506	1,574,699	1,361,203	766,266	1,040,369	**6,573,043**
TOTALS	**41,835,607**	**44,092,464**	**58,553,567**	**45,593,256**	**48,161,227**	**238,236,122**

Table 27: Budget Summary as per Strategies. Scenario 2

	Activity	Year 1	Year 2	Year 3	Year 4	Year 5	TOTALS
		US D "000"					
No:	**Strategic Direction 1: Increase availability and access (geographic and functional) to equitable Community Health services**						
	Strategic Objective 1.1: Deliver a standardized integrated essential package of community level services	7,170,673	12,689,595	4,673,482	4,577,304	4,577,304	**33,688,358**
	Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce.						-
	Strategic Objective 2.1: Standardize recruitment of Community Health workers	898,165	199,723	199,723	199,723	199,723	**1,697,056**
	Strategic Objective 2.2: Operationalize performance management framework for CHWs using the DESC approach	23,534,429	38,354,924	46,968,728	63,365,594	56,021,862	**228,245,537**
	Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through effective and transparent supply tem						
	Strategic Objective 3.1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities	31,475	-	-	-	-	**31,475**
	Strategic Objective 3.2: Strengthen capacity for community level logistics and supply chain system management in public and private sector	145,404	111,974	111,974	111,974	111,974	**593,300**
	Strategic Direction 4: Create improved and sustainable financing for community health programs						-
	Strategic Objective 4.1: Institute harmonized and equitable financing by a stakeholders	90,927	90,162	74,297	43,440	60,621	**359,447**
	Strategic Objective 4.2: Improve resource mobilization for the delivery of integrated community health services	598,772	582,700	560,613	560,613	560,613	**2,863,312**
	Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based intervention						
	Strategic Objective 5.1: Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data	2,334,561	2,310,690	2,180,332	2,711,017	2,792,976	**12,329,576**
	Strategic Objective 5.2: Digitize community health service delivery	2,340,406	2,381,348	1,005,968	-	-	**5,727,722**
	Strategic Objective 5.3: Increase utilization of Community Health Data for decision-making in the community health system	860,312	1,303,872	1,303,872	1,303,872	1,303,872	**6,075,802**
	Strategic Objective 5.4: Community-Based Surveillance systems (CBDS)	196,812	528,896	160,598	160,598	200,747	**1,247,650**
	Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in delivery community health service						
	Strategic Objective 6.1: Strengthen multi-sectoral coordination, planning and implementation of Community Health programs	152,693	140,544	123,813	123,813	123,813	**664,676**
	Strategic Direction 7: Engage and empower communities for effective accountability and improved health outcomes.						
	Strategic Objective 7.1: Enhance effective mobilization of families, communities and citizens for community engagement and participation	6,286,232	6,459,516	6,459,516	6,459,516	6,459,516	**32,124,298**
	Strategic objective 7.2: To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions	1,798,075	1,815,396	1,815,396	732,861	1,006,964	**7,168,692**
	TOTALS	**46,438,935**	**66,969,340**	**65,638,311**	**80,350,327**	**73,419,986**	**332,816,899**

Table 28: Budget Summary Scenario 3

	Activity	Year 1	Year 2	Year 3	Year 4	Year 5	TOTALS
		US D "000"					
No:	**Strategic Direction 1: Increase availability and access (geographic and functional) to equitable Community Health services**						
	Strategic Objective 1.1: Deliver a standardized integrated essential package of community-level services	10,308,537	10,337,735	4,899,335	4,803,157	4,803,157	**35,151,921**
	Strategic Direction 2: Ensure an equipped, competent, committed, and compensated Community Health Workforce.						-
	Strategic Objective 2.1: Standardize recruitment of Community Health workers	898,165	199,723	199,723	199,723	199,723	**1,697,056**
	Strategic Objective 2.2: Operationalize performance management framework for CHWs using the DESC approach	77,103,890	71,852,602	56,042,694	56,190,521	56,042,694	**317,232,400**
	Strategic Direction 3: Ensure availability of quality essential medicines and commodities at community level through an effective and transparent supply System						-
	Strategic Objective 3.1: Strengthen the dissemination and implementation of policies and standardized approaches for managing community health commodities in public and private sectors.	31,475	-	-	-	-	**31,475**
	Strategic Objective 3.2: Strengthen capacity for community level logistics and supply chain system management in public and private sector	145,404	111,974	111,974	111,974	111,974	**593,300**
	Strategic Direction 4: Create improved and sustainable financing for community health programs						-
	Strategic Objective 4.1: Institute harmonized and equitable financing by a stake holders	90,927	90,162	74,297	43,440	60,621	**359,447**
	Strategic Objective 4.2: Improve resource mobilization for the delivery of integrated community health services	1,021,616	1,018,230	996,143	996,143	996,143	**5,028,274**
	Strategic Direction 5: Strengthen collection and use of quality community health data for evidence-based interventions						-
	Strategic Objective 5.1: Enhance the capacity of the community health workforce to effectively collect, collate and report quality community health data	2,334,561	2,310,690	2,180,332	2,711,017	2,792,976	**12,329,576**
	Strategic Objective 5.2: Digitize community health service delivery	3,611,206	1,072,424	1,005,968	1,005,968	-	**6,695,565**
	Strategic Objective 5.3: Increase utilization of Community Health Data for decision-making in the community health system	860,312	1,303,872	1,303,872	1,303,872	1,303,872	**6,075,802**
	Strategic Objective 5.4: Community-Based Surveillance systems (CBDS)	1,732,362	202,716	1,742,214	160,598	1,782,364	**5,620,253**
	Strategic Direction 6: Strengthen leadership and multisectoral collaboration of key stakeholders including private sector in delivery community health services.						
	Strategic Objective 6.1: Strengthen multi-sectoral coordination, planning and implementation of Community Health programs	152,693	140,544	123,813	123,813	123,813	**664,676**
	Strategic Direction 7: Engage and empower communities for effective accountability and improved health outcomes.						
	Strategic Objective 7.1: Enhance effective mobilization of families, communities and citizens for community engagement and participation	8,611,653	6,823,631	8,854,700	6,823,631	8,854,700	**39,968,316**
	Strategic objective 7.2: To improve community participation in governance, coordination, collaboration, planning and implementation of community health interventions	1,798,075	1,815,396	1,815,396	1,580,151	1,563,043	**8,572,061**
	TOTALS	**108,700,876**	**97,279,698**	**79,350,460**	**76,054,008**	**78,635,080**	**440,020,123**


VHT