Inter-sectoral collaboration for universal health coverage at community level

David Okello, Enos Paul Emulu and Francis Omaswa summarise the outcomes of an effort to implement ISC in Ngora District in eastern Uganda

In 2017 the African Centre for Global Health and Social Transformation (ACHEST) undertook a scoping study on the status of implementation of Sustainable Development Goals (SDGs) in seven countries of East and Central Africa: Ethiopia, Kenya, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe. The study found that all these countries had integrated SDGs into their national development plans, that SDGs are interconnected and interdependent and require new ways of work across multiple sectors. Furthermore, the study found out that health was receiving less government attention, as it was perceived to be supported by donors. During 2018, ACHEST undertook further analysis on the level of implementation of ISC for health in Uganda at central, district and community levels. This study found out that ISC was hampered by a siloed approach to planning, budgeting, implementation and monitoring of government programmes; and that the entrenched mind-set of civil servants tended to defend this. To promote ISC to support the full realisation of SDGs and Universal Health Care (UHC), and in line with recommendations made by stakeholders, ACHEST from August 2020 led efforts to initiate a community level implementation of ISC in one of the study districts. Below we summarise the methods of this community-led work, and lessons learnt so far from the initiative.

The Ngora Initiative

As a follow-up to the ISC study, ACHEST in partnership with the Ministry of Health (MoH) and Ngora District Local Government (NDLG) has implemented a six-month intervention in Ngora District, eastern Uganda, to assess the feasibility of ISC for advancing Integrated People-Centered Primary Health Care (IPCPHC) in five communities. The initiative operationalises to full scale the government of Uganda ISC and IPCHC Strategy in which Health Centres level 1 are established alongside the elected Village Local Council 1 leaders who are responsible for the overall governance of the village. It supports and reaffirms the 'Whole of Society approach' for IPCPHC.

This will be attained through mobilisation of communities, local authorities, field extension workers, religious and cultural leaders, private sector and local civil society organisations (CSOs). Village Health Teams (VHTs) were trained in community mobilisation for health-seeking behaviour, monitoring the health conditions of the community, model homes, hygiene and sanitation. The VHTs made maps of the villages where they work, with all households numbered. On a daily basis, the VHTs visit five to ten houses, maintain health registers with records of the health status of each individual in the households; and promote and record good health practices, hygiene and health conditions of household members. They also identify, refer and follow-up patients in homes, ensure that immunisation, maternal health and other population health needs are addressed.

Figure 1: VHTs in Ngora receiving tools for their work

This model has been adopted for the implementation of the National Community Engagement Strategy for COVID-19 Response in Uganda. The initiative is based on the principle that good health starts with, and is created by individuals, their families and the communities; and that individuals have the primary responsibility for maintaining their own health. It is also being used to demonstrate that organised communities have power to control community spread of COVID-19 and to support each other in this effort. The Ngora District Administration under the leadership and active participation of the Resident District Commissioner (RDC), Chief Administration Officer (CAO), and the District Health Team, including other Departments such as Schools, Community development, Security, Agriculture, Cultural and Religious leaders meet every month to evaluate progress.

Five villages at Local Council 1 level (LC1) were selected in Ajeluk, Adul, Obur, Oluroi, and Okunguro in Mukura Sub county of Ngora District. Village Health Committees were established in these villages, led by the LC1 Chair and they meet to plan and discuss health and other issues that affect the health and wellbeing of the community.

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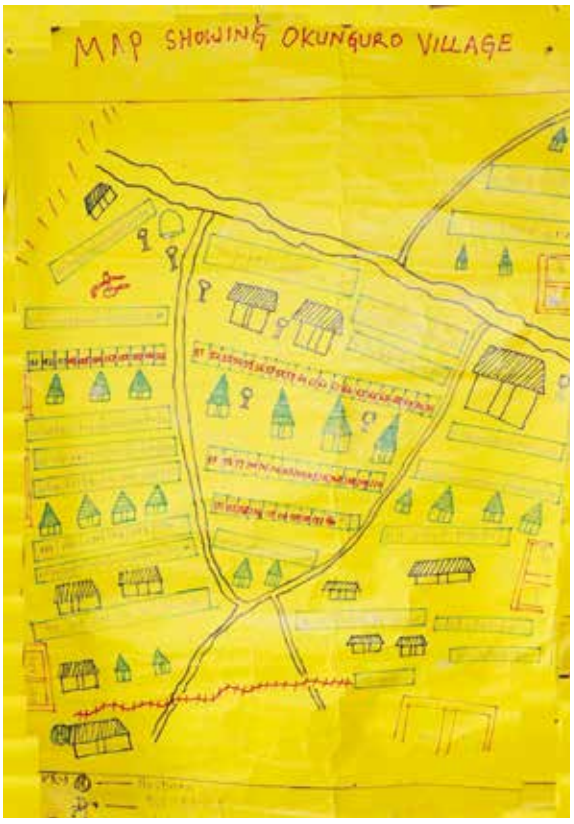
Figure 2: Example of a village map created by a VHT.



One of the VHTs from the five villages was selected by the community and were provided with training by ACHEST and the MoH. They were supplied with bicycles, gum boots, umbrellas, uniforms and backpacks containing a thermometer, gloves, face masks, some drugs and testing kits, a smart phone and a Village Health Register. Each VHT also receives an allowance of UGX 150,000 (USD30) every month so that they can dedicate more time to this work.

The VHTs were also trained to empower families to take ownership of their own health; through increasing health literacy and awareness by families of healthy practices in maternal-child health and healthy reproductive behaviours; and knowledge of nutrition, including for the prevention of malnutrition and the awareness of food-safety.

Members of the community have become each other's keepers as part of a cohesive society. Agreement is reached on model homes for each household to emulate and which are enforced by local authorities. Model homes have defined standards for ventilated pit latrines, waste disposal pits, bath shelters, kitchen with drying racks for plates and separate sleeping areas for animals. The VHTs report to the local authorities suspected cases of disease outbreaks and other outward social happenings – such as gender-based violence (GBV), juvenile delinquencies and teenage pregnancies. Every month the Village Health Committee convene for Community dialogue to identify and implement local solutions to issues emerging from the communities and VHT reports.

Key outcomes of the initiative

The partnership between ACHEST, MOH and the local leadership and the communities has had a positive impact on the behaviour and attitude of people living in the five villages in Mukura, Ngora District. The key outcomes include:

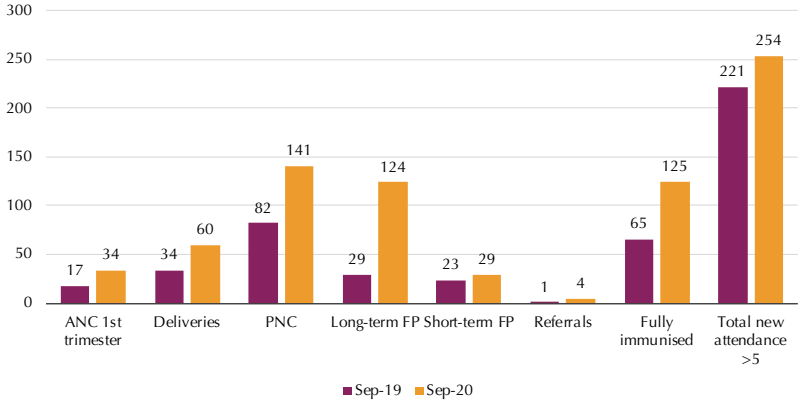
(1) The community in the villages is switched on and taking full responsibility for their health. They have demonstrated social cohesion, better health-seeking behaviour and better collaboration with district leaders.

(2) The use of health services at the local Health Centre (HCIII) have increased significantly. Comparing statistics of September, October and November 2019, with those of 2020, there has been twofold increase in mothers delivering in health facilities and post-natal care, immunisation coverage; and fivefold increase in uptake of long-term family planning methods. Figure 3 shows selected indicators for a local health facility at Mukura Health Centre III, comparing the level of service utilisation in September 2019 and in September, 2020.

(3) Local solutions are identified to deal with local social and health concerns, like juvenile delinquencies, drug abuse, teenage pregnancies and GBV. Communities freely discuss access to water, sanitation, food security and hygiene. Homes are cleaner and following standards set by the communities themselves. Every homestead has put in place hand washing facility at the entry of the homes with soap and water. Visitors to the homes are required to wash their hands.

Mobilised communities have capabilities beyond health. This initiative has become an entry point for rallying communities to build social cohesion, peace and development efforts needed to improve their livelihoods. The monthly community dialogue meetings are also known in the local language as *ainapakina*, which means peace and tranquility. It is a place where everything is discussed. ACHEST has succeeded in building trust with and within the community as a prerequisite for the success of this initiative.

Figure 3: Selected indicators for use of services at Mukura Health Centre III, comparing 2019 and 2020



(4) The community now owns and cherishes public health facilities, which are recognised as serving them, and not as 'a government-owned institution'. They are using and working with the facilities and taking an interest in their day-to-day operations and management.

(5) Universal Health Coverage does not happen until communities' own responsibilities for their health. This initiative has opened the door to reaching individuals in every household. It has demonstrated how to do it through empowered communities, working with supported Community Health Workers.

The initiative was built on existing community structures and networks; as well as private, faith-based and public healthcare system, which ensures sustainability.

(6) The community dialogue sessions have been frank and open on gender issues, equality, and advancing women and girls' capacity to participate fully in development activities. The intervention has therefore contributed to reducing and mitigating the harmful effects of GBV and increasing the capabilities of women and girls to contribute to the overall success of the households.

(7) This Ngora Model has been adopted for the development and implementation of the National Community Engagement Strategy for COVID-19 Response in the whole country. The emphasis on community empowerment and the full engagement of local leaders, cultural and religious leaders will leave the health systems stronger beyond COVID-19 pandemic.

Discussion

With the advent of COVID-19 pandemic, the country has launched the National Community Engagement Strategy (CES) for COVID-19 Response.[2] The strategy seeks to ensure that all people in Uganda are aware, empowered, and actively participating in the prevention and control of the outbreak of COVID-19 as both a duty and a right; using existing structures, systems, and resources. The development of the strategy and its implementation was led by teams from ACHEST, and based on the Ngora model.

To achieve Universal Health Coverage, emphasis should be put on community mobilisation for the health and wellbeing of individuals and communities as the foundation of IPCPHC and resilient health systems and first defense against infectious diseases outbreaks. This

Figure 4: A VHT demonstrating hand washing equipment installed at the entrance of a homestead

Figure 5: RDC Ngora conducting one of the monthly community dialogue meeting at Mukura HCIII

is a responsibility that starts with individuals in their households and communities. As stated by Professor Miriam Were, "in Africa, if it doesn't happen in the communities, it doesn't happen in the nation. And if it happens in communities it happens in the nation".[3] A cross-section of actors including employers, educators, architects, businesses and community leaders as well as government have a responsibility to create the conditions that enable all people to live healthy lives as advocated by Nigel Crisp in his book, *Health is made at home; hospitals are for repair*.[4]

The 2001 National Health Policy and Strategy for Uganda recognised the critical need to mobilise families and communities as the cornerstone of health promotion and disease prevention as 75% of the disease burden was due to preventable infectious diseases. The guiding principle of this policy is that health promotion and disease prevention should be integrated into the routine governance of society.[5]

Conclusion

The Ngora district intervention has demonstrated that it is possible to organise communities to take care of their own health through engagement and empowerment. The support of the district leaders is critical to show that this agenda is an important concern of the government. We have demonstrated in this initiative that providing incentives to the VHTs makes it possible for them to find time to focus on home visiting and reporting. Above all, regular community dialogue to build and maintain trust and supportive supervision are needed for success.

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