

**REPORT ON STUDY OF COMMUNITY HEALTH WORKERS IN UGANDA
(WITH FOCUS ON VILLAGE HEALTH TEAMS STRATEGY- VHT) 2007**

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Submitted to:
WHO Global Health Workforce Alliance

December 2007

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ACKNOWLEDGEMENTS

I wish to thank the WHO Global Health Workforce Alliance (GHWA) for giving me the opportunity and the resources to prepare this report. I thank the Uganda Ministry of Health officials, Local Government officials, various leaders, Community Health Workers, and community members for their cooperation during the survey. Last, but not least, I wish to thank officials and members of UNACOH and of KASKAA Ltd for their patient administrative, logistical and moral support during the process of preparing this report.

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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Anti-Retroviral
CAO	Chief Administrative Officer
CARE	Carry American Relief Everywhere
CB-	Community Based
CCA	Community Counseling Aide
CCF	Christian Children Fund
CDD	Community Drug Distributor
CEMH	Community Empowerment and Mobilisation for Health
CHW	Community Health Worker
CMD	Community Medicine Distributor
CORPs	Community Owned Resource Persons
CPAR	Canadian Physicians for Aid and Relief
DDT	Dichloro-Diethyl Tetrachloroethane
DHO	District Health Officer
DHT	District Health Team
DHV	District Health Visitor
DOTS	Directly Observed Treatment Strategy
EH	Environmental Health
EPI	Expanded Programme on Immunisation
FB-	Facility Based
FP	Family Planning
GHWA	Global Health Workforce Alliance
HBC	Home Based Care
HBMF	Home Based Management of Fevers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
<u>I@Mak</u>	Innovation at Makerere University
ICRC	International Committee of the Red Cross
IDPs	Internally Displaced Persons
IGA	Income Generating Activity
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment of Malaria in Pregnancy
ITN	Insecticide Treated Mosquito Net
IRC	International Rescue Committee
LC	Local Council
LCI-V	Local Council I – V
MDGs	Millennium Development Goals
MOH	Ministry of Health
NHP	National Health Policy

NGO	Non-Governmental Organisation
NUMAT	Northern Uganda Malaria etc...
PDC	Parish Development Committee
PHA	People with HIV/AIDS
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PNFP	Private Not For Profit
RH	Reproductive Health
SC	Sub-County
SHSSPP I	Support to the Health Sector Strategic Plan Project I
TASO	The AIDS Support Organisation
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOT	Training of Trainers
UNACOH	Uganda National Association of Community and Occupational Health
Under-5	Child Under 5 years of age
UNICEF	United Nations Children Fund
UNMHCP	Uganda National Minimum Health Care Package
VHT	Village Health Team
WHO	World Health Organization

EXECUTIVE SUMMARY

There have been various efforts in the past in Uganda to involve communities in health promotion and improving health services delivery. Such efforts included Home and Sanitation Improvement campaigns, Mwanamugimu Nutrition Rehabilitation model, Kasangati Health Centre Defined Area model, Ankole Pre-school Protection Programme, Community Capacity Building (CCB), Home Based Care, among others. All these good efforts were however scattered in time and geographically, and were advanced by individual Departments or organizations.

In the 1990's it was realized that in order to fight poverty and enhance development, and if PEAP targets and MDGs were to be met, there was need to harmonize and universalize efforts towards community empowerment and mobilization for health (CEMH). To this end the National Health Policy (NHP) of 1999 and the Health Sector Strategic Plan (HSSP) I (2000/2005) and HSSP II (2005/2010) have included CEMH as one of the elements of the Uganda National Minimum Health Care Package (UNMHCP). It was, however, the Home Based Management of Fevers (HBMF) programme, rolled out after the Abuja Declaration (2000), that demonstrated the practicality and massive benefit of a sustained universal community empowerment and mobilization intervention in Uganda. When this was added to successes of more focal community efforts, such as Guinea worm Eradication Programme, CB-DOTS, Ivermectin Distribution, it became clear that an all embracing integrated community empowerment and mobilization strategy, the Village Health Team (VHT) Strategy could indeed be practicable and synergistically more beneficial. The VHT Strategy roll out started in 2003.

The advantages and challenges of the VHT Strategy in Uganda are discussed in this report.

Some of the advantages of the VHT Strategy are: integratedness, health promotion at individual, family and community levels, promotion of the utilization of available health services, involvement of leaders at various levels, implementation of a Community Based Health Management Information System (CB-HMIS), linking communities with the conventional health system, mobilizing communities for epidemics control, and promoting economic productivity through promotive and preventive health action at community level.

The two main challenges to the VHT Strategy are: the misconception that implementation of the VHT Strategy is expensive (in comparison to what?), and the limited supervision of existing VHT members by professional health workers. Motivation and recognition of the VHT members would be solved if the two main challenges are addressed.

The operations and practical examples of successes of existing VHTs (and other CHWs) are presented in this report (and an accompanying video record is being prepared).

It is argued that despite the challenges to the VHT Strategy, it gives the best promise so far in Uganda, to unleash the health potential of Ugandan communities to contribute towards achieving PEAP targets and MDGs. With community empowerment and mobilization efforts from other sectors, the VHT Strategy should synergise the ushering in of an era of grassroots socio-economic development in Uganda.

REPORT ON STUDY OF COMMUNITY HEALTH WORKERS IN UGANDA (WITH FOCUS ON VILLAGE HEALTH TEAMS STRATEGY- VHT) 2007

BACKGROUND

The contribution of health workers at community level has been recognized for centuries as a key factor in raising the visibility of health at community and house hold level and therefore in improving the health of populations. Indeed prior to the introduction of Western medicine in Uganda, communities were responsible for the health of their members. Some community members were variously assigned the responsibility to lead or serve others in health matters. They were rewarded by recognition or materially. The advent of Western medicine made health care more scientific, but it also largely disarmed communities of their responsibility towards health action. The justified glorification of western magical cures, epitomised by antimalarials and antibiotics, especially penicillin, emasculated the ages old traditions and cultures of prevention and self-reliance, albeit sometimes clouded in myths.

Ugandan communities and populations therefore became completely vulnerable to health problems, which could not be cured by the “magical bullets”. Matters were not helped by the system which largely separated curative/clinical care from preventive and community health services; nor by the notion of an institution based medical care system waiting for patients, while individuals and communities waited for severe ill health before seeking the services of the medical institutions. This constituted what the author terms the “negative health culture”. Indeed in Uganda, up to this day, health units are still called “ddwaliro”, “irwarro”, “idwaliro”, “ilwaliro”, “adekis”, meaning a “place of sickness” or “dakatal” meaning a place of treatment, in various local languages.

Against the above background, various government, non-governmental and international initiatives and programmes have slowly come up to try and redress the situation. In the 1950's DDT spraying in Kanungu area was done to prevent epidemics of Malaria. From the early 1960's, following the success of small pox immunisation, childhood immunisation programmes picked up, albeit not as routinely as in the EPI era. Communities were largely mobilised by Chiefs and Health workers. Health Inspectors, Assistants or Orderlies enforced sanitation in villages, while building of latrines and maintaining of food security were backed by by-laws. However in all these efforts some degree of community participation was required, complementing the law enforcement.

A break from over-dependence on enforcement of health by-laws was pioneered by Makerere University Medical School, Department of Preventive Medicine in the 1950's and 1960s, when Kasangati Health Centre implemented the concept of “defined area”. Under this concept, communities within the “defined area” accessed medical care from the health centre, while Health Extension Workers carried out extensive preventive programmes in the same “area”. Despite limited direct community participation, the “defined area” concept started the process towards “bridging” the gap between the “community” and the “health unit”, between curative services and preventive services.

The Ankole Pre-Primary Protection Programme, based in Mbarara in the 1970s aimed at protecting under-5 children from preventable childhood illnesses, before starting school. Indeed nutrition, immunisation and early treatment of childhood illnesses were among the activities promoted.

Home Improvement and Sanitation Competitions and Campaigns were another initiative, which involved communities in promoting their health situation. They were however spearheaded by Government Health Workers.

Another unique model in Uganda was based at Mwanamugimu Nutrition Rehabilitation Unit at Mulago, in Kampala by the 1960s. Severely malnourished children were admitted to the Unit together with their care givers (usually mothers). While the children were treated with “food”, the care givers were taught about proper feeding of the children, and they were trained to go back to their communities to teach other care givers how to feed children properly to avoid malnutrition. The caregivers of severely malnourished children graduated as teachers/trainers in their own communities. Call them Community Health Workers.

The above-cited efforts were unfortunately not universally duplicated throughout Uganda, but they were definitely in the right direction towards community participation or involvement in health promotion.

The era of political turmoil, especially in the 1970s, destroyed or reversed the health system and community mobilisation gains that had been made up to that time. Therefore when political stability started being restored in Uganda from 1986, many Governments, International Organisations and NGOs were willing to assist Uganda recover her health system. Whereas much help went towards rehabilitation of health infrastructure, some assistance went towards preventive care, especially childhood immunisation. Some organisations attempted to introduce cadres of Community Health Workers (CHW), sometimes referred to as Community Owned Resource Persons (CORPs). Without Government central guidance, these CORPs were varied indeed in selection, qualifications, training, assignments and remuneration. Since many CORPs were attached to projects, their roles ended with the projects. The special role of CORPs was demonstrated in Internally Displaced Peoples’ (IDP) Camps in Northern Uganda in the 1990s and 2000s, where UNICEF and other NGOs such as IRC supported the Home Based Care (HBC) programme. Under HBC programme, CORPs provide treatment for some common illnesses such as Malaria, but also promoted preventive activities, such as sanitation. (Home Based Care is likely to be converted to Village Health Team implementation when IDPs return to their villages).

One community participation intervention that has survived for some time is the Community Capacity Building (CCB) process started by UNICEF in the 1990s. Under CCB almost all districts in Uganda introduced the Parish Development Committees (PDCs), which were composed of two persons from each village (LCI) joining this Parish level (LCII) Health and Development Committee. Parish Development Committees still exist in many districts. The PDCs had two main structural problems: being a Committee (implying policy) but required to implement health and other activities, and expecting two people only from a village to carry out voluntary work effectively only a wide range of activities, especially in large villages.

The Burden of Disease study in 1995 and the Uganda Participatory Poverty Assessment Project shortly thereafter showed that disease and poverty were viciously related, and that most of the burden of disease in Uganda is preventable. Therefore it became clear that prevention of disease/injuries was a socio-economic imperative, and that communities must be involved in the actualisation of this imperative. This called for new thinking about prevention, community empowerment and mobilisation for health, and creating extra mileage through integrating various

interventions synergistically. Uganda has thus joined the renewed global movement towards prioritizing integrated Primary Health Care (PHC) and the role of Community Health Workers (CHWs) to ensure effective community participation in health matters.

A concrete example of nationwide community health action was introduced in Uganda around 2000/2001, in the form of Home Based Management of Fevers (HBMF) for children under 5 years. This came out of the Abuja Declaration of 1997, whereby African Heads of State committed themselves and the continent, to Rolling Back Malaria, applying among others, the use of pre-package antimalarials, distributed by community members, and given at home to under 5 children within 24 hours of the onset of fever. Two main features of HBMF were its universality throughout the country, and the democratic nature of the selection of the Community Medicine Distributors (CMDs). Two main lessons from HBMF were that it was possible for Community Health Workers to do the same thing throughout the country at the same time, and that these “villagers” could keep very good records and make very good reports. The two main weaknesses of HBMF were that having only two CMDs per village made the distance to homes similar to Health Centre IIs in large villages, and that in communities with so many preventable health problems, CMDs focussed on treatment of malaria only (not prevention), among under-5s only, and did not address any of the other rampant preventable health problems.

In line with the National Health Policy (NHP) of 1999, the Health Sector Strategic Plan I (2000/2005) spelt out the role of Community Empowerment and Mobilisation for Health (CEMH), as an element of the Uganda National Minimum Health Care Package (UNMHCP) under Health Promotion and Education Division. The Village Health Team (VHT) Strategy was identified as the means of achieving Community Empowerment and Mobilisation for Health, nationwide. By 2005 the VHT Strategy had been implemented in a number of districts, but not at all in many others. The significance of the VHT Strategy was reiterated by setting the target of 100% of all villages by the year 2010, under the Health Sector Strategy Plan II (2005/2010). In fact the Annual National Health Assemblies of 2006 and 2007 (with representatives from all 80 districts of Uganda) urged the Government of Uganda to avail resources to roll out the VHT Strategy to all districts.

The Village Health Team (VHT) Strategy is a type of intervention in response to the need for Community Empowerment and Mobilisation for Health, an element of the Uganda National Minimum Health Care Package (UNMHCP), under the Health Sector Strategic Plan (HSSP) and the National Health Policy (NHP). The VHT Strategy covers mobilization for all other elements of the UNMHCP.

Because the VHT Strategy is still relatively new, and because many stakeholders still consider the training and maintaining of VHTs “expensive”, the VHT strategy has been fully rolled out to all villages only in Mpigi District (with support of WHO and Global Fund), and in the districts of Adjumani, Moyo, Yumbe, Koboko, Arua, Nebbi, Oyam, Apac, Lira, Dokolo, Amolatar, Kaberamaido, Amuria, Katakwi, Soroti, Bukwa and Kapchorwa with support of the African Development Bank, through Support to the Health Sector Strategic Plan I (SHSSPP I). Pader District has VHTs trained in 17 out of 19 SCs, while in Gulu the VHT training has covered 11 out of 15SCs. The degree of VHT coverage for other districts we have contacted ranges from **no training** at all such as in Ntungamo, to a few Sub-counties covered, such as 1 Sub county out of 14 in Kyenjojo or up to a number of Sub-counties covered, such as in Kabarole District where 6 out of 16 SCs have been covered, by September 2007. (Details are in the attached table).

Traditionally various Ministry of Health Programmes (such as Malaria Control, Vector Control, TB Control, Nutrition, among others) and NGOs, such as CARE, AMREF, IRC, among others have trained various cadres of Community Health Workers (also sometimes referred to as CORPs), who usually covered specific areas of health care, such as Home Based Management of Fevers, Ivermectin Distribution, TB DOTS, Condom Distribution, to mention but a few. In districts where the VHT Strategy has not been rolled out those cadres still operate independently, as shown in the survey table attached. However, even in districts where the VHT Strategy has been rolled out fully, some NGOs and some Ministry of Health programmes may still support parallel Community Health Workers. Examples are a recent introduction of Reproductive Health Workers by Kuluva Hospital in Arua District (where VHT was fully rolled out) and the Vector Control Division which still supports parallel Ivermectin Distributors even in districts such as Nebbi, Dokolo and Lira, where the VHT Strategy has been fully rolled out.

GOAL OF THE STUDY

To put in perspective the role of Community Health Workers in Uganda, in promoting community health action, as a contribution to health promotion, economic productivity and socio-economic development.

GENERAL OBJECTIVE

To establish the types of Community Health Workers (CHWs) in Uganda, and how they have worked to contribute to the health of the nation.

SPECIFIC OBJECTIVES

1. To identify the types of Community Health Workers in Uganda and by who established
2. To establish how the various Community Health Workers have been recruited
3. To established how the CHWs have been trained, registerer/accredited and deployed
4. To establish the roles the various Community Health Workers have played in community health action, with concrete examples
5. To establish how CHW have been supervised
6. To establish how the CHWs have been linked to the existing health system and to communities.

DELIVERABLES

- A report on the typology of CHWs in Uganda and respective roles, recruitment, deployment, training, remuneration, accreditation/registration, supervision and links with the health system and communities.
- Concrete examples of the impact of the work of CHWs - for example, in disease control, vaccination coverage, controlling epidemics e.g. Ebola haemorrhagic fever, etc.

METHODS AND SCOPE OF WORK

Literature review was done, including review of the work undertaken by AMREF on CHWs. The author and his team interviewed key contact persons in Ministry of Health and other Government Departments, District and Lower Level Governments, NGOs, academia, the public and private sectors, and most importantly the CHWs themselves (mainly VHT members), and the communities they serve across the country.

The author and his colleagues and assistants at UNACOH and Ministry of Health developed a check list of items to be used for various interviews. They then undertook to contact various stakeholders across the country by e-mail, telephone and physical visits or interviews, involving the Districts of Amolatar, Amuru, Apac, Dokolo, Gulu, Kotido, Lira, Oyam and Pader in the Northern Region; Adjumani, Arua, Koboko, Moyo, Nebbi, and Yumbe in West Nile Region; Luweero, Masaka, Mpigi, Mukono and Nakaseke in Central Region; Busia, Bukwo, Jinja, Kapchorwa, Kumi, Pallisa and Soroti in Eastern Region; Bundibugyo, Kabarole, Kasese, Kibaale, Kyenjojo and Masindi in Mid-Western Region; and Bushenyi, Ibanda, Isingiro, Kabaale, Kanungu, Kiruhura, Kisoro, Mbarara, Ntungamo and Rukungiri in South-Western Region. That is a total of 43 out of the current 80 Districts in the country (Appendix 3). The author has however recently worked directly with the districts of Kaberamaido, Amuria and Katakwi and is aware of the community empowerment and mobilisation for health efforts in those districts. The author and/or his assistants also engaged various stakeholders in consultative discussions at District Leaders' fora on VHT in Kyenjojo and Masindi Districts. The author attended national discussions on Village Health Teams at the UNACOH Annual Scientific Conference September 20 and 21, 2007 and at the Annual Health Assembly and Joint Review Mission of the Health Sector, 22 to 26 October 2007 in Kampala. There was video recording of some of the above activities.

OBSERVATIONS AND FINDINGS

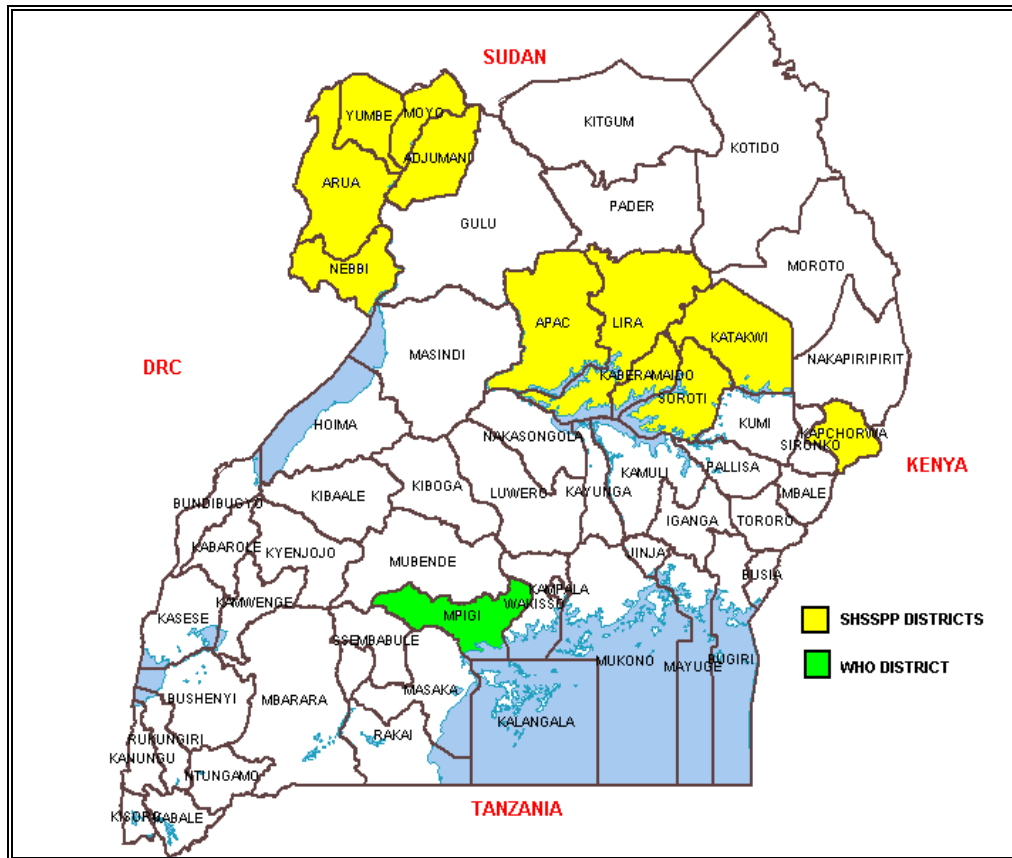
- **To identify the types of Community Health Workers in Uganda and by who established**

The range of Community Health Workers was derived from the interviews with stakeholders from national and district levels, and are shown in Table 1 and Appendix 3. They include Community Agents for Home Based Care (TASO trained), Community Condom Distributors, Community Counselling Aides (CCA), Community Health Workers for HIV/AIDS and Reproductive Health (Arua District only), Community Medicine Distributors (CMDs) or Community Drug Distributors (CDDs), CORPs, Community Reproductive Health Workers, Family Planning Products Distributors (Mukono District Only), Growth Monitors, Growth Promoters, Guinea Worm Volunteers, Ivermectin Distributors, Parish Development Committee (PDC) members, Parish Mobilisers for Immunisation, Popular Leaders (Apac District only), TB-DOTS Volunteers, Traditional Birth Attendants (TBAs), Vaccinators, VHT members, Village Helpers for Mental Health (Adjumani District only). Only Community Medicine Distributors (CMDs) or Community Drug Distributors (CDDs), and Traditional Birth Attendants (TBAs) are currently found across the country. Although VHTs are by policy supposed to be across the country, some districts have not yet rolled out the VHT Strategy at all.

Table 1: Types of CHWs, their promoters and geographical distribution (actual or planned)

Type of CHW	By whom established	Where deployed
Community Agents for Home Based Care	TASO	Selected Districts
Community Condom Distributors,	Ministry of Health and NGOs	Selected districts
Community Counselling Aides (CCA),	NGOs	Selected districts
Community Health Workers for HIV/AIDS and Reproductive Health	Kuluva Hospital (UPMB)	Arua District
Community Medicine Distributors (CMDs) or Community Drug Distributors (CDDs),	Ministry of Health	Nation wide, all villages
CORPs,	UNICEF and NGOs	Various districts
Community Reproductive Health Workers,	NGOs	Selected districts
Family Planning Products Distributors	NGOs	Mukono District
Growth Monitors,	NGOs	Selected districts
Growth Promoters,	NGOs	Selected districts
Guinea Worm Volunteers,	Ministry of Health	Selected districts
Ivermectin Distributors,	Ministry of Health	Selected districts
Parish Development Committee (PDC) members,	UNICEF and Ministry of Health	Nationwide
Parish Mobilisers for Immunisation,	NGOs	Selected districts
Popular Leaders	? NGOs	Apac District
TB-DOTS Volunteers,	Ministry of Health	Selected Districts
Traditional Birth Attendants (TBAs),	Ministry of Health	Nationwide
Vaccinators	Various NGOs	Various districts
VHT members	Ministry of Health	Nationwide, all villages
Village Helpers for Mental Health (NGO	Adjumani District only).

Figure 1: MAP OF UGANDA: Showing Districts that had implemented VHT Strategy fully by July 2006



- To establish how the various Community Health Workers have been recruited**

The recruitment of CHWs depends on criteria set by the originator or the funder of the particular category of CHWs. However in general terms all CHW must be popular, and preferably endorsed by the community members or the community leaders. Literacy and dependability are important attributes. Knowledge of English, the national medium of communication, is usually an advantage. The CHW is preferably a resident of the area he or she is supposed to serve. Gender consideration is important, but due to the factor of lower female literacy, especially in rural areas, gender balancing is commonly not practicable for selection of CHWs.

Selection of VHT members is done by popular vote after sensitization and consensus building of all stakeholders in the village and from all households (approximately 1 VHT member per 20-30 households). The following criteria are used to guide the voting process:

- Maturity (above 18 years of age).
 - A resident of the village.
 - Ability to read and write at least in the local language.
 - A good community mobilizer and communicator.
 - A dependable and trustworthy person.
 - Someone interested in health and development.
 - Willingness to work for the community good (showing a spirit of voluntarism).
 - Preference is given to already serving CHWs, especially if they have served well.
- **To established how the CHWs have been trained, registerer/accredited and deployed and remunerated**

The details and duration training of the various cadres of CHWs depend on the originator, the level of education of the CHWs and the tasks to be undertaken by the CHWs. As an example, the very elaborate cascade of VHT selection, training and supervision is shown in the table below.

The nearest Health Centre, the Health Sub-District and the District Health Office register the trained VHTs. VHT members get a national certificate of recognition (think globally), but are deployed in their own communities to serve their closet neighbours, but as a team to serve the village (act locally). The accompanying figure shows the institutional linkages supporting the implementation of the VHT Strategy. **VHTs members are primarily volunteers, though when their Quarterly Meetings take place at the HCIIIs, a token allowance has been arranged.** There are in-kind incentives such as T-shirts, Bags, Certificates, ITNs, given to VHTs depending on availability of resources. In situations where VHTs are called upon to mobilize for funded health campaigns, such as mosquito net retreatment, an additional allowance may be given. The Uganda Government (Ministry of Health) has not yet institutionalized any incentives for VHTs.

The remuneration and other incentives for other CHW cadres depend on the funder.

- **To establish the roles the various Community Health Workers have played in community health action, with concrete examples**

The attached table gives examples of some interventions as summarized by District Health Officers. However during the field visits some interventions were described by the Community members, VHTs, Community and District Leaders, Health Workers etc. As mentioned video recording has been done on the field visits.

At Budondo in Jinja District the VHTs highlighted their achievements as reduction in number of children treated at Health Units for Malaria, due to the success of the Home Based Management of Fevers (HBMF); promotion of Family Planning, promotion and improvement in sanitation, particularly increased latrine coverage and increase in boiling of drinking water in their communities.

Table 2: CASCADE OF IMPLEMENTATION OF THE VILLAGE HEALTH TEAM (VHT) STRATEGY IN DISTRICTS

No.	Activity	Type or Focus
1.	DISTRICT LEADERS SENSITISATION <i>INCLUDING DISTRICT HEALTH TEAMS, DISTRICT HEADS OF DEPARTMENTS, HSDs, AND REPS OF HEALTH NGOS</i>	LEADERS
2.	TRAINING OF DISTRICT TRAINERS <i>INCLUDING DHT MEMBERS, CDA, HSD INCHARGES, NGOs</i>	TECHNICAL STAFF
3.*	TRAINING OF SUB-COUNTY TRAINERS 3 PER SUB-COUNTY: HEALTH ASSISTANT, COMMUNITY DEVELOPMENT ASSISTANT, A CLINICAL STAFF FROM HCIII	TECHNICAL STAFF
4.*	SENSITISATION OR ORIENTATION OF ALL HEALTH WORKERS IN THE WHOLE DISTRICT	TECHNICAL STAFF
5.	SENSITISATION OF SUB-COUNTY LEADERS SUB-COUNTY COUNCILLORS, SC CHIEF, PARISH CHIEFS, SUB-COUNTY EXTENSION WORKERS, 2 LC LEADERS PER PARISH, 2 LC LEADERS PER VILLAGE	LEADERS
6.	SELECTION OF VILLAGE HEALTH TEAM (VHT) MEMBERS BY VILLAGE LEADERS WITH SUPPORT OF SC TRAINERS	LEADERS&COMMUNITY
7.	TRAINING OF VILLAGE HEALTH TEAM MEMBERS BY SUB-COUNTY TRAINERS	COMMUNITY
8.	SUPERVISION OF VILLAGE HEALTH TEAM MEMBERS BY SUB-COUNTY TRAINERS AND LOCAL LEADERS	LEADERS/ TECHNICAL STAFF
	I. EVERY FIRST AND SECOND MONTH SC TRAINERS VISIT EACH PARISH TO MEET VHTs MEMBERS, DELIVER SUPPLIES (e.g. HOMAPAK) AND RECEIVE REPORTS – promote COMMUNITY BASED HEALTH MANAGEMENT INFORMATION SYSTEMS (CBHMIS) ETC...	VHT Members, Sub-county Trainers Community Leaders
	II. EVERY THIRD MONTH ALL VHT MEMBERS TO MEET AT HCIII TO EXCHANGE EXPERIENCES WITH VARIOUS STAKEHOLDERS (COMMUNITY DIALOGUE)	VHT Members, Sub-county Trainers Community Leaders
9.	REFRESHER TRAINING OF VHT MEMBERS WITH MORE MODULES E.G. MENTAL HEALTH, IMCI, EPI, EH, ETC... CAN BE ADDED AT EACH QUARTERLY MEETING	LEADERS/ TECHNICAL STAFF/ COMMUNITIES
10.	THE ABOVE CYCLE CAN BE REPEATED WHENEVER NECESSARY	POLICY MAKERS AND FINANCIERS

* 3 and 4 may be combined to save time and to create a cohesive team in the district with a common understanding of issues.

In Kumi District, the PDC members reported that they have recorded improvement in Family Planning. For example Tubal Ligation was accessed by 24 persons in July 2007 and by 16 persons in August 2007. They have also promoted Antenatal Care, delivery in Health Units and Prevention of Mother to Child Transmission of HIV. They have also promoted HBMF and Sanitation.

In Bugondo SC, Soroti District, VHT Members have promoted HIV/AIDS Control through participating in Drama. They have also promoted HBMF, Borehole maintenance, and Sanitation.

In Atira SC, Soroti District the VHTs have particularly focused on Mental Health. They report that 160 persons have been helped to access Mental Health treatment, while many epileptic children have accessed treatment and gone back to normal schooling. Also the VHTs have sensitized HIV/AIDS patients, and 128 such patients are now openly on ART or other treatment. The VHTs are also involved in Borehole maintenance.

In Adjumani District, apart from the other interventions, the VHT members have been tracing for patients with Buruli Ulcer and they refer them to the hospital for surgery. The VHT also assist with identification and follow-up of patients with Mental Health problems. Earlier on, the Guinea Worm Scouts participated effectively in the Guinea Worm Eradication Programme.

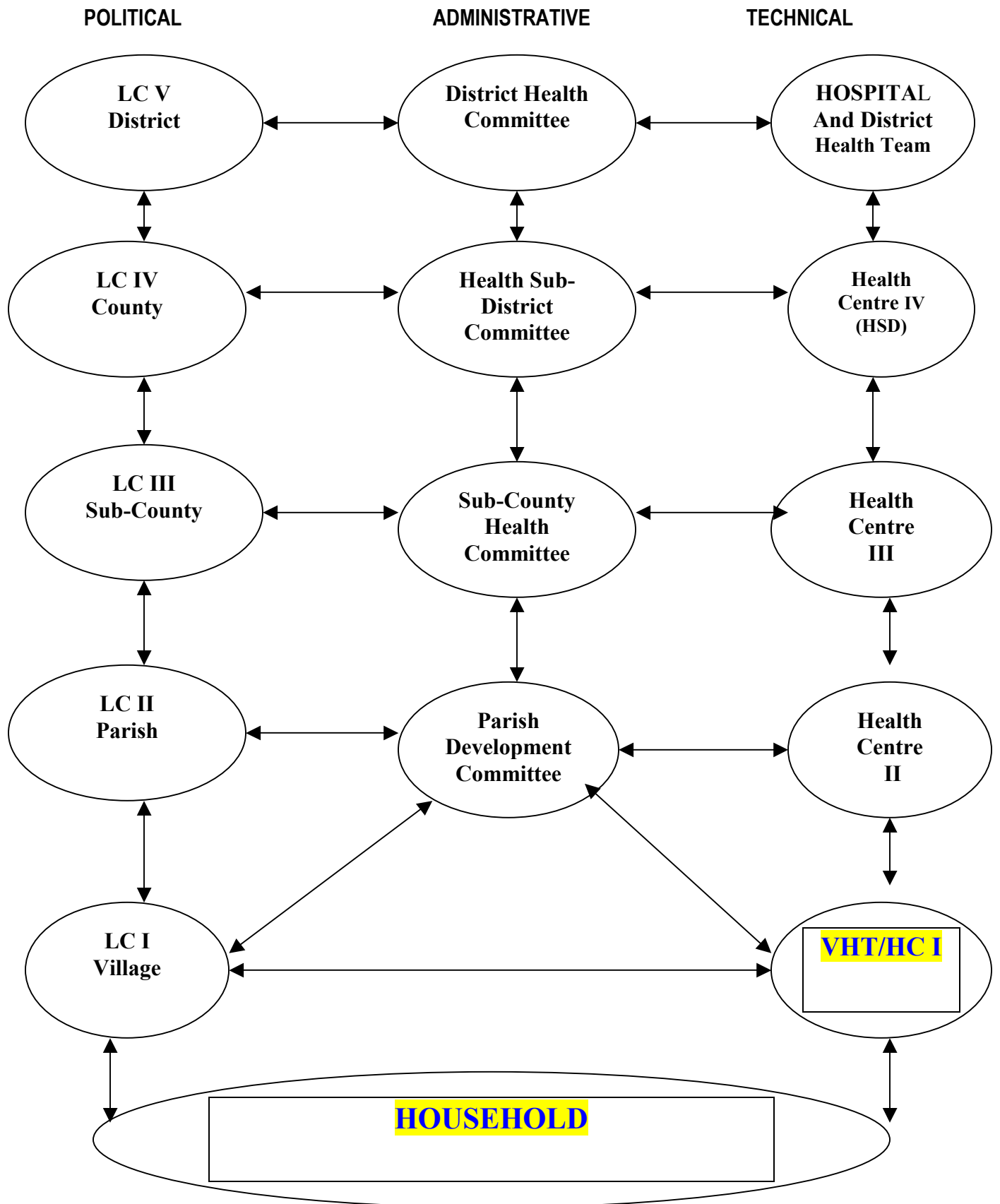
In Maruzi HSD, Apac District, apart from the common activities, the VHT mobilized communities for mass Bilharzia treatment, earlier this year (2007). They also carry out Ivermectin DOTS in Onchocerciasis prone areas. Some members of VHT have been trained as promoters of Family Planning (Condom and Pill Distribution).

The VHT members in Agwata SC, Dokolo District reported that they were mobilizing the communities for the Home Based Management of Fevers (HBMF), Immunisation, Family Planning, Sanitation, Nutrition, STD and HIV/AIDS Control, among others..

At Ovujo Health Centre III (Arua District), the health workers and the patients who had come to the Health Unit for treatment, testified that the VHTs were distributing Homapak to children at home, but referring those who did not improve. The VHTs were also reported to be promoting Family Planning. The VHTs were involved in the sensitizing of the communities during a Meningitis outbreak earlier this year, 2007 (and late last year 2006).

A pregnant woman whom we gave a lift on our way to Koboko Health Centre, eloquently told us how the VHTs in her village, Dranya, in Koboko District mobilized pregnant women for antenatal care, so that they could benefit from IPT for malaria and TT immunization against tetanus. In the Immunization clinic at Koboko Health Centre IV, a young mother, who had brought had newborn baby for immunization, also testified about the effectiveness of the VHT members in her village of Bukutu in Koboko Municipality. The Kuluba Sub-county Chief and a VHT Mobiliser for Oraba Parish in Kuluba SC, Koboko District reported that VHTs are very effective in mobilizing communities particularly for sanitation and immunization. The VHTs were reported to have played a key role in sensitizing people during the Meningitis outbreak, late 2006 and early 2007.

Figure 2: DISTRICT INSTITUTIONAL FRAMEWORK/LINKAGES OF THE VHT STRATEGY



The LCV Vice Chairperson Secretary for Health, Koboko District, Hon Beatrice Agele and the Assistant CAO, Mr Asendu Patrick, also gave the account of the benefits VHTs have brought to their District. In particular they singled out a sharp rise in latrine coverage, against a history of cholera outbreaks in the past. The District Health Officer Koboko, Dr Alfred Driwale showed us data indicating that the latrine coverage in the district had risen from about 52% two years ago, to about 85% overall by September 2007. However in Kuluba SC the latest survey (August 2007) was indicating latrine coverage of about 96%. In all villages of Koboko District, using the VHT database, it was possible to pinpoint households without latrines, so that they can specially targeted for appropriate action.

In Odravu SC, Yumbe District, apart from HBMF, the VHTs have also promoted Sanitation. The District Health Inspector reported that through the effort of VHTs, the latrine coverage in Odravu SC had risen from 52% during a cholera outbreak last September (2006) to the current 70%.

In Olio Division (low income) in Arua Municipality, the VHTs have promoted Home Based Management of Fevers, Sanitation, Epidemic Control (eg. Meningitis and Cholera), Immunisation, Antenatal Care and Family Planning. Oli Division gave us an urban perspective of poverty, overcrowding, solid waste management, but also of proximity to health services, which in real terms may be inaccessible because of lack of time or lack of money. So even in the urban setting VHTs were seen to be very relevant.

At Olago Upper Village, Nyaravur, Kuchwiny SC, Nebbi District, apart from noting what the VHTs have done, as elsewhere, we saw very good health records at community level. The VHT members keep a Village Register and make monthly returns to the DHO. (The record books and reporting forms were supplied under SHSSPP I). The LCI Vice-Chairman of Olago Upper Village, Mr Saulo Ochamgui, praised the VHT programme and the VHT members for promoting health in the village.

In Mpigi District the VHTs attached to Gombe Hospital and those in Golola Parish, in Mpenja SC had written reports about their work. We also talked to some members of the community. They all appreciated the effectiveness of the VHTs especially in Malaria Control (HBMF), Sanitation and Hygiene Promotion, Immunisation and Antenatal Care Promotion. The VHT System in Mpigi District seems to be the most elaborate on supervision, as WHO had developed the supervision mechanism fairly well before handing over the operations fully to the district.

From Gulu District we had communication from the Health Educator, Mr Lokach. He was in charge of Community Mobilisation during the Ebola Epidemic in 2000/2001.

He reports that during the Ebola epidemic communities selected volunteers, about 3 per village to assist the limited number of health workers. The Health Educator, Mr Lokach, coordinated the Community Volunteers, himself. They carried out the following tasks:

1. Raising community awareness about the disease and its control
2. Following up patients and contacts- every day for 21 days
3. Referring suspected cases to health units and reporting them to local councils (LCs) and health authorities.

The Community Volunteers were paid an allowance, by WHO, on a weekly basis.

Later on, those who had performed well were selected again by the community members to become VHT members.

So far 11 out of 15 Sub-counties in Gulu District have trained VHTs. The VHT training is 5 days. Then the VHT members are trained for a further 5 days for Home Based Care. WHO and UNICEF have supported this exercise. ICRC is also planning to assist.

In Lira District in the year 2005/2006 (July 2005 to June 2006), both the VHT Strategy and the Home Based Management of Fevers (HBMF) had been fully rolled throughout the district. From the District Health Management Information System (HMIS), for that period a total of about 210,000 cases of fever (presumed malaria) had been treated in the Government and Private Not for Profit (PNFP) health units (all ages). In the same period about 140,000 children under 5 years had been treated at home (using Homapak) by VHT members, and only 7,000 of these (5%) were referred to health units for failed treatment. In other words the HBMF within the VHT Strategy handled 40% of all cases of suspected malaria in the district, moreover for the most vulnerable group of under 5s.

In summary for places where the author and his team made physical visits there is on-the-ground testimony by District, SC and Community Leaders, Health Workers, VHT members and community members that the VHT Strategy works and is effective.

The other interventions by CHWs that have been very successful include Guinea Worm Eradication initiative, Ivermectin Distribution, TB-DOTS, of course Home Based Management of Fevers (HBMF), among others. The advantage of the Village Health Team (VHT) strategy is that it covers all types of health interventions, is rooted in record keeping and reporting, and is permanent. Even where supervision has been weak because professional health workers were unwilling to supervise without allowances, the Village Health Team (VHT) members have continued to serve in whichever limited way they could, such as mobilizing communities to utilize the health services available in their localities.

- **To establish how CHW have been supervised**

The supervision of the various CHWs depends on the originator and the funder. For Community Drug/Medicine Distributors, Ivermectin Distributors and Village Health Team (VHT) members the supervision is by Health Workers in the formal health sector.

Table 2 and Figure 2 above show both the operational linkages and the supervision mechanism for the Village Health Teams. The supervision is elaborate and involves both linking the Community Based Health Information Management System (CB-HMIS) based on data collection by VHTs to the Facility Based Health Information Management System (FB-HMIS) by HCIII based trainers/supervisors. The supervisors/trainers are expected to have monthly contacts with the VHT members every month. And every quarter all VHT members in the Sub-County are supposed to meet at the HCIII to discuss health issues they have observed in their localities with many other stakeholders in the Sub-county, including their trainers/supervisors. This quarterly meeting also serves as a point for continuing education for the VHT members, and also as a forum for “Community Dialogue” (the concept promoted by UNICEF).

- **To establish how the CHWs have been linked to the existing health system and to communities.**

Initially CHWs were originated and funded by NGOs or Government Departments for very specific activities. Their linkage to the health systems and communities depended on originator or the funder. It was possible to have a multiplicity of CHWs working on similar or different health problems in any given locality, but without any linkage to the health units or the District Health authorities. Because of the uncoordinated nature of CHWs and their funders, some districts or sub-counties could have many NGOs and many categories of CHWs, while some districts and sub-counties had none. Also because of sources of funding for NGOs, some areas of health care had many NGOs and categories of CHWs than others. The case in point is HIV/AIDS, which has had a fairly sustained window of international funding, leading to a multiplicity of HIV/AIDS related CHWs (e.g. Community Agents for Home Based Care (TASO trained), Community Condom Distributors, Community Counselling Aides (CCA), Community Health Workers for HIV/AIDS and Reproductive Health (Arua District only)). Immunisation has also had a lot of appeal with Vaccinators, Parish Mobilisers for Immunisation, as has Malaria Control with Community Medicine Distributors (CMDs) or Community Drug Distributors (CDDs) and CORPs as examples of CHWs. Reproductive Health had Community Reproductive Health Workers, Family Planning Products Distributors, Community Condom Distributors and Traditional Birth Attendants (TBAs), among others. CHWs dealing with Malaria did not have to link up with those dealing with Immunisation for example. An extreme example is where Ivermectin Distributors for Onchocerciasis Control and Ivermectin Distributors for Lymphatic Filariasis Control could be in the same locality using the same medicine, but reporting to two different Vector Control Programmes of Ministry of Health.

With the eventual acceptance of the long overdue recognition of the crucial linkage of good health to economic productivity, poverty eradication and economic development; and with the overall funding for health not improving significantly from all sources to match the fast growing Ugandan population, and realizing that community participation was sine qua non to achieving the health related PEAP Goals and the Millennium Development Goals (MDGs), the Ministry of Health eventually pronounced itself on creating a nationally applicable form of community empowerment and mobilization for health. The Village Health Team (VHT) Strategy was chosen for this important task.

In the sections above, and especially in Table 2 and Figure 2 the linkages of the Village Health Team members to the conventional Health System and the communities have been elaborated. The VHT members are CHWs who are in each village, each responsible for health promotion among 20-30 households, each keeping vital statistics and other health records, linking the communities and the community based records to the conventional health system. The VHTs are supervised by the LCI Council, the LCII Council, the Parish Chief, and the Sub-County Trainers, based at the HCIII. The VHT members are thus linked to the Health Sub-District, the District Health Office and Ministry of Health. Each quarter VHT members in a Sub-County are supposed to meet many other stakeholders in the sub-county at the quarterly meeting. This is an example of the Community Dialogue promoted by UNICEF. Most important is that the VHT community-health system linkage is institutionalized and permanent.

CONCLUSIONS

- There has been a multiplicity of CHWs in Uganda in the past. They did a good job, but because of the uncoordinated nature of their work, and because of the uncertainty of continuity due to unreliable sources of funding, most categories of CHWs withered away.
- With the advent of the National Health Policy in Uganda, its operationalisation by the Health Sector Strategic Plan I and II, with the recognition of the need for sustained community empowerment and mobilisation for health and the need for integrated health service delivery at community level, the Village Health Team Strategy was born. The VHT Strategy promises to support a permanent cadre of CHWs, the VHT Members, who will effectively and sustainably link communities to the conventional health system in Uganda.

RECOMMENDATIONS

- The VHT Strategy should replace (or incorporate) all other cadres of CHWs in Uganda.
- All stakeholders from community, to district, national and international levels need to support the VHT Strategy, and VHT members as the ideal CHWs, in recognition of the need to have a permanent and sustainable cadre of CHWs, as a means to accelerate the health sector's contribution to poverty eradication, economic development and the desired early achievement of the PEAP targets and the Millennium Development Goals (MDGs), in Uganda, and may be elsewhere in the world.

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APPENDICES

APPENDIX 1: TERMS OF REFERENCE

STUDY ON VILLAGE HEALTH TEAMS IN UGANDA

Background

The contribution of health workers at community level has been recognized for centuries as a key factor in raising the visibility of health at community and house hold level and therefore in improving the health of populations. Today, there is a renewed movement towards prioritizing integrated Primary Health Care (PHC) and the role of Community Health Workers (CHWs).

In January 2008, the Prince Mahidol Award conference will take place in Bangkok, Thailand, with the theme: "Who Delivers Primary Health Care" and there will be a special session on CHWs. The Global Health Workforce Alliance (GHWA) has been requested to conduct case studies from a number of countries: Botswana and Uganda in Africa, the Bolivarian Republic of Venezuela in South America and the Serbian province of Kosovo in Europe. Similar studies are also taking place in China and Thailand. These studies will be synthesized and presented both in Thailand and later at the first Forum of GHWA, which will take place in Kampala on 4 -7 March 2008.

Uganda was selected because it is one of the countries that has an active program of CHWs delivering a variety of PHC services including drug distribution, TB DOTS, Home Based Management of Fevers, vaccination and pregnancy monitors etc. Village Health Teams have a clearly defined place in the National Health Policy and the Health Sector Strategic Plan.

Deliverables

- A report on the typology of CHWs in Uganda and respective roles, recruitment, deployment, training, remuneration, accreditation/registration, supervision and links with the health system and communities.
- Concrete examples of the impact of the work of CHWs - for example, in disease control, vaccination coverage, controlling epidemics e.g. Ebola haemorrhagic fever, etc.

Method and Scope of Work

The consultant will undertake a literature review, link up with the work currently being undertaken by AMREF on CHWs and interview key contacts in NGOs, academia and the public and private sectors. The consultant will focus discussions with communities and CHWs themselves, political leaders, programme managers and any other stakeholders. The study will involve a cross-section of the country.

Timeline and fees

The Consultant will commence work on 20 August 2007 for a duration of no more than 6 weeks (1 October 2007). The deliverables are expected to be handed in to GHWA in electronic format (MS Word; Excel or other PC-compatible software) for a total fee of **USD 12 000** (cf. budget in annex).

Contact information

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Appendix 2: Persons Met/Contacted

Name	Title	Organisation
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Dr.Sam Zaramba	Director General of Health Services	GOU/Ministry of Health
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Ms.Lilian Luwaga	SHE/ Health Promotion and Education	GOU/Ministry of Health
Mr Cherkut Yekko	SHE/ Health Promotion and Education	GOU/Ministry of Health
Ms Rose Tiridri	SHE/ Health Promotion and Education	GOU/Ministry of Health
Ms.Marcella T.Ochwo	Consultant	AFFORD/USAID <i>Formerly Community Mobilisation Unit, WHO Country Office, Uganda</i>
Mr.Patrick Ayer	Clinical Officer i/c Akokoro HCIII	Apac District Local Government
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Mr.Richard Atepo	Assistant Health Educator Maruzi HSD	Apac District Local Government
Ms.Dorcas Okello	VHT Member, Atopi B LCI, Apac SC	Apac District
Mr.Bosco Akwanga	VHT Member, Village Inn LCI, Apac Tow Council	Apac District
Mr.Johnson Olobo	VHT Member, Teibu LCI, Akere LCII, Apac SC	Apac District

Ms. Jacinta Okori	VHT Member, Atopi Trading Centre, Apac SC	Apac District
Mr. Vincent Ocen	VHT Member, Ayera A LCI, Apac SC	Apac District
Mr. Alfred Obote	VHT Member, Akar LCI, Apac SC	Apac District
Ms. Dorothy Auma	VHT Member, Hospital & Around LCI, Apac TC	Apac District
Mr. Frederick Okai	VHT Member, Alyeciping LCI, Apac TC	Apac District
Dr. Cerino Achar	ADHO/Dokolo HSD	Dokolo District
Ms. Judith Alyek	Health Educator	Dokolo District
Ms. Santa Ejang Malinga	Nursing Officer i/c Agwata HCIII	Dokolo District
Ms Gloria Apio	Staff, Agwata HCIII	Dokolo District
Mr Charles Oguta	Staff, Agwata HCIII	Dokolo District
Ms Stella obala	Staff, Agwata HCIII	Dokolo District
Ms Santa Etang	Staff, Agwata HCIII	Dokolo District
Mr. Bernard Obace	Staff, Agwata HCIII	Dokolo District
Ms Judith Auma	VHT Member, Adwila LCI	Dokolo District
Mr. Alfred Omuni	VHT Member, Okiipukere LCI	Dokolo District
Mr. Severino Alea	VHT Member, Adwila LCI	Dokolo District
Ms Helen Acheng	VHT Member, Odeye LCI	Dokolo District
Ms Regina Okello	VHT Member, Ayito LCI	Dokolo District
Mr. Charles Adupa	VHT Member, Adedi LCI	Dokolo District
Ms Hellen Okidi	VHT Member, Agula LCI	Dokolo District
Ms Florence Okwir	VHT Member, Acilkom Agwiciri LCI	Dokolo District
Ms. Beatrice Ogwal	VHT Member, Awekipalo Agwiciri LCI	Dokolo District
Ms. Susan Ogwal	VHT Member, Agula LCI	Dokolo District
Ms. Rose Opio	VHT Member, Abongorwot LCI	Dokolo District
Ms. Margaret Ocen	VHT Member, Agula LCI	Dokolo District
Ms. Alice Candiru	Registered Midwife i/c Ovujo HCIII	Nyadri District
Nine (9) Male Community Members	Attending OPD at Ovujo HCIII	Nyadri District
Nine (9) Female Community Members	Attending OPD at Ovujo HCIII	Nyadri District
Ms. Harriet Angucia	Attending ANC at Koboko HCIV	Koboko District
Ms. Sarah Morine	Attending Immunisation Clinic, Koboko HCIV	Koboko District

Ms.Lucy Fidah	Vaccinator, Immunisation Clinic, Koboko HCIV	Koboko District
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Dr.Alfred Driwale	District Health Officer	Koboko District
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Mr.Alonga Loyama	Sub-County Chief, Kuluba SC	Koboko District
Mr Richard Chandiga	Parish Chief, Oraba & VHT Mobiliser	Koboko District
Mr Abdul Anguzu	Assistant Water Officer Koboko Town Council	Koboko District
Mr.Stephen Dramani	Health Assistant, Kuluba SC	Koboko District
Ms.Prisca Anyonga	Health Inspector & Ag District Health Educator	Yumbe District
Mr.George Madara	Health Inspector, Midigo HCIV	Yumbe District
Mr.Bakole Karala	Clinical Officed i/c Kulikulinga HCIII	Yumbe District
25 Member of Village Health Teams	VHT Members, Odravu SC	Yumbe District
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Mr.Habib Kalema	Resident Oli Division, Arua Municipality	Arua District
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Mr.Ongera Sam Ajoga	Health Inspector/VHT Focal Persn	Nebbi District
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Ms Margaret Wedunga	VHT Member, Olago Upper LCI, Olago LCII, Kuchwiny SC	Nebbi District

Mr.Lincoln I.B.Ongei	VHT Member, Olago Upper LCI, Olago LCII, Kuchwiny SC	Nebbi District
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Mr.Godfrey Kaggwa	VHT Focal	Mpigi District
Dr.Haruna Lule	Medical Superintendent Gombe Hospital	Mpigi District
Ms.Farida Nanyanzi	Health Inspector, Butambala HSD	Mpigi District
Ms. Resty Kisitu	District VHT Educator	Mpigi District
Ms Anati Semuggya	VHT Mobiliser	Mpigi District
Thirteen (13) VHT Members	VHT Members from Gombe Area, Butambala HSD	Mpigi District
Mr.Colder Kasozi	Clinical Officer i/c Mpenja HCIII	Mpigi District
Ms Sarah Wako	Enrolled Midwife Mpenja HCIII	Mpigi District
Ms Alice Nassiwa	Enrolled Midwife Mpenja HCIII	Mpigi District
Ms.Gladys Namukasa	Nursing Assistant, Mpenja HCIII	Mpigi District
Fifteen (15) VHT Members	VHT Members from Golola LCII, Mpenja SC, Gomba HSD	Mpigi District
Dr.Kitimbo	District Health Officer	Jinja District
Mr.Dennis Kirunda	Health Inspector Kira HSD	Jinja District
Mr. Balidawa Khalid and 4 other VHT Members	VHT Members Budondo SC	Jinja District
Betty Okalany and 26 other CHWs	CORPS/VHTs Kumi SC	Kumi District
Dr.Okwana N	District Health Officer	Soroti District
Mr.Amodoi	District Health Educator	Soroti District
Mr.Donath Eswilu	Deputy Chief Administrative Officer	Soroti District
Mr William Enyimu	VHT Mobiliser Bugondo HCII	Soroti District
Ms Schola Alyadi and 10 other VHT Members	Chairperson, VHT Kamodo SC	Soroti District
Mr John Opolot Okul and 5 other PHAs	PHA Kamodo SC	Soroti District
Ms Rose Akwi	Health Worker, Atiira HCIII	Soroti District
40 VHT Members	VHT Members, Atiira SC	Soroti District

190 Participants at UNACOH ASC and Dr Mathew Lukwiya Memorial Lecture 20-21, September 2007	Participants from various health and other disciplines attended from across the country and discussed the Village Health Team Strategy, Home Based Management of Fevers and other interventions by CHWs
At the Annual Health Assembly and Joint Review Mission of the Health Sector held October 22-26, 2007, participants from all districts in Uganda, officials from Ministry of Health and Development Partners from within and outside the country, discussed the role of Community Mobilisation and Empowerment for Health in health care delivery, and particularly how the rolling out of the Village Health Team Strategy could be accelerated in Uganda.	

APPENDIX 3: SOME DISTRICT RESPONSES TO COMMUNITY HEALTH WORKERS (CHW) SURVEY – UGANDA – AUGUST 2007

DISTRICT	PERSON CONTACTED	CATEGORY AND NUMBER	LOCATION/ COVERAGE	ACTIVITIES	EFFECTIVENESS	ANY OTHER COMMENTS
NORTHERN REGION- Luwaga Liliane Team Leader						
Amuru	DHO -0772930244	600 VHTs but need 1150.	They are scattered throughout the district.	Mobilizing for EPI, Distribution of drugs	Coartem distribution, Surveillance. Can be located in Alero S/C, Awero S/C and Ometu Parish	Have received support from UNICEF, WHO, ICRC, MAP International
Apac	DHE – 0772668302	4773 VHTs 40 Popular leaders	100% coverage 2 S/C of Chawente and Apac TC	Distribution of Homapak, Mobilisation for EPI and FP Distribution of Schistosomiasis drugs Sensitising the communities on common health conditions e.g. HIV/AIDs, Malaria, URTI, FP, Safe Water	Safe water, Family Planning, distribution of Malaria drugs and ITNs, Mobilising for ARV outreach centers. These best practices can be identified in Apac Town Council, Akalo S/C.	The district is currently reviewing performance of VHT and identifying the drop out rate. Results will be available next week. Received support from SSHSSP, CPAR supported retraining for HBC, UNICEF. NUMAT plans to support the district too.
Kotido	DHO – 0772381451	330- Community Medicine Distributors TBAs Guinea worm volunteers	2 or more per village and kraal	Management of fever, Lymphatic Filariasis control, Control of Trachoma	CMBs in any place can be documented for their good practices.	VHT selection initiated. TOT to be done next week

Oyam	DHO – 0772565645	897 villages each had 4 trained VHTs (Total 3212)	8/8 S/C covered	Distribution of drugs e.g. Homapak, Coatem, Mobilising mothers for FP, ANC. Mobilising for HIV/AIDS testing and counseling	Best examples can be found in Aber S/C and Minakulu S/C Ngai SC	TBAs seem to be de-campaigning deliveries in health facilities. Support received from CPAR, CESVIL, CCF
Pader	DHE - 0772572254	2400- VHT.	17 S/C out of 19 S/C	Health Education, Malaria Drug distribution, FP commodities distribution	Very good but motivation is still a problem. Examples can be located in Lira Paluo S/C, Patong S/C, Atanga S/C	Supported by WHO, AMREF, MED CARE, INTERNATIONAL MEDICAL CORPS. Now lobbying UNICEF for more support
Amolatar	DHO – 0772614354	980 – VHT by SSHSSP Support, 140 VHT by UNICEF support	The VHTs are distributed in all 346 villages and 5 S/Cs	Treatment of Malaria, Distribution of nets, TB drug distribution.	Best examples can be located in Muntu S/C where malaria treatment is done within 24 hours.	Some of the VHTs are multi trained and some are only trained in Malaria. The plan is to have them all oriented on new upcoming programs/initiatives periodically.
Gulu	Okot DHE/Ag DHO – 0772518727	575 VHTs (325 operational, 200 trained but not yet operational-no kits) 30 trained by ICRC but not yet operational	11/15 S/C covered. Municipality not yet covered completely.	Mobilisation Distribution of Home based Care Kit (Coatem, Panadol, GV paint)	Best practices on referral, treatment and creating good rapport with health workers can be found in Koro S/C Ongaaco S/C, Bunga Kira S/C	TBAs and other community health workers have been integrated into the VHT structure. VHT has been fully embraced by the implementing partners at the

						community level.
Lira	DHE - 0772590907	4,000 VHTs	19/19 S/Cs have been covered but VHT training in the Eastern S/Cs of Oluker and Moruto was affected by Insurgency	Treat fever in 24 hours Mobilization for EPI, ANC, Sanitation. Health Education. Surveillance, ITN distribution	Best examples are in Amach S/C	CORPs trained by UNICEF have been incorporated into the VHT. WHO assisted retraining of VHTs in 3 S/Cs of Apala, Aloji and Abako. S/Cs are so large that the number of VHT recommended is too small. The district wishes to train more VHTs.
Dokolo	DHO -0752497016	1320 VHTs	100 percent coverage in all the 5 S/Cs, 355 villages. DHO to communicate the details per S/C later.	Distribution of Homapak, Health Education, Mobilization for community health programs e.g. EPI	Home based management of fever. Monthly reporting. Community Mobilization and health education. They can be sampled from any village.	Motivation has been a problem. The DHO has solicited for some supplies from MOH like registers for the VHTs.
WEST NILE REGION						
Yumbe	Grace Drabu DHV	1741 VHT trained with SHSSPP and UNICEF support 60 Community Condom Distributors 72 TBAs	All 8/8 SCs covered In 4 SCs only In all 8/8 SCs	All areas of UNMHCP, especially HBMF, Community Mobilisation Mainly Reproductive Health Mainly deliveries	Odravu SC good example of effectiveness, esp. HBMF and regular reporting	VHT in Yumbe District implementation won 1 st Prize of <u>I@Mak</u> competition in 2005

Moyo	Dr Opigo Deputy DHO	1300 VHT trained with SHSSPP support Ivermectin Distributors	In all 8/8 SCs Not sure of number but in all 8/8SCs	All areas of UNMHCP, especially HBMF, Community Mobilisation Ivermectin distribution	Effective especially for HBMF and for health campaigns They are effective	Problem of funding supervision and motivating VHTs They are parallel to VHTs
Koboko	Dr Alfred Driwale DHO	930 VHTs trained with SHSSPP support	In all 5/5 SCs and all villages	All areas of UNMHCP especially HBMF, ITN Distribution, EPI, Sanitation (Cholera control) and Community Mobilisation	Effective especially in Sanitation (raising latrine coverage from about 58% to 82% in 2 yrs in Lobule SC) Examples Lobule and Kuruba SCs	District has 51 HWs vs 930 VHTs All other CHWs were absorbed into VHT
Adjumani	Dr Rabin Drabe DHO	1,232 VHTs trained with support of SHSSPP 142 Village Helpers for Mental Health	In all 6/6 SCs In all 6/6SCs	All areas of UNMHCP Mental Health	Effective especially in Pekele and Dziapi SCs, on EPI, HBMF, Sanitation and tracing/ referring Buruli Ulcer patients for surgery MH especially effective in Dziapi SC	Guinea worm scouts were in all 6 SCs, but have been absorbed into VHT
Arua	Mr Ronald Ochatre DHE	6168 VHT in old Arua District with SHSSPP support Community Reproductive Health Workers under	All 18/18SCs and all villages In Vurra SC of Vurra HSD through Kuluva	All areas of UNMHCP Reproductive Health	Effective especially in HBMF, Sanitation (especially Arua Municipality) and general community mobilization for health Programme started recently	Some stakeholders still push for separate groups of CHWs despite VHTs in all villages

		Uganda Protestant Medical Bureau Family Planning Association of Uganda started a programme on male involvement in RH 40CHW for HIV/AIDS and RH advocacy	Hospital In Manibe and Pajulu SCs of Ayivu HSD 20 Oli Division of Arua Municipality and 20 Oluko SC of Ayivu HSD	Male involvement in RH HIV/AIDS and RH	Effectiveness not yet assessed No results yet	
Nebbi	Dr Jakor Oryema DHO	11,388 VHTs trained with support of SHSSPP Ivermectin Distributors	All 19/19 SCs and all villages covered Many absorbed into VHTs	All areas of UNMHCP Onchocerciasis affected Okoro HSD	Effective mainly in HBMF, Sanitation, especially in Erusi, Panyimur and Wadalai, Kuchwiny and Nyaravur SCs Effective	A number of VHTs have dropped out due to little motivation and limited supervision
CENTRAL REGION						
Nakaseke	Mr Patrick Kizito HMIS Focal Person	VHT and other CHW groups Numbers not known	?	Various elements of UNMHCP through HomeVisiting, Health Education, Record Keeping, Distribution of medicines, etc...	? Supervision by Health Assistants in specific geographical areas	
Luwero	Sister Ruth Acham DHV	1000 VHT trained with support of Plan International	?	Various elements of UNMHCP	? Supervision by Health Assistants in specific geographical areas	

		? Growth Monitors				
Masaka	DHO	2600 Community Medicine Distributors (CMD) VHT scattered around the district (but few) Condom Distributors (mainly NGO)	In all 23SCs 2 per Village In various locations In various locations	HBMF All elements of UNMHCP HIV/AIDS Control	Supervision by nearest HC staff Supervision by nearest HC staff Supervision by NGOs training them	No resources available yet to complete training of VHTs
Mukono	DHE	210 VHT trained 2200 CMD Family Planning products distributors	In 2/28 SCs In all 28/28 SCs Trained by AMREF, location and numbers not clearly known	All elements of UNMHCP HBMF RH esp FP	Mainly HBMF Mainly HBMF Effectiveness not known	Drop-out high (50%)
Mpigi	Mr Kaggwa VHT Focal Person	3000+ VHT trained	In all 16/16 SCs	All elements of UNMHCP	<ul style="list-style-type: none"> - Community mobilization for health programmes - Community health data collection 	All other CHW groups absorbed into VHT. There is a video documentary on VHT activities in the district
WESTERN REGION						
Kibaale	DHO	1880 Community Medicine Distributors 160 Vaccinators 80 Community Counselling Aides (CCA)	2 per village in all 16/16 SCs 2 per Parish In some Parishes	HBMF EPI HIV/AIDS control	Homapak distribution Immunisation Counselling	

		CB-DOTS TBAs and other CHWs	Number unknown Numbers uncertain	TB Control RH and others	DOTS ANC and deliveries plus other activities	
Mbarara	Dr Amooti Kaguna DHO	About 1500 CMD No other standard CHWs	2 per village in all 17/17 Scs	HBMF but assist with other health campaigns	Effective for HBMF and Immunisation	
Kanungu	Dr Stephen Sebudde	800+ TBAs CDDs or CMDs VHT Others include Community Reproductive Health Workers (2SCs), Ivermectin Distributors (1 per village, only in 4SCs), Growth Promoters (4 Parishes only in 2 SCs)	In all 11/11 SCs 2 per village in all 11/11 SCs Only in 4 parishes in 2/11 SCs Limited geographical and service areas	RH and other health programmes HBMF In Ruyeyo and Kayonza SCs only for all health programmes In various limited locations	They report to HCs and are effective They report to nearest HCs They report to their various trainers or NGOs	
Rukungiri	Dr.Z.Karyabakabo DHO	VHT in 1 SC only (Nyakagyeme SC)	In 1/11SC	Mainly involved in community	Effectiveness limited due to limited numbers and	VHTs have minimal supervision

		CDD (CMD) Community Reproductive Health Workers TASO has some Community Agents for Home Based Care (ART etc..)	2 per village in all 11/11 SCs Trained by CARE in 7/11 SCs (2 per Parish) Number not known	mobilisation HBMF RH HIV/AIDS	geographical coverage CDDs are effective Not sure about effectiveness Not sure about effectiveness	About 80% of trained CDDs still active
Ntungamo	Dr William Kalikwisya DHO	No VHTs Community Drug Distributors (CDD) TBAs Parish Mobilisers for Immunisation	2 per village in all 15 SCs 300+ trained and many others not trained 2 per Parish	HBMF RH EPI	Effective	
Ibanda	Dr Bamwine Julius DHO	No VHTs Community Drug Distributors (CDD)	2 per village in all 8 SCs	HBMF		
Kisoro	Dr Assay Ndizihiwe DHO	Selected 1602 VHT members, but 801 trained as Community Drug Distributors (CDD)	All 14 SCs	HBMF	Effective as CDD	

		Some Ivermectin Distributors and a few other CHW cadres	Various	Onchocerciasis control and others	Effectiveness not assessed	
Kabale	Mr Arsen Nzabakurikiza DHE	VHT selected in all villages but trained only in 1/20 SCs, But CDDs part of VHT 2 per village throughout the district. Also 140 Condom Distributors, Parish Mobilisers for Immunisation (2 per Parish) belong to VHT. There are also TBAs and Community Reproductive Health Workers (trained by CARE)	VHT 1/20SCs CDDs 20/20SCs	All elements of UNMHCP HBMF	Mobilising for Child Days and other health campaigns Effective HBMF	
Bushenyi	Dr Ben Twesigire DHO	No VHTs but 2 CDDs per Village A few Ivermectin Distributors in 3 SCs only	CDDs in 29/29 SCs In 3/29SCs	HBMF Onchocerciasis Control	Effective for HBMF	
Kyenjojo	Dr Julius Balinda DHO	Less than 200 VHTs trained in only 1/14 SC CDD 2 per village in all 14/14SCs Ivermectin Distributors in	In 1/14SCs In all 14/14 SCs In 4/14SCs in Mwenge North HSD	All areas of UNMHCP HBMF Oncho. control	Not yet fully effective Reported to be effective Effectiveness not assessed Effectiveness not assessed	

		4/14SCs TBAs all over the district (trained 6 years ago)	In all 14/14 SCs	RH		
Kabarole	Dr Joa Okech Ojony DHO	VHTs trained in 6/16 SCs CDDs in all 16/16 SCs Condom Distributors in 8/16 SCs Ivermectin Distributors in 2/16 SCs	6/16 SCs 16/16 SCs 8/16 SCs 2/16SCs	All areas of UNMHCP HBMF RH Oncho..control	VHTs effective where they exist Very effective - -	UNICEF has been requested to scale up VHTs Training to all 16 SCs in support of Child Survival and Maternal Health
EASTERN REGION						
Kumi	Dr Ochom DHO	No VHTs 816 CDDs 140 Trained TBAs Parish Mobilisers and CORPs	2 per village in all SCs Across the district At Parish level	HBMF Birth Attendance Mobilising for health		
Busia	Dr Oundo G.B. DHO	CDDs (1000+) TBAs (1000+) PDCs (1000+) Condom Distributors (58)	2 per village 2 per village In 4/10 SCs 1 per parish in all 10/10 SCs	HBMF RH Various RH/HIV/AIDS	Homapak distribution Birth Attendance EPI, Birth/Death registration, Distribution of ITNs, etc.... Distribution of condoms	Lack of motivation Had helped to reduce bilharziasis

Bukwo	Dr Engwau Ag. DHOs	VHTs (500+) Also 324 CDDs, 486 Parish Mobilisers, 486 Parish Development Committees members and 50 CORPs	VHTs in all villages training supported by SHSSPP Other CHWs at Parish level	VHT covers all health related matters CCDs for HBMF Other CHWs deployed as trained	Community mobilization for health HBMF Other health mobilisation	There is need to motivate CHWs
Kapchorwa	Dr Boyo M DHO	VHTs (2000+) Also 786 CDDs, 1179 Parish Mobilisers, 1179 Parish Development Committees members and 80 CORPs	VHTs in all villages training supported by SHSSPP Other CHWs at Parish level	VHT covers all health related matters CCDs for HBMF Other CHWs deployed as trained	Community mobilization for health HBMF Other health mobilisation	No motivation for CHWs