Community Engagement for COVID-19 Response and Health: Lessons from Uganda

Francis Omaswa, David Okello, Enos Paul Emulu and Robert Odedo summarizes their experience in implementing Community Engagement Strategy for COVID-19 Response and Health in Uganda.

Introduction

Japan International Cooperation Agency (JICA) worked with the African Center for Global Health and Social Transformation (ACHEST) as a Technical Partner to test and model approaches for the engagement of communities in the prevention and control of COVID-19 in Uganda from April 2021 to March 2023. Four districts of Uganda, namely, Amuru, Busia, Mukono and Ngora were selected for the intervention. The objective of this intervention was to ensure that all people were aware, empowered and were participating actively in the prevention and control of the outbreak of COVID-19 as both a duty and a right, using existing structures, systems and resources as much as possible.

The COVID-19 outbreak was seen as an opportunity to implement to scale the existing multi-sectoral Community Health Strategy which was first articulated in the National Health Policy and Strategic Plan launched in the year 2000. This approach is expected to accelerate the achievement of SDGs and UHC in Uganda through enhanced ownership of the health and development agenda by the communities themselves. The approach would also ensure that COVID-19 infections are minimized or do not occur in the community; and if they occur, it would enable prompt identification, testing, treatment and rehabilitation as needed.

Methodology used

The strategy adopted for this intervention was to strengthen the existing Community Health Systems for Integrated People Centered Primary Health Care as the National COVID-19 response transitioned to Phase 4, manifested by widespread community transmission in most of the districts of Uganda. Village COVID Task Forces (VCTFs) were established in all districts in the country, aligned to existing governance structures. The VCTFs were led by elected leaders and membership included; Community Health Workers known as Village Health Teams (VHTs), cultural and religious leaders, extension workers from community development, civil society organizations (CSOs), agriculture, schools, women groups and opinion leaders.

The VHTs were supported and supervised by the Health Assistants and health facility staff at the nearest Health Center. They were linked to the District health system and reported to the District COVID Task Force and shared data with the District Health Biostatistician . The VHTs received additional training and were provided with a tool kit for 160 VHTs per district, including a back pack, a reflector jacket, bicycle, smart phone, first aid box, temperature gun, umbrella, rain coat and gum boots. They also received an allowance of UGX 100,000 (one hundred thousand only) per month which motivated them to do their work optimully.

The four project districts of Amuru, Busia, Mukono and Ngora were followed up closely by ACHEST teams as learning sites with the support of JICA and the Government of Uganda. The VHTs in the project sites were trained and acquired skills to handle the following activities: i). Community based surveillance and case detection including deaths, ii). Community case management including supporting self-isolation, community-based drug distribution and referrals as appropriate, iii). Community contact tracing and reporting, iv). Community shielding of vulnerable members, v). Strategic Communication, creating awareness, information and education to gain and hold trust of the communities as well as promoting household hygiene and sanitation, vi). Maintaining the Village Health Register on households, data management and reporting, and vii). Responding to other health needs as appropriate including Water, Sanitation and Hygiene issues; as well as maternal and child health conditions.

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

Results

The key result of the intervention demonstrated that empowered and organized communities have the capacity to own and take charge of their own health. The project helped to revitalise and enhance the capacity of the VHTs, as well as raise their visibility within the health system. The role they play has been highly appreicated by Government, development partners and members of the communities. They were very effective in supporting COVID-19 control measures, including creating public awareness COVID-19 vaccination and Standard Operating Procedures. The VHTs gained skills in home visits, how to relate to households and obtain the trust of

Francis Omaswa. Founding CEO, African Center for Global Health and Social Transformation (Kampala, Uganda). Founding Executive Director of the Global Health Workforce Alliance, WHO and publisher Africa Health Journal

the community.

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

The recently launched National Community Health Strategy for Uganda has benefitted immensely from the CES, and it is a direct output of the application of lessons learned from the implementation of the CES. ACHEST played a key role in influencing this major policy direction in the country. ACHEST also influenced policy direction for the utilization of VHTs trained under this project who are now widely utilized in the implementation of community health programs by partners and the Government.

Figure 1. A VHT interacting with a community member in one of the Model homes during routine home visit

ACHEST obtained data from the DHO Teams during regular interactions with them and from the stakholders' meeting in March 2022, which showed general improvements in the Results Based Financing (RBF) indicators over the project period as shown in Figures 2 and 3 of Ngora district.

Almost all monitored RBF indicators improved since this project started; hygiene and sanitation improved, open defecation no longer observed, handwashing facilities at more than 90% and practical handwashing observed in the households. It was also reported from the ground level; increased child births in health facilities, reduction in hygiene associated diseases like diarrheal illness, eye diseases and intestinal worms; as well as increased antenatal care attendance over the project period.

There was also an increase in the number of women taking the use of modern family planning services; and many households achieved minimum standards for model homes. These improvements were a result of the efforts of Village Health Committees and VHTs in mobilizing the populations in their community.

Figure 4: VHTs receiving bicycles and kits

Sustainability of Efforts

VHTs are present in all parts of the health systems in Uganda. Their work, however, has been by and large treated as voluntary, despite their enormous time commitment for the work. Nowadays, most incentives for the VHTs are donor-driven, in-kind, inconsistent, and non-monetary. Indeed, lack of incentives and support to VHTs has been a major challenge to sustain the system since its inception more than 20 years ago. It is against this background that the JICA supported Project in Uganda decided to pay a facilitation of UGX 100,000 (US$25-30) per month from September 2021 to the end of the project in March 2022. The reason of this decision was to facilitate the VHTs' activities further so that the impact of the intervention could be realized and on the realisation of how important the incentive and motivation to VHTs is for the sustainable community health system.

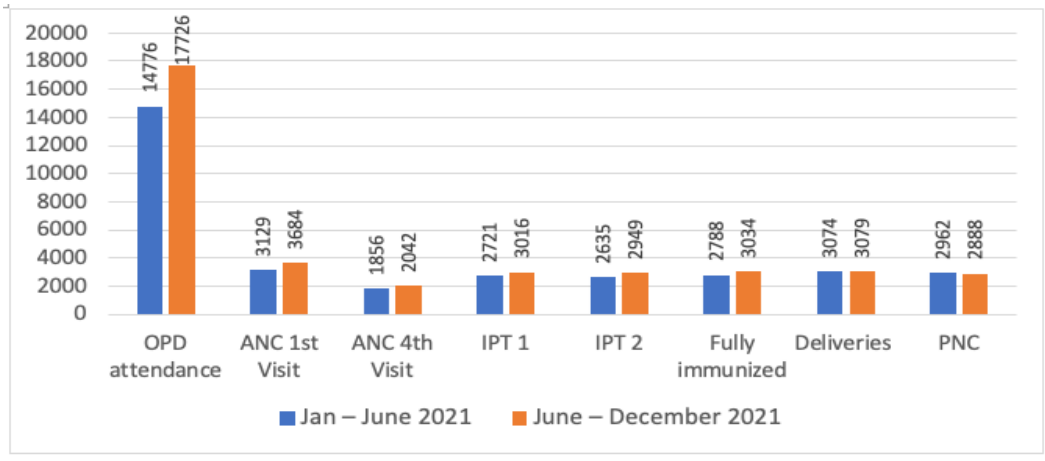

Figure 2: Comparison of RBF Indicators for 6-month period before

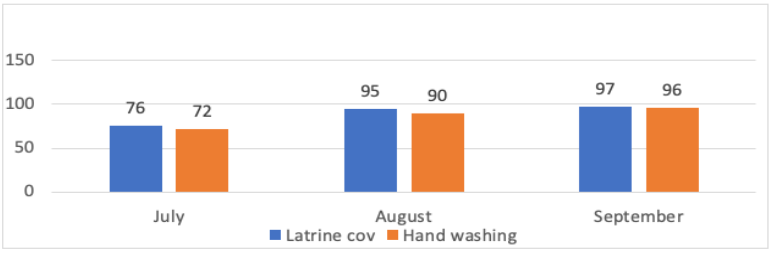

Figure 3: Improvements in Hand washing and Latrine Coverages (%) in Ngora District from July to September 2021

The facilitation apparently led to the stunning achievement. The number of home visits by VHTs drastically increased during the time they were incentivized; namely, the VHTs' activities seemingly became more active after the introduction of the facilitation. The change might be affected by the procurement of equipment and the technical inputs and empowerment through the project. On the other hand, it was also observed that some VHTs have been apparently discouraged to continue their activities after the end of the Project when the facilitation was terminated.

In addition, the experience with the COVID-19 response has brought to light the potential of the communities to take charge of challenges facing them. Sustainability of these efforts rests in embedding community engagement activities into the district plans, and ensuring that the partners follow the '3 ONES'; namely, One district plan, One implementation arrangement, and One monitoring and evaluation mechanism. Such efforts are already underway, but implementation is hampered by low funding support from the Government and partners. On the other hand, a few health development partners are supporting the district plans and utilizing the VHTs who have become key players at the community level. Such efforts are commendable and should be encouraged.

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

Challenges

The youth particularly boys in the communities were engaged in idleness and consumption of alcohol and illicit drugs. Payment of allowances for VHTs was implemented by Government for one quarter of FY201/22 and then stopped. JICA was able to sustain VHT payments through the remaining period of the project. There is a strong call to have at least one VHT per village to get paid allowances to allow them devote more time to their work. Male participation in supporting their spouses to attend antenatal and delivery services is too low. This leaves the women to struggle on their own without male support. VHTs also need regular supply of Village health registers, Referral forms and support supervision from the Health Assistants.

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

In the JICA supported Project areas, ACHEST made special efforts to train all the VHTs recruited into the Project. Nevertheless, strong demands were made by the District Health Offices and the District COVID Task Forces for training for other VHTs who were not benefitting from the Project as they are as well invaluable human resources in the communities. In addition, the districts also pointed out that some VHTs have been dedicating themselves for decades and have aged; and new VHTs should now be recruited to sustain the community health system. Above all, however, the costs and resources for regularly providing training to VHTs could hinder the expansion of community health programs in the country. In Oyam district, the Development Partners combined efforts and resources to ensure that VHTs got refresher training in Integrated Community Case Management (iCCM) and other Maternal, Newborn and Children Health (MNCH) areas. This cost sharing arrangement eases the burden on the funders whilst ensuring VHTs are well equipped to serve their communities more effectively.

Recommendations

Based on our experience implementing this project, we recommend as follows:

1. The lessons learnt from this project should be incorporated and used during the implementation of the new National Community Health Strategy;
2. Village COVID-19 Task forces should become the Village Health Committees and meet regularly for Community Dialogue; and
3. There is need to continue with modelling the successful practices in the current project districts and to expand to new districts.
4. The paper-based Village Health Registers as used in the project should be transformed into an electronic Community Health Information system (e-CHIs).