PROFESSIONALIZING UGANDA'S VILLAGE HEALTH TEAMS FOR IMPROVED SERVICE DELIVERY

PROBLEM STATEMENT

Despite significant improvements in the global under-5 (U5) mortality rate over the years, too many Ugandan children are still dying from preventable but treatable diseases.

In Uganda, Primary Health Care (PHC) has been the key means for addressing and delivering some of these health services at the community level. PHC has been recognized as an essential element of health systems globally, but financing for it varies widely by country, with spending ranging between 2% and 56% of total government spending on health.

Despite committing to allocate 15% of the government budget to health per the Abuja declaration, Uganda has struggled to fulfil this commitment: in the last decade, the health budget has been relatively stagnant – between 6% to 9%. Government contributes 57% of the health budget whilst the rest comes from development partners. Only a small proportion goes to PHC service delivery at the community level, yet it is a critical means evidenced to save lives, particularly children under five-years of age, pregnant women, and new-borns.

By the numbers
Mortality for U5 children in sub-Saharan Africa are 14x higher than in Europe and North America.
Uganda's U5 mortality rate is 64 deaths per 1,000 live births.
Uganda's infant mortality is 45 deaths per 1,000 live births.
Top causes of U5 mortality include malaria, pneumonia, neonatal conditions, and anemia.

THE EVIDENCE

Evidence shows that community health worker (CHW) programs are a cost-effective and efficient way to increase access to primary healthcare—especially in resource-limited settings—and can lead to a reduction in maternal mortality and child and infant mortality and morbidity—especially from common illnesses such as malaria and pneumonia.

These programs can also increase immunization coverage and vaccine uptake, and help reduce unplanned pregnancies through health education and the provision of family planning counselling and short-term methods at the community level. Uganda's CHW cadres—the Village Health Teams (VHTs)—have been instrumental in ensuring robust health promotion, disease prevention, referrals and linkages to the health system for people at the community level, and have proven essential for disease surveillance.

Preliminary results of a large-scale randomized controlled trial of Living Goods-supported VHTs in Uganda conducted by IPA shows an estimated 28-30% reduction in U5 mortality and a 27% reduction in infant mortality from midline to endline. It also found a 5x increase in pregnant women receiving an antenatal care-focused home visit, an 8x increase in follow-ups for sick children who had been treated for malaria, diarrhoea, and pneumonia, and better health knowledge among CHWs, which led to increased numbers of children receiving correct treatments for illnesses.

To accelerate the gains made in reducing child mortality, it is important to strengthen the health care system by focusing on providing high impact interventions that have the potential to significantly reduce U5 mortality.

WHY OYAM?

Based on the District Health Systems Progression Monitoring data, Oyam district has had gaps in service delivery, resulting into poor maternal neonatal and child health indicators. In 2020, the Oyam District Local Government, Malaria Consortium, and Living Goods, co-designed and started implementing an exemplar program to support the strengthening of the community health system through holistic performance management of VHTs.

This includes equipping them with digital tools and medicines, ensuring they are adequately trained and supervised, and compensated. Oyam District Local Government is committed to utilising a potion of the allocated PHC funding to compensating VHTs. If well capacitated, VHTs are instrumental in linking communities to the formal health system and managing basic conditions at the community level, which can lead to improved health outcomes.

District performance in 2020
Maternal mortality – 309 deaths per 100,000 live births
Total under-five malaria cases - 570 cases in 2020 compared to 460 per 1,000 population in Uganda
U5 mortality – 48/1,000 live births, compared to 43.3/1,000 live births
Proportion of mothers who received three or more doses of IPTp – 57.9%

PROGRESS OF THE PROJECT

Reporting and decision making: At the start of the program, VHTs were using a paper-based register to submit quarterly reports. This caused delays in reporting into the health information systems, including DHIS2, which was compromising report accuracy and timeliness. Multiple reporting tools by implementing partners add to the reporting burden. Whereas the government has digitised HMIS tools at the health facility level, there is no national community level digital reporting tool – which can enable tracking and measurement of VHT performance.

Building on experience supporting government VHTs to deliver community health services in other 19 districts, Living Goods trained a cohort of 200 VHTs and 13 government supervisors in three sub-counties in Oyam. Living Goods equipped them with mobile phones powered with an app to support the reporting of community level data. The app is also used as a decision support tool and job aid. This has not only eased how VHTs do their work, but has enabled supervisors to be more targeted in their guidance, as they have access to a tablet and dashboard with real-time metrics to monitor the performance of VHTs. Evidence shows that digital tools and data are key enablers in achieving health impact at scale, but also critical for reporting and precision performance management.

Incentives: VHT's work is largely treated as voluntary in Uganda, despite the enormous time commitment involved. Most incentives are donor-driven, in-kind, inconsistent, and non-monetary. VHTs in the Oyam program are currently paid a small transport refund of UGX 10,000 ($3) via PHC funds and Results Based Financing (RBF) from the Uganda Reproductive Maternal and Child Health Improvement Project (URMCHIP), and an extra UGX 20,000 ($6) from the partners each month. To drive VHT motivation, it is important that they are budgeted for and paid a stipend (both performance based and non-performance based).

Training and capacity building: Most government-supported VHTs don't have access to regular in-service training. Due to their large numbers, the estimated cost of regular trainings for VHTs is also high. In Oyam, partners combined efforts and resources to ensure that VHTs got refresher trainings in iCCM and other MNCH areas. This cost sharing eases the burden on the funders whilst ensuring VHTs are well equipped to serve their communities more effectively. There is a direct correlation between VHT training and increases in health knowledge, which correlates with more children receiving timely and correct treatments for illnesses.

Supply chain: At the time of scoping, the stock rate for VHTs was around 10% for all essential supplies (MUAC tapes, thermometers, medicine boxes and essential medicines specifically, coartem, ORS, Zinc, amoxycillin, and malaria rapid diagnostic test kits). The mechanism for determining rational quantities of medicines for VHTs is not clear, as well as forecasting and tracking of supplies. This has affected the performance of VHTs, even as the district explored the use of emergency procurements and re-allocated commodities from overstocked health facilities to understocked ones to ensure better stocks at the VHT level.

Supervision: At the start of the exemplar, VHT supervision was irregular, happening once or less in a quarter. Since the introduction of digital tools, supervisors now have access to dashboards and data, which has enabled them to give targeted supervision to VHTs, and in a timely manner. This has led to improved performance and accountability of VHTs.

WHAT DOES IT COST TO HAVE AN EFFICIENT AND EFFECTIVE COMMUNITY HEALTH PROGRAM?

VHTs do not replace licensed doctors, nurses, and other trained healthcare providers. Rather, they help relieve the burden on hospitals and facilities in resource-strapped areas by reaching more people before their health conditions turn life-threatening. When integrated into the larger primary health system, they can help close the health care gap far faster and cheaper than health facilities on their own. Though there is limited literature on the actual costs, it is estimated that effectively supported and utilized community health workers can prevent more than 3 million child deaths annually while also providing a 1:10 return on investment.

WHAT LEGACY DO YOU WANT TO HAVE?

At the height of the COVID-19 pandemic, when many community members were afraid to seek services from health facilities, VHTs stepped up and provided life-saving services to children and pregnant mothers in their communities. Data shows up to 35% declines in the number of people who sought facility-based care and treatments for common childhood diseases such as malaria, diarrhea and pneumonia due to COVID-19. In contrast, treatments for these same diseases nearly doubled in areas with well-supported and digitised VHTs. Digital technology was a particularly critical driver enabling remote health care delivery.

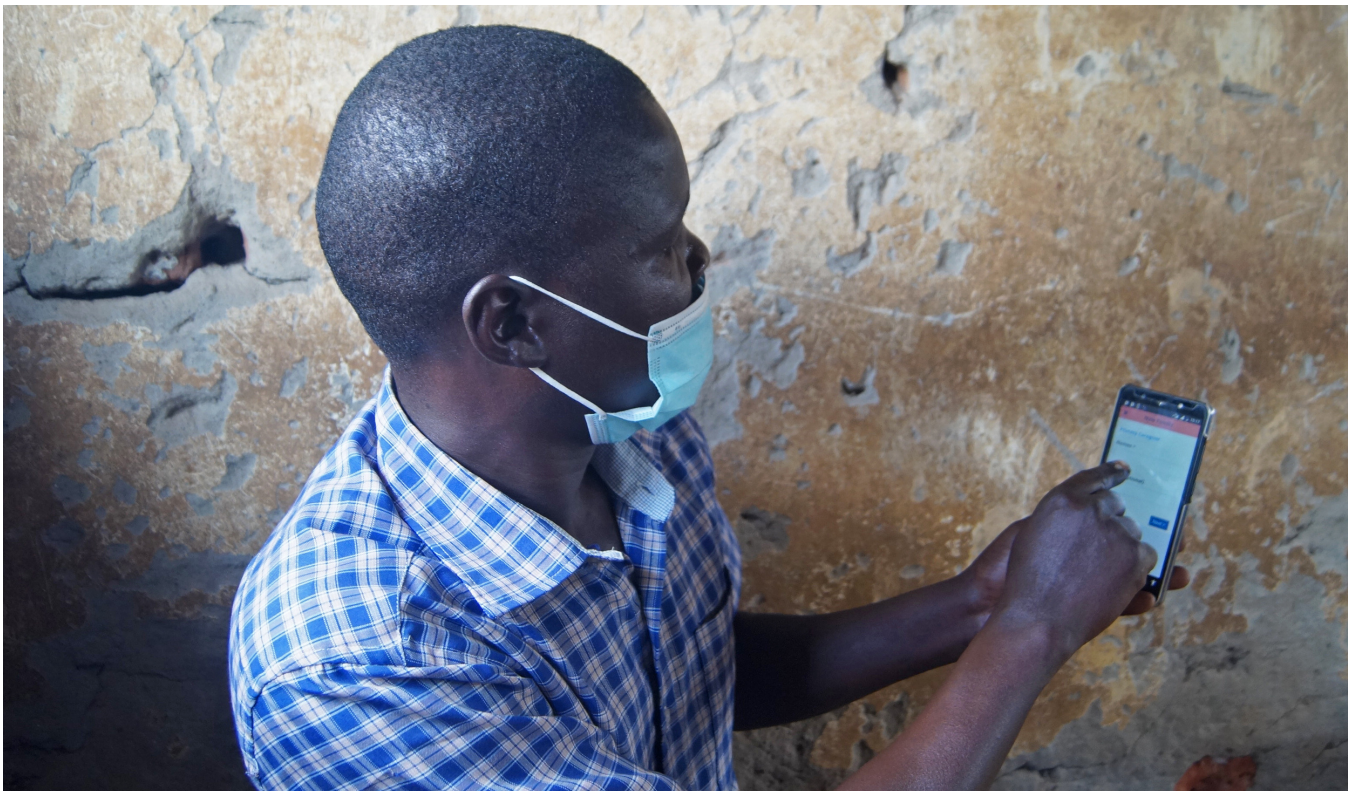
Evidence shows that the cost of services prevents many people from seeking health services, which if left untreated can be life threatening and have severe adverse consequences, such as pushing individuals and households into poverty. Every human being has a right to access healthcare, irrespective of where they live and their socio-economic background. You can make this a reality for your community, by ensuring allocation of resources to strengthen delivery of community-based services through VHTs.

WHAT CAN YOU DO?

With is your responsibility to formulate laws that advance the rights and wellbeing of the people you represent; you can significantly impact the health of communities. The power is in your hands to ensure a more equitable future where every person can survive and thrive.

1. Influence the Parliamentary Budget Committee to appropriate funds for VHT compensation of at least UGX 100,000 for one VHT/village/month
2. Influence an increased allocation of PHC funding in the health sector budget
3. Support digitization of VHTs by advocating for formulation of facilitative policies

If the government invests in training and equipping VHTs with digital tools and essential medicines, and adequately supervising and incentivizing them, they will save more lives and significantly reduce child and maternal mortality at a large scale—thus ensuring delivery of greater impact in a more sustainable and cost-effective way.



ABOUT THE TECHNICAL ADVISORY COMMITTEE

The Technical Advisory Committee is led by the Ministry of Health's Commissioner of Community Health—and comprised of other departments at MoH, key partners from Oyam District Local Government (DLG), the Ministries of Local Government, ICT, and Gender and Social Development, Living Goods, and Malaria Consortium. Since the beginning of her mandate, the TAC has been instrumental in providing guidance and expediting the resolution of challenges in the implementation of the exemplar.

REPUBLIC OF UGANDA
OYAM DISTRICT
Local Government

LivingGoods
Delivering Data-Driven Health Care, Door-to-Door

malaria consortium
disease control, better health