MINISTRY OF HEALTH

NATIONAL VILLAGE HEALTH TEAMS (VHT) ASSESSMENT IN UGANDA

Submitted to

Ministry of Health

MARCH 2015

Abbreviations and Acronyms

ADB	African Development Bank
ACTs	Artemisinin Combined Therapy
AVSI	Association of Volunteers in International Service
AMREF	African Medical Research Foundation
ASARECA	Association for Strengthening Agricultural Research in Eastern and Central Africa
AIDS	Acquired Immune Deficiency syndrome
CAAIP	Agricultural Infrastructure Improvement Programme
CAO	Chief Administrative Officer
CDO	Community Development Officer
CHW	Community Health Worker
CIAT	International Centre for Tropical Agriculture
DG	Director General
DHO	District Health Officer
DHT	District Health Team
GISO	Gombolola Internal Security Officer
FAWEU	Forum for African Women Educationalists Uganda
FGD	Focus Group Discussion
HC	Health Centre
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
HSSIP	Health Sector Strategic Investment Plan
IDC	Ideal Development Consults Ltd
IDI	Infectious Disease Institute
IEC	Information Education Communication
IPs	Implementing Partners
KII	Key Informant Interviews
LC	Local Council
MDG	Millennium Development Goal
MoH	Ministry of Health
MUAC	Mid Arm Circumference
mTrac	Mobile Tracking
NAADS	National Agricultural Advisory services
NCDs	Non Communicable Diseases
NGO	Non-Governmental Organization

NTDs	Neglected Tropical Diseases
ORS	Oral Rehydration Solution
PIU	Pathfinder International Uganda
RUFORUM	Regional Universities Forum
RDC	Resident District Commissioner
RDT	Rapid Diagnostic Tests
SACCO	Savings and Credit Cooperative Organization
SPSS	Statistical Package for Social Scientists
SPRING	Strengthening Partnerships, Results and Innovations in Nutrition Globally
SHSSPP	Support to Health Strategic Sector Plan Project
STAR EC	Strengthening TB and HIV & AIDS Responses in East-Central Uganda
TBA	Traditional Birth Attendants
TB	Tuberculosis
TEREWODE	Association for the Rehabilitation and Re-Orientation of Women for Development
TORs	Terms of Reference
ToT	Training of Trainers
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VHTs	Village Health Teams
WHO	World Health Organization

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Foreword

Uganda's health indicators on maternal mortality, child mortality and morbidity remain high despite continued investment in maternal, neonatal and child health. According to the HSSIP (Health Sector Strategic Investment Plan) 2000/01 – 2005/06, the key challenge to the health care system was to extend basic health care services to the entire population especially in rural areas where access to health care is limited. It is in this regard that HSSP I recommended establishment of VHTs and HSSP II and HSSP III called for roll out and consolidation of the VHT strategy respectively.

The Ministry of Health established Village Health Teams (VHTs) in 2001 as a means to close the gap in delivery of health services to the households. Strategy and implementation guidelines were developed and distributed to the development partners and the districts to utilize in establishing, training and motivating the VHTs to undertake their activities.

A number of districts and partners have established and trained VHTs in their operational areas with and without guidance of MOH. In some instances, partners have taken up VHTs, provided training on their programmatic areas without the basic/core training required of VHTs using the MOH VHT training manual. This therefore leaves a gap in operational means of VHTs.

The Ugandan MOH, with partners, commissioned a VHT assessment to establish and ascertain the number, coverage and functionality of VHTs in the country to be able to come up with an improvement framework.

I am confident that this document will provide guidance to stakeholders to improve the VHT strategy in Uganda.

Dr Ruth Aceng
Director General, Ministry of Health.

Acknowledgement
The Ministry of Health would like to acknowledge the efforts of a number of organizations and individuals who contributed immensely to the success of the assessment. Financial assistance was provided by the United Nations Population Fund (UNFPA) and the GAVI HSS (Health Sector Support). The United Nations Children's Fund (UNICEF) and World Health Organization (WHO) provided technical support into the assessment. Pathfinder International Uganda coordinated the process of carrying out the entire assessment. We are grateful to all the implementing partners who have supported the VHT programme and who contributed to the success of the assessment.

We are grateful to Ideal Development Consults Ltd for ably carrying out the assessment particularly; Prof. Christopher Orach, Mr. Julius Twinamasiko, Dr. Frank Kaharuza, Dr. Stella Neema, Mr. Richard Opio and Ms. Alice Ladur.

We are grateful for the efforts of officials at local government level who supported the assessment by providing the necessary data. We highly appreciate all the hard work of field staff and, most importantly, the contributions of survey respondents whose participation was critical to the successful completion of this assessment.

The Ministry of Health would like to particularly thank the following task force for participating in the difference stages of the assessment including reviewing the report.

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Map of Uganda

Source: Uganda Bureau of Statistics, 2014

Executive Summary

Background

Uganda adopted the Village Health Teams (VHTs) strategy in 2001 as a bridge in health service delivery between community and health facilities. This assessment sought to establish the VHT programme functionality in Uganda.

The overall ojective of the assessment was to establish the national status and functionality of VHTs in Uganda in order to improve the planning and delivery of health services to households and communities. The specific objectives of the assessment were: 1) To establish the number and socio demographic profiles of the VHTs in Uganda; 2) To establish the training that was provided to the VHTs (VHT training, duration of the training, the content, methods and materials used for the training); 3) To establish the partners working with VHTs and the activities VHTs are currently implementing; 4) To review the extent to which the VHT implementation guidelines are being implemented by the MOH and the districts and partners; 5) To identify approaches for VHT motivation mechanisms and arrangements and lastly, 6) To assess the functionality of VHTs in Uganda.

Methods

The assessment employed a cross-sectional study design using qualitative and quantitative techniques of data collection. The assessment was conducted in all 112 districts in Uganda from November 2014 to January 2015. Individual interviews were conducted with a total of 2,610 VHT members, 224 health workers and 112 VHT focal persons. Key informant interviews (KIIs) were conducted with 112 district partners and 200 district leaders including Resident District Commissioners, Local Council V Chairpersons and Chief Administrative Officers. Additionally, key informant interviews were conducted with seven Ministry of Health officials and 13 national partners. Focus group discussions were conducted with 112 District Health Team (DHTs) and 30 community groups.

Results

Objective 1: To establish the number and socio demographic profiles of the VHT in Uganda**:** Overall, we found a total of 179,175 VHT members in the country. Thirty percent of these do not have basic training. More than half (52%) of the VHTs had a minimum of ‘O’ Level qualification. The highest level of education attained by some VHTs (0.4%) is University. Slightly more than 1% (1.3 %) of the VHTs interviewed had no formal education, of which 82% are VHTs in Karamoja region.

Objective 2: To establish the training provided to VHTs: We found that the majority (84%) of the 112 districts had VHT trainers. Almost half (47%) of the districts had training of trainers (TOTs) in the last 4 years. TOTs were largely conducted by the Ministry of Health. Fifty percent of the districts have more than 75% active Trainers. Most VHTs (91.1%) have had initial training. Overall, more than half of the VHTs were trained for 5-7 days. This duration is too short compared to the content of VHT Training manual and the ever increasing roles of VHTs. The main contents of the basic trainings were disease prevention, health education, community mapping, community registers, home visits, community mobilization and referrals. The initial trainings were conducted based on MoH guidelines. On average, VHTs had generally received 6 refresher trainings after the basic training. The refresher trainings were varied in content, duration and methodology.

Objective 3: To establish the partners working with VHTs and the activities VHTs are currently implementing**:** The roles VHTs play include mobilization of communities to access health interventions such as immunization, mosquito nets distribution, fistula services, HIV/AIDS counselling and testing services. VHTs conduct community sensitizations on disease prevention such as hygiene and sanitation practices e.g. hand washing, construction of pit latrines and drinking boiled water, importance of uptake of health services e.g. HIV testing, antenatal care and family planning. They were also actively involved in treatment of common ailments such as malaria, diarrhea and promotion of health services including immunization activities, identifying patients suffering from neglected tropical diseases (NTDs) in their communities. VHTs were also involved in distributing contraceptives such as condoms. They were also instrumental in the distribution of drugs mainly deworming tablets and anti-malaria in the communities to population groups such as children under five.

Partners

The study established that several implementing partners (IPs) (109) are working with districts to support VHT activities. These include the UN agencies UNFPA, WHO, UNICEF and UNDP, implementing partners including Pathfinder International, World Vision, Malaria Consortium, PACE, AMREF, Baylor Uganda and several CBOs. These IPs provided financial, technical and logistical supports to the VHT programme. The partners were using the MoH VHT guidelines in the implementation of VHT activities.

Although there are many partners supporting VHT implementation in the districts, they are not equitably distributed in geographical distribution and their activities as shown in the concentration of partners in some districts and not in the others. Even in districts, partner activities are concentrated in some sub-counties and not in others.

Objective 4: To review the extent to which the VHT implementation guidelines are being implemented by the MOH, districts and partners: Overall, there was adherence to the MoH guideline for VHT recruitment and selection in most districts. Supervision of VHT activities varied across the districts. What was however common was the involvement of the IPs, DHTs and the district leaders in supervising VHT activities either directly or indirectly. The assessment did not validate the extent of this supervision since no supervision reports were found.

A general hierarchical VHT reporting from the village through the parish (health centre), sub-county to the district level exists as evident in some districts. In a few districts such as Otuke, Sheema and Buhweju, there was practically no reporting due to the absence of a reporting format/tool and lack of training. It was also found that there is non-uniformity in reporting tools amongst IPs.

Objective 5: To identify approaches for VHT motivation: Monetary and non-monetary forms of VHT motivation were mentioned. Financial motivation included lunch and transport allowances, activity and monthly allowances. Non-monetary forms of motivation included verbal recognition and appreciation on media and on public occasions. Capacity building in the forms of educational short courses, trainings and mentorship were cited as ways of motivating VHTs. Provision of tools and supplies such as uniforms, bags, gum boots, umbrellas, identity cards, bicycles, among others and provision of special rewards for VHT were also mentioned.

These forms of motivation were found to be non-uniform and irregular amongst IPs. This resulted into demotivation among some VHTs. Monetary motivation was largely provided by IPs. As a result, VHTs efforts are concentrated more on IPs programmes compared to Government programmes. This in effect lessened government ownership of the VHT programme.

Objective 6: To assess the functionality of VHTs in Uganda: In terms of governance, the assessment found that there is a coordination office at the national level for the VHT programme. However, this office is incapacitated by lack of staff, logistics and inadequate and/or inaccessibly funding for VHT implementation, coordination, monitoring and supervision of the entire programme. This is reflected in the ever reducing funds that come from government since the inception of the programme.

At the district level, functionality of the VHT programme is weak due to lack of funding to the programme both from the center and the districts. Districts do not have databases for the VHTs and lack evidence of monitoring, supervision and coordination of the VHT programme. The districts reported that VHTs are being supervised by in-charges of health centers, Health Inspectors, Assistants and Educators. However, these workers were found to lack facilitation in

terms of transport and some of them were neither oriented to the VHT strategy nor formally mandated to monitor and supervise VHT activities.

At community level, the programme was appreciated in the rural communities while urban communities did not know or knew little about the programme. This calls for more sensitization of the urban communities on the roles of VHTs.

At individual VHT level, although most of the VHTs reported having been supervised, there was no evidence of supervision in form of reports at the nearest health facility or district. The VHTs reported multiple reporting requirements from partners which is a burden to VHTs especially those with low or no education.

Conclusion

The assessment has shown that the VHT strategy has been implemented to varying levels across the districts. Funding of the programme by government has been gradually reducing since its inception, leaving the IPs to fund most of the activities. Districts have different levels of capacity to coordinate, train and supervise VHT activities but have been hampered by lack of funds. Coordination and support supervision to partners and districts by the MoH have not been conducted as desired due to funding constraints.

Recommendations

1. There is need to review the whole strategy of VHT including selection, training, contents, redefinition of roles and responsibilities of VHTs, and coordination structure at the national and district level.

2. Government should have a clear commitment to adequately finance and institutionalized the VHT strategy and ensure regular payments of VHTs for sustainability of the programme.

3. A strong VHT coordination structure as well as clear monitoring and supervision mechanisms should be established at all levels of government.

4. The Ministry of Health should establish an accurate data base for VHTs at the national level to aid monitoring and supervision of the programme. Each district should also be helped to create district specific VHT data base.

5. Ministry of Health should streamline training and refresher courses for VHTs to ensure quality, equity in capacity building for all VHTs and control over VHT activities.

6. Lastly, government and all relevant stakeholders should avail conducive working environment for VHTs. This should include efforts to improve working relationships between VHTs and health workers and supporting economic development opportunities for VHTs.

Women Focus Gropu Discussion in Masaka district, 2-12-2014

Mixed Focus Group Discussion in Sembabule district, 11-12-2014

1.0 Introduction

1.1 Definition of Village Health Teams and Functions

According to the **VHT Strategy and Operational Guidelines** , the Village Health Team is a non-statutory community (village) structure selected by the people themselves to manage all matters related to health and cross-cutting issues. The Village Health Teams are chosen by their own communities to promote health and wellbeing of all village health members (MoH, 2009).

The basic functions of VHTs articulated in the **VHT Strategy and Operational Guidelines** include community information management, health promotion and education, mobilization of communities for utilization of health services and health action, simple community case management and follow up of major killer diseases (malaria, diarrhoea, pneumonia and emergencies, care of new-born and distribution of health commodities (MoH, 2009).

1.2 The History of Community Health Worker Programmes Around the World

The concept of using community members to render certain basic health services to the communities from which they come has been in existence for at least 50 years. The Chinese barefoot doctor programme is the best known of the early programmes, although Thailand, for example, has also made use of village health volunteers and communicators since the early 1950s (Kauffman & Myers, 1997; Sringernyuang, Hongvivatana & Pradabmuk, 1995).

The barefoot doctors were health auxiliaries who began to emerge from the mid-1950s and became a nationwide programme from the mid-1960s, ensuring basic health care at the brigade (production unit) level (Zhu et al., 1989; see also Hsiao, 1984; Sidel, 1972; Shi, 1993). Partly in response to the successes of this movement and partly in response to the inability of conventional allopathic health services to deliver basic health care, a number of countries subsequently began to experiment with the village health worker concept (Sanders, 1985).

The early literature emphasizes the role of the village health workers (VHWs), which was the term most commonly used at the time, as not only (and possibly not even primarily) a health care provider, but also as an advocate for the community and an agent of social change, functioning as a community mouthpiece to fight against inequities and advocate community rights and needs to government structures: in David Werner's famous words, the health worker as "liberator" rather than "lackey" (Werner, 1981). This view is reflected in the Alma Ata Declaration, which identified Community Health Workers (CHWs) as one of the cornerstones of comprehensive primary health care.

Examples of VHW initiatives in Africa driven by this rationale include Tanzania's and Zimbabwe's VHW programmes in their early phase. Both were set in the political context of wholesale systemic transformation (decolonization and the Ujamaa movement in Tanzania, and the liberation struggle in Zimbabwe), and both focused on self-reliance, rural development and the eradication of poverty and societal inequities.

The economic recession of the 1980s, which seriously jeopardized particularly the economies of developing countries, and brought shifts in the policy environment as the focus on liberation, decolonization, democratization, self-reliance and the "basic needs" approach to development was replaced by World Bank-driven policies of structural adjustment and its successors. CHW programmes were the first to fall victim to new economic stringencies and most large-scale, national programmes collapsed (although numerous nongovernmental organizations (NGOs) and faith-based organizations (FBOs) continued to invest in mostly small, community-based health care). The collapse was further facilitated by the fact that many large-scale programmes had suffered from a number of conceptual and implementation problems such as "unrealistic expectations, poor initial planning, problems of sustainability, and the difficulties of maintaining quality" (Gilson et al., 1989).

While many policy-makers turned their attention away from CHWs altogether, others, wanting to rescue the concept and practice, suggested subtle shifts, as the following quote from a WHO publication on CHWs illustrates:

> *CHW programs have a role to play that can be fulfilled neither by formal health services nor by communities alone. Ideally, the CHW combines service functions and developmental/promotional functions that are, also ideally, not just in the field of health….Perhaps the most important developmental or promotional role of the CHW is to act as a bridge between the community and the formal health services in all aspects of health development….the bridging activities of CHWs may provide opportunities to increase both the effectiveness of curative and preventive services and, perhaps more importantly, community management and ownership of health-related programs… CHWs may be the only feasible and acceptable link between the health sector and the community that can be developed to meet the goal of improved health in the near term (Kahssay, Taylor & Berman, 1998).*

Although this concept of CHWs continues to focus on their role in community development and bridging the gap between communities and formal health services, their role as advocates for social change has been replaced by a predominantly technical and community management function. Over the years, and within the prevailing political climate, this pragmatic approach to CHWs has gained currency, and undoubtedly today constitutes the dominant approach,

although the fundamental tension between their roles as extension worker and change agent remains.

1.3 Evolution of VHTs in Uganda

In 200I, the Uganda Health Sector Strategic Plan 1 recommended the establishment of Village Health Teams (VHTs) to bridge the gap and improve equity in access to health services. The VHTs were charged with the responsibility to empower communities to take control of their own health and wellbeing and to participate actively in the management of the local health services (NHP, 1999). The decision to establish VHTs was in line with the Alma Ata (1978) and the Ouagadougou (2008) Declarations on Primary Health Care.

The roll out of the VHT strategy during 2001 - 2010 faced many challenges including ownership, sustainability, governance, motivation, selection and training which were flawed in many ways. In addition, the VHT strategy relied heavily on the concept of volunteerism.

1.4 VHT Roles and Services Globally

The participation of community health workers (CHWs) in the provision of primary health care has been experienced all over the world for several decades. There is evidence showing that VHTs can add significantly to the efforts of improving the health of the population, particularly in those settings with the highest shortage of motivated and capable health professionals[1].

The review of CHWs across the globe provide a diverse picture of the current outreach services of health care workers. The review indicates that a wide range of services are offered by the CHWs to the community, ranging from provision of safe delivery, counseling on breastfeeding, management of uncomplicated childhood illnesses, from preventive health education on malaria, TB, HIV/AIDs, STDs and NCDs to their treatment and rehabilitation of people suffering from common mental health problems. The services offered by CHWs have helped in the decline of maternal and child mortality rates and have also assisted in decreasing the burden and costs of TB and malaria. However, the coverage by such programs and the overall progress towards achieving the MDG targets is very slow (WHO, Report Global Health Workforce Alliance Year).

Given the broad role that many CHWs play in primary care, a program must assure that a core set of skills and information related to MDGs be provided to most CHWs. Therefore, the curriculum should incorporate scientific knowledge about preventive and basic medical care, yet relate these ideas to local issues and cultural traditions. They should be trained, as required, on the promotive, preventive, curative and rehabilitative aspects of care related to maternal,

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[1] WHO, Global Health Workforce Alliance: Global experience of community health workers for delivery of health related millennium development goals: A systematic review; country case study and recommendations for integration into national health systems.

newborn and child health, malaria, tuberculosis, HIV/AIDs as well as other communicable and non-communicable diseases. Other training content and training duration may be added pertinent to the specific intervention that the CHW is expected to work on.

The CHW/VHT programs should be coherently inserted in the wider health system, and CHWs should be explicitly included within the human resources for health (HRH) strategic planning at country and local level.

While CHWs may not replace the need for sophisticated and quality health care delivery through highly skilled health care workers, they could play an important role in increasing access to health care and services, and in turn, improved health outcomes, as an effective link between the community and the formal health system, and as a critical component in the efforts for a wider approach that takes into account social and environmental determinants of health.

Successful examples are evident by the efforts of the Bangladesh Rural Advancement Committee (BRAC), Bangladesh for setting up a CHW program based on cumulative experience and learning[2] Brazil is another example where CHWs provide coverage to over 80 million people[3,4] Ethiopia is currently training about 30,000 workers with emphasis on maternal and child health, HIV and malaria.

Similar programs are also being considered in other developing countries like India, Ghana and South Africa. In Pakistan, a huge public sector program for training and deploying Lady Health Workers (LHWs) has been in place since 1994 and has been expanded to cover over 70% of the rural population with a work force exceeding 90,000[5].

1.5 Selection of VHTs

The CHW programs should regulate a clear selection and deployment procedure. Ideally engage community in planning, selecting, implementing, and monitoring) that reassures appointing those who certify the course completion and pass the writing or verbal exam at the end of training. Government should take responsibility in making a transparent system for selection and deployment and further quality assurance of the regulated set system. On scaling up a

[2] Macharia CW, Kogi-Makau W, Muroki NM. Dietary intake, feeding and care practices of children in Kathonzweni division, Makueni district, Kenya East African Medical Journal 2004;81(8):402- 407.
[3] Freedman LP, Waldman R, De Pinho H, Chowdhury M, Rosenfield A. Who's got the power?: Transforming health systems for women and children: Earthscan/James & James; 2005
[4] WHO, UNICEF, UNFPA, World Bank. Maternal Mortality in 2005 WHO, UNICEF, UNFPA, World Bank; 2006
[5] Campbell OM, Graham WJ. Lancet Maternal Survival Series Steering Group. Strategies for reducing maternal mortality: getting on with what works. Lancet. 2006;368:1284-1299.

CHW program, decision makers should consider how to link them up with the wider health system[6].

1.6 Performance

For CHW programs to effectively perform, it is vital to lay due emphasis on training and supervision. Prior experiences have documented that low interest/use by the government, inconsistent remuneration, inadequate staff and supplies and lack of community involvement are key factors that negatively impact the CHW program.30 These factors can be alleviated by certified training and supportive supervision, along with other incentives (financial and nonfinancial) to keep CHWs satisfied and motivated to perform their duties well. Furthermore, efforts geared to standardize training and certification for CHW programs, could further provide a career pathway and enable them to effectively contribute to their communities. A recent study by Kash et al.[7]have concluded that certified CHWs are potentially an important health task force towards improving access to health care and social services and improve utility of resources to the underserved.

Equipment and Supplies issues such as the reliable provision of transport, drug supplies and equipment have been identified as another weak link in CHW effectiveness.1 The result is not only that they cannot do their job properly, but also that their standing in communities is undermined. Failure to meet the expectations of these populations (with regard to supplies), destroys their image and credibility. If CHWs are used in programs that have drug treatment at their core, such as TB DOTS or HAART, the situation becomes more critical but most programs include the need for supply of drugs and/or equipment, including transport.1 Ideally, supplies and equipment should be organized through district or regional dispensaries, and collected and delivered by CHWs.1 In cases where villages are very remote to the central health centre, village dispensaries can be established to cater for the drug needs of the populations.48 Equipment and supplies may be added pertinent to the specific intervention that the CHW is expected to work on.

1.7 Incentives

Keeping in mind the dearth of health workers and the rising need of CHWs to meet the health care demands, it is imperative to prevent dropouts from training programs. CHWs are poor people, living in poor communities, and thus require income. From the global and country case studies review we found that programs pay their CHWs either a salary or an honorarium and

[6] [6] WHO, Global Health Workforce Alliance: Global experience of community health workers for delivery of health related millennium development goals: A systematic review; country case study and recommendations for integration into national health systems.

[7] Kaseje MA, Kaseje DC, Spencer HC. The training process in community-based health care in Saradidi, Kenya. Annals of Tropical Medicine and Parasitology. 1987;81 (Suppl 1):67-76.

almost no examples exist of sustained community financing of CHWs.1 Even NGOs tend to find ways of financially rewarding their CHWs. Moreover, control on attrition can be achieved with regular and performance based financial incentives and hiring CHWs as full time employees rather than part time volunteers.1 They should also be given a wage if they work as full time, and those working as part time should be given small incentives for their work. We would make a strong recommendation for ensuring the CHWs be paid adequate wages commensurate with their work load and timings. Performance incentives could be the other pay back option, which can also motivate them to work with full determination. Moreover, in kind awards, such as an identification pin, can provide a sense of pride in their work and increased status in their communities.1 In cases where possible, free health coverage for themselves and for their family should be provided. In the end, we would recommend that CHWs should be given pay for performance to keep them stimulated[8].

1.8 Justification of the Assessment

A number of districts and partners have established and trained VHTs in their operational areas with or without guidance of MOH. In some instances, partners have taken up VHTs, provided training on their programmatic areas without the basic/core training required of VHTs using the MOH VHT training manual. This therefore leaves a gap in operational means of VHTs.

Currently information in relation to number, coverage and functionality of VHTs has gaps. While the VHT strategy and implementation guidelines are in place, most partners implementing programs in the communities do not follow the strategy as reflected in the Health Sector Strategy Investment Plan II (HSSIP II). Therefore the Ugandan MOH, with partners, undertook a VHT assessment to establish and ascertain the number, coverage and functionality of VHTs in the country to be able to come up with an improvement framework.

2.0 Objectives

2.1 General Objective

To establish the national status and functionality of VHTs in Uganda in order to improve the planning and delivery of health services to households and communities.

2.2 Specific Objectives

i) To establish the number and socio demographic profiles of the VHT in Uganda.

ii) To establish the training that was provided to the VHT (VHT training, duration of the training, the content, methods and materials used for the training)

[8] Douthwaite M, Ward P. Increasing contraceptive use in rural Pakistan: an evaluation of the lady health workers programme Health Policy and Management. 2005;20(2):117-123.

iii) To establish the partners working with VHTs and the activities VHTs are currently implementing.
iv) To review the extent to which the VHT implementation guidelines are being implemented by the MOH and the districts and partners.
v) To identify approaches for VHT motivation mechanisms and arrangements
vi) To assess the functionality of VHTs in Uganda.

3.0 Methodology

3.1 Study Setting

The study was conducted country wide in all the 112 districts in Uganda. The study was conducted from November 2014 till January 2015.

3.2 Study Design and Sampling

A cross-sectional, mixed-methods study was conducted, that included a structured survey of Village Health Teams, focus group discussion with District health teams and in-depth interviews.

The country was subdivided into 10 sub regions (Table 1) following Uganda Bureau of Statistics (UBOS) criteria. A total of 10 teams consisting of 5-6 members were trained and deployed for data collection.

Table 1: Districts in the different regions

Region	District	No of districts
Karamoja	Kaabong, Kotido, Abim, Napak, Moroto, Nakapiripirit, Amudat,	7
Eastern	Kween, Kapchorwa, Bukwo, Sironko, Bulambuli, Bududa, Manafwa, Mbale, Bukedea, Kumi, Ngora, Serere, Soroti, Tororo, Amuria, Katakwi, Busia	17
East Central	Butaleja, Budaka, Kibuku, Pallisa, Buyende, Kaliro, Namutumba, Bugiri, Namayingo, Mayuge, Kamuli, Luuka, Jinja, Iganga	14
Central 1	Kalangala, Masaka, Rakai, Lwengo, Bukomansimbi, Kalungu, Butambala, Ssembabule, Lyantonde, Gomba, Mpigi, Mubende, Mityana	13
Central 2	Buikwe, Buvuma, Mukono, Wakiso, Kayunga, Luwero, Nakaseke, Nakasongola, Kiboga,	10

	Kyankwanzi	
South Western	Kiruhura, Mbarara, Ntungamo, Isingiro, Kabale, Kisoro, Kanungu, Rukungiri, Bushenyi, Sheema, Mitooma, Buhweju, Ibanda	13
Western	Rubirizi, Kasese, Kamwenge, Kabarole, Kyenjojo, Kyegegwa, Kibale, Bundibugyo, Ntoroko, Hoima, Masindi, Bulisa, Kiryandongo	13
North	Amolatar, Kaberamaido, Dokolo, Apac, Lira, Oyam, Kole, Alebtong, Otuke, Agago, Kitgum, Lamwo, Pader, Gulu, Amuru, Nwoya	16
West Nile	Nebbi, Zombo, Arua, Adjuman, Moyo, Yumbe, Koboko, Maracha	8
Kampala	Kampala	1

3.3 Study Respondents

Table 2 shows the data collection methods and the respondents that were interviewed. District leaders including Local Council V Chairman (LCV chairman), Resident District Commissioner (RDC) and the Chief Administrative Officer (CAO) were purposively selected. Members of the district health teams were mobilized in each district to participate in a focus group discussion. At each district, two sub counties were selected at random by drawing from a "hat". Health Centre II facilities in the sub counties were also randomly selected. HCIII or higher facilities were selected if they were in the selected parishes. A minimum of 12 VHT members from the villages in a parish were selected with the help of Parish VHT supervisors and health entre in-charges. Focus group discussions were held with 10-12 members selected from community where the health centre under the assessment is located.

Partner selection was done in consultation with the DHT. The criterion of selection was based on the "most active" partner in the district in terms of geographical and area of coverage. This meant that the partner's contribution to the VHT programme in the district was significant. In districts where the partner had been interviewed before in the region by the research team, the second most active partner was then considered.

Data were collected during this assignment through comprehensive review of available literature from, VHT manual/hand book, VHT Strategy and Operational Guidelines, VHT register, , Situational analysis of VHT 2009 and other documents deemed relevant. Also teams extracted reports for review to capture information on VHTs/profile during data collection.

Table 2: Respondents and data collection technique

Data collection techniques	Category of respondents	Actual Number	Target number	% of respondents interviewed
Desk review	Reports and all relevant documents			
Focus Group Interviews	District Health teams	105	112	94
	Community	30	30	100
Key informant interviews	District VHT focal person	112	112	100
	Implementing partners (district level)	70	112	63
	District KIs	240	336	71
	MOH Officials	7	10	70
Interview Administered questionnaire	VHT	2610	2688	97
	Health care workers	217	224	97

3.4 Quality Control

The research assistants were trained for five days in research methods and data collection tools. Pretesting of the data collection tools for a day prior to data collection was also done. All the tools were translated into the appropriate local languages. The central management team and partners including MoH, Pathfinder International and UNFPA conducted supervision of the data collection. Daily debrief meetings were held with data collectors/research assistants to review questionnaires.

3.5 Data Management and Analysis

3.5.1 Data Management

The quantitative data were checked for completeness prior to capture into an electronic data base using Statistical Package for Social Scientists (SPSS) Version 20. Qualitative data were transcribed, cleaned and entered into a master sheet. Trained research assistants under the guidance of the field supervisor captured data, which were securely kept in password-protected files.

3.5.2 Data Analysis

Descriptive data analysis was conducted using SPSS Version 20 to obtain frequencies distributions, graphs and cross tabulations for statistical association. The qualitative data were analyzed by reviewing the FGD transcripts several times while making notes in the transcripts. Any disagreements that required further clarity were resolved through discussions among the data analysis team and data triangulation. These data were then coded, grouped/sorted

according to themes and relative occurrence of the responses. Extracted meanings were summarized according to key /important messages. Thematic and content analysis, summaries, scenarios were used.

3.6 Ethical considerations

Permission to conduct the study was sought from the district leadership including District Health Officers (DHOs), Chief Administrative Officers (CAOs) and the Resident District Commissioners (RDCs). Verbal consent to participate in the survey was sought from all respondents. In the event that consent was not granted, such respondents were at liberty not to participate in the study. Maximum confidentiality was observed at all levels of data collection and processing.

Table 3: Team Composition

Name of Consultant	Qualifications	Roles
Prof. Christopher Garimoi Orach	(PhD) in Public Health	Team Leader
Dr. Frank M .Kaharuza	PhD in Epidemiology	Field Coordinator
Mr Julius Twinamasiko	MSc Agricultural Economics Cert in Public Health, Cert in Nutrition Research Methods	Data Manager
Dr. Stella Neema	PhD Anthropology	Qualitative Research lead
Mr Richard Ongom Opio	MSc Public Health	Qualitative data analyst
Ms Alice Ladur	MSc Public Health	Qualitative data analyst

3.7 Limitations of the Assessment

The timing of the assessment coincided with some major events such as the national immunisation days and World AIDS Day that made the availability of the key respondents hard. Some of the district officials could not be reached for this assessment.

4.0 Findings and discussion

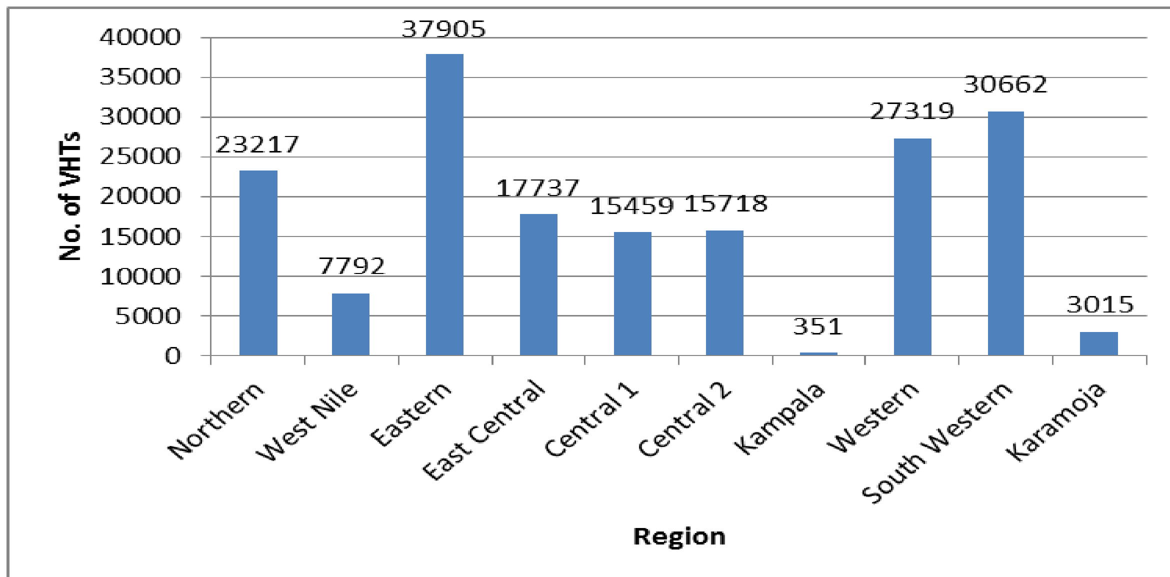
4.1 Introduction

The findings of the assessment are presented in six sections following the specific objectives of the study. Section one addresses the socio-demographic profiles of VHTs. Section two focuses on the training provided to VHTs. Section three addresses activities VHTs are engaged in and partners supporting the VHT programme. Section four addresses the extent to which the VHT implementation guidelines were implemented. Section five presents VHT motivation mechanisms and arrangements and section six addresses the functionality of VHTs.

4.2 Number and Socio-demographics of VHTs in Uganda (Objective 1)

The VHT focal persons reported an estimated total of 179,175 village health team members from all the 112 districts. The Eastern region had the highest number, followed by South Western and Western regions. These regions also happen to have the biggest number of districts. Kampala region has the lowest number, 351, of VHTs (fig 1).

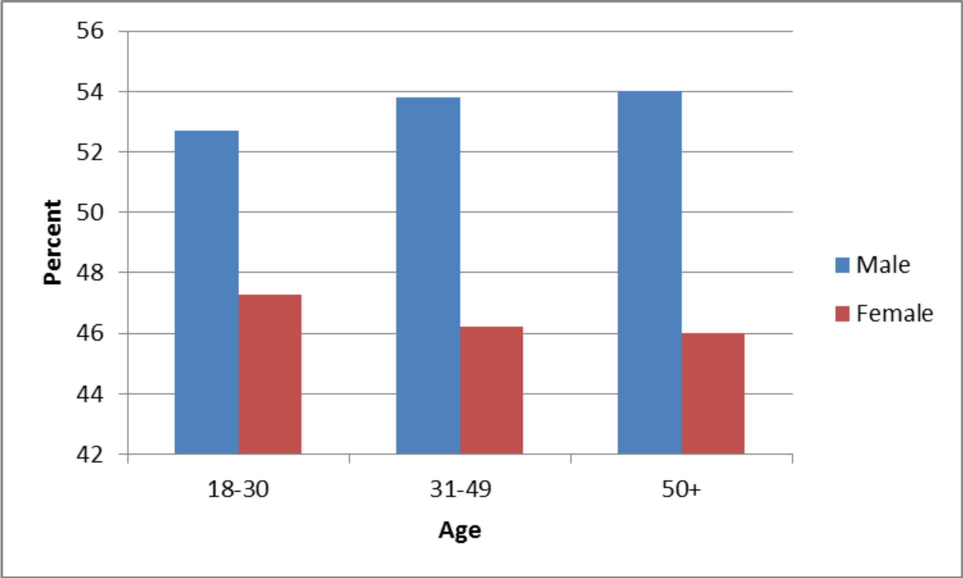
Figure 1: Distribution of VHTs by region



4.2.1 Age of VHTs

The assessment established that the age of VHTs ranged from 18 years to 78 years, with an average of 40 years. Age was categorized into three groups (Figure 2). The majority of VHTs (59.3%) were in the age range of 31 to 49 years.

Figure 2: Age group by sex



4.2.2 Sex of the VHTs

The majority of the key informant interviews reported the existence of more female VHTs than male. For instance, in Mitooma district as well as in Kibaale district, this situation and challenges of gender disparities affecting female VHTs were acknowledged.

"Many of the VHTs are women of which most men overlook them; they say it is a women`s thing", **KII_ Mitooma district.**

"Most VHTs are female, the married ones tend to be bullied by their husbands, tending to discourage them from that commitment", **KII_ Kibaale district.**

While the majority of the sample of VHTs who attended the interviews were male (53.9%), it should be noted that this may not be a true reflection of the general gender composition of the VHTs. Rather, it is a reflection of the unbalanced male-female roles in the communities. The mobilization of the VHTs was undertaken by the districts and it is possible that because the male VHT always have less domestic chores to do as opposed to female VHTs, the female VHTs could most likely not reach the interview venues on short notice due the gender roles they play (Table 4).

Table 4: Sex of the VHTs interviewed

Gender	Frequency	Percent
Male	1396	53.7
Female	1203	46.3
Total	**2599**	**100.0**
No Data provided	11	0.4

4.2.3 Level of education of VHTs

Of the VHTs interviewed, the majority (61.2%) had a qualification above primary level (table 5). Overall, the study found that more than 52% of the VHTs had a minimum of 'O' Level qualification. A few of the VHTs (2.9%) had attained tertiary level of education. 1.3% of the VHTs interviewed had no formal education, of whom 82% are VHTs in Karamoja region.

Table 5: Education level

Level of education	Frequency	Percent
No formal education	34	1.3
P1-P4	81	3.1
P5-P7	887	34.3
O-level	1367	52.8
A-level	75	2.9
Vocational	68	2.6
Tertiary	75	2.9
Total	**2587**	**100**

Overall, Karamoja region had the highest percentage of VHTs without formal education. Among VHTS with O-level education and above, Karamoja contributed the least (table 6).

Table 6: Percentage (row) distribution of level of education by region

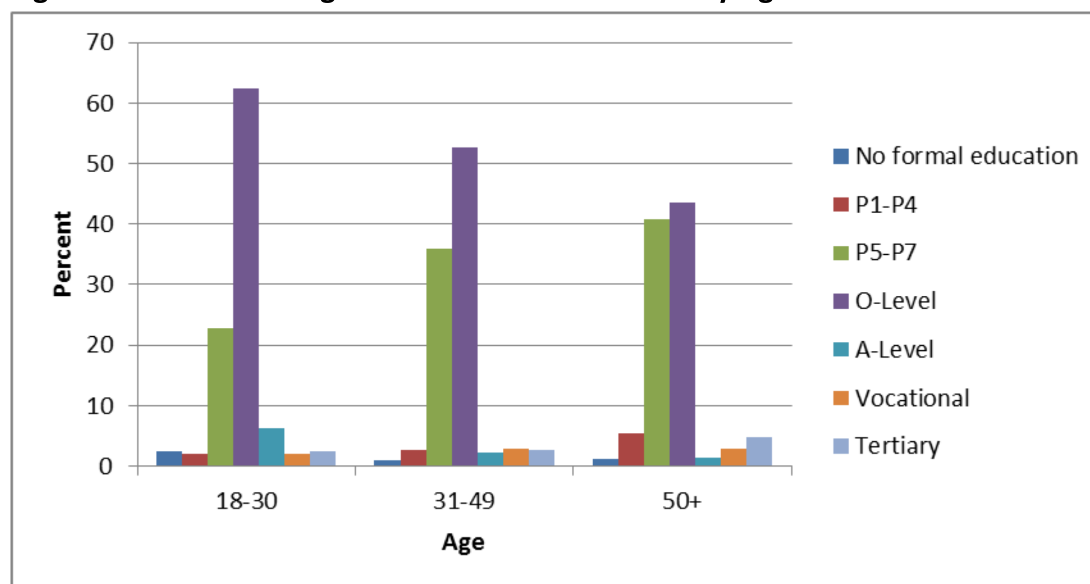
Region	n	No formal education	P1-P4	P5-P7	O-level	A-level	Vocational	Tertiary
Northern	352	0.9	1.7	27.8	61.9	1.4	4.3	2
Karamoja	137	20.4	19.0	24.1	32.1	2.9	0.0	1.4
Eastern	438	0.2	2.7	34.5	55.0	3.4	1.4	2.7
Central 1	310	0.0	2.9	37.1	51.0	3.9	1.6	3.5
Central 2	236	0.0	4.2	30.1	53.8	4.2	2.5	5.1
East Central	341	0.0	2.1	28.2	64.2	4.1	0.6	0.9
West Nile	203	0.5	2.0	41.9	51.7	2.5	1.0	0.5
Western	259	0.4	1.2	32.0	47.5	2.3	10.4	6.2
South western	311	0.0	1.3	49.8	42.4	1.3	1.6	3.5
Kampala	20	0.0	0.0	15.0	60.0	5.0	0.0	20

However, the criterion of being able to read and write in the local language seems not to have been followed in some districts such as Kaabong, Napak and Moroto as highlighted by key informants. A number of VHTs reported not knowing how to read and/or write.

"The general challenge is low literacy rate among VHTs…., there are those who do not know how to read and write. So we use colours, numbers and pictures to help them identify (conditions such as) malnutrition, a bleeding woman to show certain aspects of a health condition or complication", **FGD_DHT, Kaabong district.**

4.2.4 VHT Education Level by Age

Figure 3: Percentage of Education Distribution by Age



From the above figure, majority of the VHTs have attained 'O' level as the highest level of education. Qualitative findings from various focus group discussions showed a general preference for more educated VHTs.

> *"The minimum level of education for VHTs should be 'O' Level. But some of the things we are (assigning VHTs to do) require someone who has done 'A' Level"* **FGD_DHT, Lyantonde district.**
>
> *"..we appreciate the role VHTs have played but where the world has reached , when recruiting new VHTs, at least the person selected should have completed at least senior four. It will really help on the people's side",* **Community FGD (Men's Group), Luwero district.**

This finding underpins the need to invest in younger and more educated VHTs for effective health services delivery. The current National VHT guidelines do not stipulate the age and education level of VHTs.

4.2.5 Relationship between level of education and sex

Overall, a large percentage of both male (56.2%) and female (49.0%) VHTs had completed O-level as illustrated in the table 5 above. A higher percentage of females did not have formal education compared to 0.8% of males.

Table 6: Relationship between level of education and sex

Level of Education	Male (n=1396)	Female (n=1202)
No formal education	0.8	1.9
P1-P4	2.9	3.3
P5-P7	29.3	39.7
O-level	56.2	49.0
A-level	4.1	1.6
Vocational	2.8	2.4
Tertiary	3.2	1.9
University	0.7	0.2
Total	**100**	**100**

The assessment has shown that the education level among the sex groups is generally the same. A higher proportion of male (60.3%) as compared to female (50.6%) has attained post-primary education. A higher proportion of female (1.9%) compared to male (0.8%) has no formal education. It was also noted that about 0.2% of female and 0.7% of male had tertiary education (table 6).

The majority (~85%) of VHTs is peasant farmers, and this does not vary by sex. No significant differences were observed in other categories of occupation. It should be noted that some VHT-members are employs of NGOs (~1.5%) or LC members (~1%), which is inconsistent with the requirement for being a VHT-member according to the recruitment guidelines.

Table 7: Main Occupation of VHTs

Occupation	Male	Female
Overall	**1313 (100%)**	**1151 (100%)**
Farmer	86.1	85.6
Business/self employed	9.4	11.5

Employed by NGO	1.5	1.4
Student	0.7	0.1
Fisherman/fisher flock	0.4	0.2
LC member	0.8	0.9
Boda boda	0.4	0.0
Religious leader	0.7	0.3
Cultural leader	0.0	0.1

4.2.6 Marital Status of VHTs

Nearly 4 in 5 VHT members are married suggesting a degree of stability within their respective communities (Table 8), and may be more acceptable because of the perceived respect accorded to such persons in this setting.

Table 8: Marital Status of the VHTs

Status	Frequency	Percent
Single	129	4.9
Cohabiting	179	6.9
Married	2084	79.9
Separated	56	2.1
Divorced	17	0.7
Widowed	142	5.4

Discussion

Although an estimated 179,175 village health team members were reported by focal persons for all the 112 districts, nearly a third (30%) did not have basic training. These estimates could not be verified due to lack of other sources of data such as databases at the district level. This implies that they are not technically VHT-members according to the

.

This means that for 57,735 villages, there is an average of 3 VHTs members serving a village. This figure, however, may be inaccurate since there are some districts such as Kibuku, Kampala, among others that have not carried out the basic VHT training. The number of VHTs are as reported by the districts and could not be independently verified. The regional imbalance in VHT distribution in VHT coverage requires government to conduct VHT training in districts that have not yet had their own trainings to ensure equitable delivery of health services.

The assessment found that just over a half (52%) of VHTs were below 40 years of age. They are able to sensitize the communities on health promotion but also do other health related activities. This age bracket may be more susceptible to attrition as they are considered more mobile. Some of the VHTs were 50 years or older, a factor that may have led to inefficiencies with regards to report writing and swift movement during mobilization activities. For example, administrators in districts such as Kalungu, Butambala and Mpigi expressed dissatisfaction with the manner in which the older VHTs were performing in terms of reporting and drug distribution as well as efficiency in movement during mobilization.

"Some of the VHTs in this area are aged and cannot see well", **FGD_DHT, Butambala district.**

Given the unique health challenges of the young people in Uganda, there is need to review the guidelines for eligibility and recruitment of people to be trained as VHTs to recruit more of 35 years and below to handle young people who are a majority in the population.

While the majority of the VHTs interviewed (54%) were male the assessment could not establish the exact sex composition of the VHTs in the Country due to the absence of accurate VHT databases in the districts. Thus future revised recruitment guidelines should consider to fill in the gender gap by having 50% male and 50% female targets for VHTs.

The data shows that more than 50% of the VHTs have attained at least 'O' Level education and can therefore read and write. This position was also supported by community data showing preference for people who have attained 'O' Level education and above. This would imply that Government could consider the minimum level of education for a VHT member could be 'O' Level. This would suit the expanding scope of responsibilities of VHTs such as administering antimalarial drugs, data gathering and reporting, family planning. However, it should also be pointed out that there is a challenge of identifying people with 'O' Level education in some places, more especially in Karamoja region, where about 20% of the VHTs had at least 'O' Level education as compared to the rest of the Country.

VHTs are involved in various activities. Although majority of the VHT members were involved in farming, some are employed by NGOs and others work as Local Council (LC) members and students. Availability of such cadres to do VHT work may be limited thus affecting their output. It is also important to note non-adherence of the guidelines when such VHT-members are involved in VHT work, especially the LC-members who may introduce political interferences.

4.3 Training provided to Village Health Teams (Objective 2)

4.3.1 Retention and Training of District Trainers

Of the 112 districts visited, the majority 94 (84%) reported having VHT trainers in the district (Table 8). Almost half of the districts had training of district trainers in the last four years. The majority of the new districts did not have active district trainers. Training of district trainers were largely conducted by the Ministry of Health while 41% of the districts have more than 75% active Trainers.

Table 8: Year district trainers were trained

TOT Training	Number	Percent
Year		
2001-2004	14	13
2005-2009	22	20
2010-2014	52	47
Missing	24	21
Total*	**112**	**100**

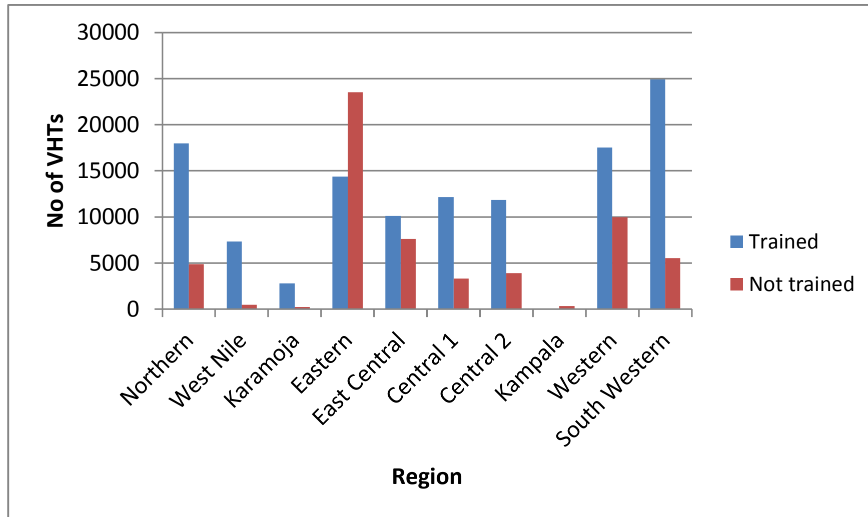
4.3.2 Training of VHTs

Of the 179,175 VHTs as reported by the VHT Focal Persons, only two thirds had received basic training. While most of the VHTs had undergone the basic training, there were exceptions in

the newly created districts such as Bulambuli, Amuria, Dokolo, Kibuku and Buikwe, among others where VHTs have not undergone the basic training.

> *"Kibuku as a district has never trained any VHT on comprehensive training apart from the trainings by NGOs (on specific projects)",* **FGD_DHT, Kibuku district.**

Fig 3: Distribution of Trained and Untrained VHTs by Region.



South Western region had the highest number of trained VHTs followed by Northern and Western regions. The Eastern region had the highest number of untrained VHTs. In Kampala district, VHTs did not receive basic training. Eastern, East Central and Western regions had very high numbers of untrained VHTs.

However, in the interviews with selected VHTs, the vast majority of the VHTs (91%) reported having received basic training. A few of the VHTs could not remember or did not know if they had received initial training. This may be attributed to the multiplicity of trainings that the VHTs could not differentiate between basic and refresher training (Table 9). There have been various kinds of trainings conducted for the VHTs across all the districts.

The basic training is based on the MoH guidelines and originally was designed to last for two weeks. However, respondents explained that the length of training fell short of two weeks. The training days were compressed by the Ministry of Health from 14 to five days due to financial limitations (MoH 2009), though the curriculum was not adjusted to fit in this short time Due to financial constraints, supervision has not been adequately done to ensure that training is the same across the board for all VHTs.

> *"Training of VHT is through the district partners but this is not standardized- trainings are sometimes different –without a properly laid out approach",* **KII_MoH.**

Program specific trainings have been conducted by various IPs. The program areas included HIV and TB by STAR EC, malaria and HIV/AIDS by Malaria Consortium, family planning by Pathfinder International and Reproductive Health Uganda (RHU), hygiene and sanitation by Uganda Sanitation Fund, neglected tropical disease (NTDs), maternal, new born and child health by World Vision and nutrition by SPRING, among others. On average, these trainings lasted for 2-5 days. However, very few VHTs have been trained within each district and most often the same VHT members have been selected for the various trainings. Usually, the most active VHT members continue to receive these trainings to the disadvantage of those perceived to be inactive. However, the training of those perceived to be inactive proved successful with the NTD programme in Serere.

> *"We tried this with NTD programme where we picked the ones regarded as inactive and they performed well",* **FDG DHT, Serere district.**

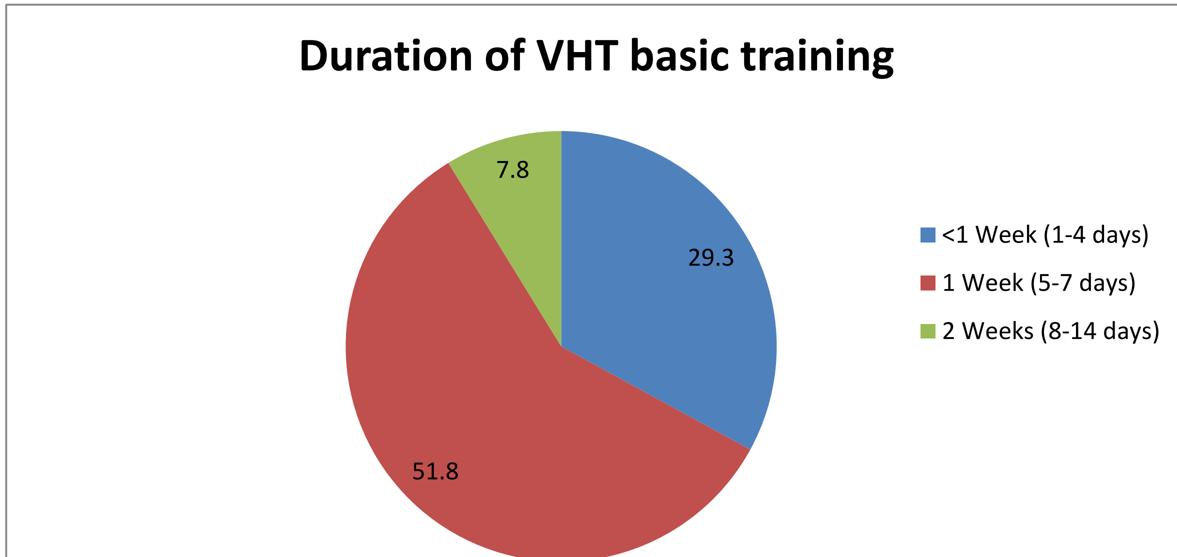
The majority of interviewed males (90.1%) and females (92.5%) received basic training as shown below.

Table 9: Basic Training by Sex of the VHTs

Response	Males		Females	
	Frequency	Percent	Frequency	Percent
Had initial training	1254	90.1	1109	92.5
Not had initial training	129	9.3	86	7.2
Not sure if had initial training	9	0.7	4	0.4
Total	**1392**	**100**	**1199**	**100**

According to the Ministry of Health Operational Guidelines (MoH 2009), basic training of 5 days is recommended. The study established that the VHT basic training time ranged between 1 to 14 days. Overall, we established that just over half of the VHTs were trained for 5-7 days. Nearly a third was trained for 1-4 days. Figure 4 below shows period of training given to the VHTs.

Figure 4: Duration of VHT Basic Training



Training Content

The VHT training content, as per **VHT Strategy and Operational Guidelines** , is disease prevention and health promotion, identifying simple illnesses and provision of simple treatment, identification of danger signs, referral, maintenance of VHT registers and community mapping.

The most commonly recalled / mention content area for the VHT training was disease prevention (90.2%), while 63.2% reported having had training in health education, and home visits (62%) see Table 10.

Table 10: Reported Content of the Basic Training

Content	Frequency	Percent
Disease prevention	2098	90.2
Health education	1469	63.2
Home visits	1450	62.3
Community mobilization	1255	54.0
Referrals	797	34.3
Community registers	771	33.1
Community mapping	584	25.1

4.3.3 Refresher Training

Refresher training is any additional training conducted after the initial VHT training and is usually tailor-made to the specific programme needs of the individual implementing partners.
Refresher training is conducted for the various programme areas. It usually lasts 3-6 days and is conducted by implementing partners. They include training on communicable diseases such as

malaria, HIV/AIDS, TB, Pneumonia, hygiene and sanitation, referrals the roles of VHTs, among others. On average the reported number of additional trainings were 6, but ranged from 1 to 30.

Table 11: Category, Content and Duration of VHT Training

Category	Training Content	Duration	Training Partners
Basic training	Community mobilization, Records keeping, Health promotion, Prevention , Treating the sick, Referrals and Home visits	1-14 days 5-7 days (MOH)	MOH with support from Partners
Refresher training (disease/ program specific)	Communicable diseases – Malaria, HIV/AIDs, TB, Pneumonia, Diarrhea, Hygiene and Sanitation promotion, eMTCT, Referral, Diagnostic testing – RDT, Family Planning, community mobilisation for health care	Varied 3-6 days	Partners with MOH and District support

> *"The Ministry also apart from implementing partners should provide resources for refresher trainings because if a VHT was trained three years ago, things are changing. Something should be done in trainings",* **FGD_DHT, Lamwo district.**
> *"VHTs should have refresher trainings to boost them to carry out their work most efficiently",* **FGD_DHT, Mubende district**

4.3.4. Who Conducts the Training?

The VHT initial trainings are conducted by district trainers. District trainers are trained by MoH master trainers. The master trainers are Ministry of Health staff. Trainings, such as refreshers or program specific trainings, can be conducted by district health officials, health assistants, health centre in-charges and some implementing partners.

4.3.5 Who Supports the Training?

The MoH provided support to the VHT training through its master trainers and provision of guidelines for selecting and training the VHTs as articulated.

> *"The Ministry of Health would coordinate training and provide guidelines and information",* **KII, MoH.**

Several implementing partners helped to support programme specific courses for the VHTs. These trainings included HIV/AIDS, TB, Malaria, Maternal and Child Health, Hygiene and Sanitation, Integrated Community Case Management, Neglected Tropical Diseases. (Appendix 6.2)

"We trained them to recognize community members in need of rehabilitation and refer them especially those that need HIV/AIDS testing and counselling and refer them to our clinic for services. We also trained them to do home visits and do follow up on patients to make sure they remind them to take and complete medication. We trained them on counselling and guidance and how to handle properly people living with HIV/AIDS. We trained them to encourage community members to go for HIV/AIDS testing and to do community mobilization in case of outreach. We trained them on how to write and what to capture in reports. We trained them on how to approach people, communicate and encourage them and how to link them to our clinics or to the nearest health centres", **KII_Partner, Sheema district.**

"Yes, we train them on specific programmes such as nutrition, immunization and general good health practices", **KII_ Partner, Kiryandongo district**.

Discussion

When new VHT Focal Persons in the districts are brought on board they have a difficult time understanding the effectiveness of the VHT program due to a lack of information on what has happened in the programme in the previous years. The lack of a database to keep track of this information also results in not being able to accurately track the number of VHTs and the trainings they have attended.

Despite the high number of VHTs in the Eastern region, the majority have not had initial VHT training. The high number of untrained VHTs in Eastern region shows disfunctionality of the VHT programme. People who did not receive initial training were considered VHT members in some districts. For example, in Kampala district where no initial training has taken place, 351 people were reported to be VHTs. These were only trained on programme-specific areas. In such districts, it is apparent that the VHT guidelines have not been followed with respect to training.

It was noted that the content of the initial training reported by VHTs country-wide was largely consistent with the content stipulated in the VHT operational guidelines. However, this content may not have been fully covered in the short duration of the training (5-7 days) even when qualified trainers were used. The reduction of the training duration by the Ministry of Health from 10 to 5 days may have led to rushing of the trainings. The trainings may have been inadequate to equip the VHTs with appropriate knowledge and skills. This therefore could affect the quality of services VHTs provide to the community.

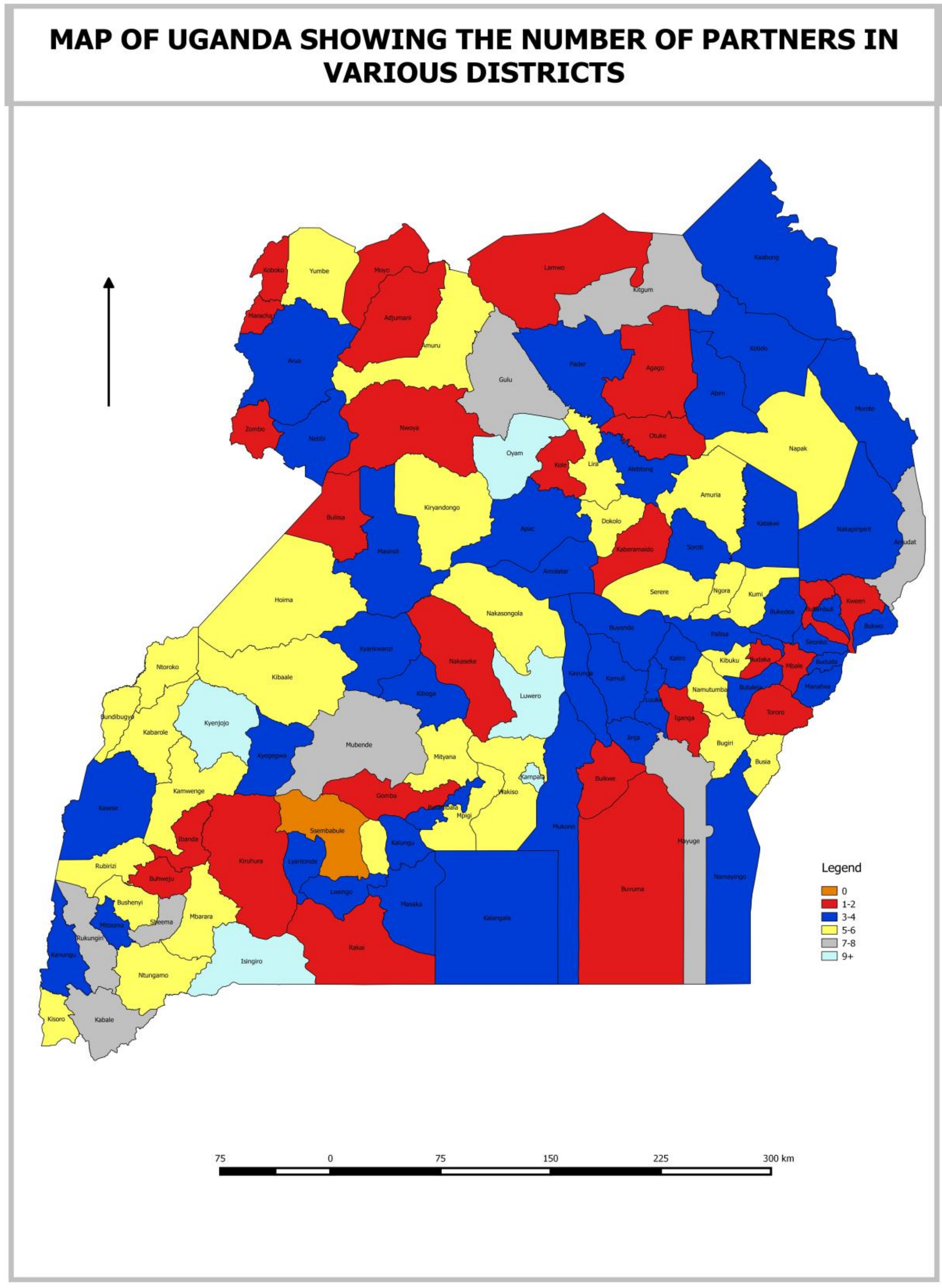
At times, trainings are conducted directly by the IPs without notifying and involving the DHTs or using the district trainers. This indicates a problem of VHT programme coordination,

streamlining and training. Since IPs choose where to go and implement their programmes, it creates disparity in the capacity of VHTs since trainings are provided to some VHTs in some areas and not to others. This leads to differences in knowledge and skills levels among the VHTs. Such a situation may lead to demotivation of the VHTs and may result into drop out.

Poor IP coordination creates a problem in supervision of the programme and eventually in sustainability when the partners' projects end. In areas with few or no implementing partners, it implies that the communities may not be benefitting from the VHT activities supported by such partners.

While these multiple trainings can strengthen the capacity of VHTs to deliver services to the community and provide feedback to the health facility staff, it also means that the same VHTs receive multiple trainings which increase their reporting burden. It may also mean there is inadequate time to have quality training given the low level of education of some of the VHTs.

4.4 Partners working with VHTs and the activities VHTs are currently Implementing (Objective 3)



4.4.1 Partners supporting and working with VHTs

Several development partners support VHT activities in the districts. These development partners include UNFPA, WHO, UNICEF, UNDP DFID, USAID, SIDA and others (Appendix 6.2), They support the programme through the implementing partners that include; Pathfinder International, RHU, Baylor Uganda, World Vision, PACE, AMREF, Community Based Organizations such as; Mayanja Memorial, Kagum Development Organization, Uganda Sanitation Fund and Community Connector among others. However there was no evidence to ascertain the criteria followed by the IPs in selection of the districts of operation. South western region was found to have the highest number of implementing partners (table 12).

Table 12: Number of Implementing Partners by Region

Region	Number of Partners
Central 1	49
Central 2	41
Eastern	62
East Central	53
Kampala	12
Karamoja	31
Northern	64
South West	69
Western	60
West Nile	20

Development partners have made significant contributions to the overall implementation of the VHT programme through the provision of financial, technical and logistical support. They provide financial support to implanting partners to run the VHT programme related interventions. Such support is used to conduct training, logistics supplies, supervision and motivation.

> "*We support partners with money to go and do the work. Training has been done especially family planning and door to door mobilization, pregnancy mapping and referrals. We work in Yumbe, Oyam, Kotido, Moroto, Kabong, Katakwi, Mubende and Kanungu. We give money to the Local Governments, Pathfinder International and Reproductive Health Uganda. On top of family planning, these partners support VHTs. CDFU radio health choice programme is one of the programmes supported by the partners. During radio shows, VHTs mobilize people to listen to the programme***",** **KII_UNFPA, National Partner.**

"We trained 125 VHTs and we give them 25,000= per month for bicycle maintenance facilitation. They qualify for this facilitation upon the submission of a report and attending a monthly meeting. The health assistant is provided with a tracking system that he fills while supervising them" **KII_Baylor Uganda, Serere district.**

"We also support VHT quarterly meeting with allowance of 7,000= given to every VHT member. We usually support the health center in-charges throughout the district through the provision of airtime of 5,000= per month to enable them to easily coordinate with the VHT within their respective health facility", **KII_Malaria Consortium, Mbale district.**

Improvement in the VHT program has been reported in districts and or sub counties where IPs have been operating as earmarked by regular reporting, supervision and activeness of VHTs.

*"Sub-counties that have implementing partners are performing so well as compared to those without partners". **FGD_DHT Busia***

"The VHTs getting support from partners have a stronger system and work better than those who are not getting any support or those working as volunteers", **Community FGD_Masaka district.**

The presence of partners and VHT engagement in the districts is largely tailored to the specific program interests of IPs as reported in this extract from Dokolo District Health Team.

*"Most of these trainings have been conducted by partners. NUHITES support them (VHTs) in training and equipping them with what they call MUAC tapes, tape for measuring the upper arm circumference and then they use that for assessment of nutrition. There is Uganda Sanitation Fund that supports sanitation at home stead, some facilitation to make them do sensitization on sanitation in households. Then ABT associates have come in now; they are training them to be pump operators, spray pump operators. If a partner comes for a particular disease that is there, another one comes like that, may be specifically for malaria, and may be for NTDs, it's not the same partners". **FGD_DHT Dokolo***

As reported by the district health teams during Focus Group Discussions, implementing partners were not coordinated in offering their support to the VHTs. For example, they motivated VHTs differently; they had different reporting formats and their programme training followed different methodologies and the duration was different. This led to motivation of some VHTs more than others which may have led to drop outs and reduced enthusiasm at work. Moreover, partners were concentrated in some districts leaving others with few or no partners.

"*different partners have different areas of interest e.g. Marie Stopes focuses on family planning but again when they come in and they want VHTs we tell them to select VHTs already selected by the community and for the content we select and train using the*

manual. Partners come in with a specific agenda much as we are mandated to gate keep them and sometimes it isn't easy. So we just may be say let's pick on what we can get though the training is supposed to follow the guideline. We wish partners to give them the training for the entire package but they say they can't afford that", **FGD_DHT, Sheema district**.

"The partners have no well-organized guidelines. For example, Crane Health Services has a different package", **FGD_DHT, Otuke district.**

"*The VHTs were not trained on malaria. They were only trained on NTDs".* **FGD_DHT, Otuke district.**

"*as a district, it is hard to get information from the VHTs as data is submitted to partners directly as they have the capacity to facilitate and link up with them and by the time we ask for reports from them, it is long overdue. Thus we have to go partners for the information yet it is the partners supposed to get these reports from the district.* **FGD_DHT, Kyejonjo district.**

The number of partners supporting the VHT programme varied across districts and regions. Reports from the District Health Teams showed that Sembabule district did not report the existence of an implementing partner supporting the VHT programme; Adjumani, Moyo and Rakai districts have the least number of partners (1) and with Kampala Kyenjojo district having the highest number of Implementing Partners. These variations may be attributed to partner interests in particular districts and sub counties or to budgetary constraints. (Appendix 6.1).

4.4.2 Activities VHTs are Currently Implementing

Implementing partners have incorporated VHTs on several community based programs on maternal and child health, Integrated Community Case Management, HIV/AIDS, Tuberculosis, reproductive health, immunization, nutrition and sanitation. VHTs are actively involved in conducting health education, community mobilization, referrals, rapid diagnostic testing for malaria, distribution of drugs, condoms, mosquito nets and water guard and linking communities to health facilities.

"When our partners come, we also introduce our structures to them including the VHTs. So when they come, they use them- like recently we have been having a faith based organization that was sub- contracted by Star- East; Caritas Tororo. It has done a lot of community work and wanted community linkage facilitators. It took up all our VHTs to do that- linking up the village clients who are HIV positive to the clinic, linking up services in the health facilities to the community, and they have really done it for us". **FGD_DHT Bukwo district.**

Village Health Teams members have been active in playing their role of mobilizing the community. This has been through home to home visits, village meetings and during church events such as prayers.

> *"They teach us to go for family planning methods so that we can have a better life and at least we space the children", **FGD_Community, Kamuli district.***
>
> *"They are teaching people how to construct that system where you can wash hands without touching the Jerrycan (tippy tap). I have also seen them doing health education in church after service"* **FGD_DHT, Ibanda district.**

The VHTs have helped to mobilize their community members to access health interventions such as immunization, mosquito nets distribution, fistula, HIV/AIDS counselling and testing services, conduct community health education and sensitization meetings,.

> *"Recently we had a team from TEREWODE organization and they wanted mothers who had a problem of fistula and wanted to identify them and were not in town but in villages and it was the VHTs that mobilized these mothers and (they) came very many. If there is an activity for family planning and are using permanent methods, they mobilize. They are not technical per se but are given some skills to mobilize people to come for services**",*** **FGD_DHT, Namayingo.**

Village Health Teams members sensitize community members on epidemic outbreaks and how to detect danger signs. They have also been contracted to provide edutainment through their VHT groups to deliver health education messages at public events.

VHTs conduct community sensitizations on disease prevention strategies such as hygiene and sanitation practices e.g. hand washing, construction of pit latrines, utensils stand, sleeping under mosquito net and drinking boiled water.

> *"What I have at my home has been as a result of VHT efforts. I have managed to construct a pit latrine, a drying rack and a rubbish pit. I never used to have any of these things"* **FGD_Community, Butaleja district.**
>
> *"They teach people about the dangers of dirt like not having a latrine and this has helped people to be clean. Some years back, people did not find it important to dig deep latrines but now they dig deep latrines of about 30-40 feet. VHTs have helped people to be clean in their homes"* **FGD_Community, Mbarara district.**

In addition, VHTs carry out community sensitizations on importance of uptake of health services e.g. going for HIV tests, antenatal care and delivery at health facilities, safe male circumcision, immunization and family planning. They equally sensitize communities on collective social responsiveness e.g. building fences around boreholes and clearing bushes along village paths.

"They mobilise us to make fences for the boreholes and advise us to keep the jerrycans used for fetching water clean" **FGD_Community, Butaleja.**

Due to their active roles in disease prevention, treatment, promotion of health services, their prompt response and commitment, VHTs have earned the respect of the communities they serve.

"Those health workers are good and we admire them and personally, I would love to be part of them based on the way they conduct their work. When a VHT comes to your home, and it is dirty, he or she can help you clean your place and continually advise us to maintain hygiene in the homes" **FGD_Community, Butaleja district.**

VHTs identify patients in the communities suffering from neglected tropical diseases (NTD). These include Onchocerciasis (river blindness), elephantiasis, bilharzia etc. In addition, once VHTs have identified the sick in the communities, they ensure that they access health services. VHTs identify and notify health facilities on the outbreaks of epidemics such Marburg fever, Ebola, Polio, Hepatitis E and nodding syndrome.

Whereas VHTs can also provide basic treatment of some kinds of illnesses among patients in the community, they are encouraged to refer patients with danger signs or those who present with unknown conditions or conditions which they are unable to manage to the nearest health facilities.

VHTs have been instrumental in the distribution of drugs in the communities to population groups such as children under five. Such drugs are mainly deworming tablets and anti-malaria. In addition, VHTs have been involved in the distribution of the neglected tropical diseases drugs. Whilst it is true that the VHTs have played vital roles in distributing drugs to community members, it is however noted that this role has been constrained by the shortfalls in drug supply from the health facilities. This shortfall has been blamed on drug theft in some cases. Quite often community members were being told by VHTs that there were no drugs whenever they wanted to be given the drugs. Some VHTs are also alleged to have been selling the drugs or only giving them to relatives and friends. VHTs have themselves also carried out immunization activities.

"Like right now we are doing this mass polio campaign. We are using the VHTs for immunisation and some of them are even immunising – vaccinating children". **Bukwo FGD _DHT.**

In most instances, they have contributed in terms of mobilisation of community members for uptake of immunization services. Therefore, VHTs can be credited with ensuring their

functionality in regards to the role of promoting immunization services uptake in the community.

Discussion

Implementing partners have made significant contributions to the overall implementation of the VHT programme through the provision of financial, technical and logistical support. This support has improved utilization of health care services provided by VHTs in the areas of immunization, sanitation, HIV/AIDS services, antenatal care, deliveries and family planning services. However, there is inequitable distribution of partners among and within districts. This may be caused by the uncoordinated selection criteria of the districts of operation. This leads to inequitable distribution of skills among VHTs. Districts with many partners may have VHTs who are more skilled than those with few partners or none at all. This has implications on quality of health care services VHTs deliver to the community.

The roles played by the VHTs as indicated by the community FGD data are reflective of the content of the VHT training. The most common roles played by VHTs are community mobilization and this is consistent with the content and requirement of the basic VHT training guidelines. The community members are appreciative of the roles played by VHTs in health service delivery especially in hygiene and sanitation, drug distribution, antenatal care, HIV and family planning.

Although the Government of Uganda owns the VHT programme, VHTs pay more allegiance to the IPs who provided them with more facilitation than government. This is reflected in the VHTs willingness to participate in IP related projects as opposed to those for the government where there is less or no facilitation.

4.5 Extent to which the VHT implementation guidelines are being implemented by the Ministry of Health, the Districts and Partners (Objective 4)

4.5.1 Introduction

The VHT guidelines (2009) stipulate the modalities of the course of action regarding VHT recruitment/selection, training, reporting and supervision. The review assessed the extent to which the Ministry of Health, districts and the partners were implementing the guidelines.

4.5.2 Selection of VHTs

According to the MoH VHT operational guidelines (2009), members of the Village Health Team should be selected by the community itself and not imposed by political structures and selection should be gender sensitive. It is recommended that VHT members should be selected

from the communities that they will serve and that the communities should have a say in their selection. The common practice for the VHT recruitment involves community mobilization and sensitization by members of the District Health Team or a health worker from the nearest Health Center; this health team member then facilitates the community to select a VHT often by popular vote based on the agreed selection criteria. The following is the recommended VHT selection criteria according to the guidelines:

- Should be exemplary, honest and trustworthy and respected
- They should be willing to serve as a volunteer
- Must be a resident of the village
- Should be available to perform specified VHT tasks
- Should be interested in health and development matters
- Should be a good mobiliser and communicator
- May already be a CHW TBA, drug distributor or similar
- Ideally should be able to read and write at least the local language

The assessment could only determine adherence to selection criteria on two components of being able to read and write and community participation in selection. Findings from the study indicate that only 4.4% of the VHTs are below upper primary, the level below which VHTs may not be able to read and write in the local language. This shows adherence to the guidelines in regards to selection.

As far as community participation was concerned, close to 10% of the VHTs were selected without following the selection guidelines. They were selected by community leaders, NGOs while others joined on their own (Table 13).

Table 13: Recruitment of VHTs

Modality of Recruitment	Frequency	Percent
Recruited by the community	2320	90.6
Community leader	229	8.9
Selected by the NGO	6	0.2
Just joined by myself	3	0.1
Total	**2558**	**100**

In practice, while the guidelines for selection of VHTs were adhered to in most instances, they were flouted in others. The adherence is reflected in the community members' participation in the selection of the VHT through village meetings.

"The chairman and community in the local council one gathered and selected those that never leave the village and they were guided on how to select the VHTs. In selecting these VHTs, we considered those people who are always in the village, approachable and those who have had some education. We also selected those who can take good care of our medicine and are clean", **FGD_Community, Gomba district.**

As summarized in the above extract, there was adherence to the MoH guideline for VHT recruitment and selection in most districts. Community members were mobilized and guided on whom to select based on their residential status, education level, inter-personal relations and integrity. However, some Local Council leaders (LCs) were reported to have individually identified their relatives or themselves for the VHT positions.

"People choose their relatives and friends and also LCs impose themselves into these positions. Because of some small money and bicycles, someone wants to be both an LC1 and a VHT", **KII, Alebtong district**.

We observed no significant regional variation in the selection of the VHT members. However, the central region had 15.7% of the VHT members selected by community leaders, which markedly deviate from the guidelines (table 14). Conversely, Karamoja region had the highest community participation in the selection of the VHT members largely attributed to the UNICEF's guidance and support in this region.

Table 14: Selection of VHTs by Regions in Percentage

Selection criteria	Northern n=549	Karamoja n=134	Eastern n=772	Central n=541	Western n=562	Overall Country N=2558
By the community	93.4	99.3	92.0	83.9	90.7	90.7
Community leader	6.6	0.7	7.1	15.7	9.3	9.0
Other Selection*	0.0	0.0	0.9	0.4	0.0	0.3

*Other selections included selection by IPs or self

The DHTs were instrumental in VHT selection by facilitating the process and the communities were empowered through this process to make informed decisions in the selection of their VHTs. The assessment therefore found that to a large extent there was adherence to the VHT recruitment and selection criteria.

Discussion

The VHT selection guidelines are in place and have largely been used. This is evident in the involvement and participation of the communities in selecting VHTs. However, a small proportion of VHTs were not selected in accordance with the guidelines in place. This included selection by local leaders, IPS and self-selection. This may imply that the quality of VHTs not selected according to the selection guidelines may not meet the selection criteria such as being able to read and write or trusted, committed to working and are permanent residents in the community.

4.5.3 Training

VHT training includes the initial and continuing/refresher training. In the initial trainings, the content included, among others, disease prevention, community mapping, community registers, home visits, community mobilization, health education and referrals which is in line with the stipulated guidelines.

A third of VHTs (34%) did not receive initial training but are working as VHTs in the districts. The initial training is required to run for five days. The study established that the VHT initial training time ranged between 1 to 14 days. Overall, it was established that more than half of the VHTs were trained for 5-7 days. Among VHTs who received basic training, nearly a third was trained for only 1-4 days.

The methodology of training has followed what is stipulated in the guidelines as it involves more of participatory methods. These included brainstorming, group discussions, role-plays, games, field visits, sharing of experiences, practical. Training manuals have been used to facilitate the cascade approach. This included the VHT participants' manual; VHT facilitators Guide; and VHT ToT guide. These training manuals are user friendly with pictorial illustrations relevant to the specific audience.

The MoH VHT (2009) guidelines recommend that in addition to the initial training, continuing/refresher training should be conducted based on the health needs as defined by the community, DHT and partners. The refresher training should target only the VHTs who completed basic training. The study established that 60,149 VHTs received programme-specific trainings by partners but not initial. The length of time for the refresher courses varied. The content included: HIV and AIDS, malaria management, maternal health, nutrition, record keeping, family planning, integrated community case management (ICCM)

In this assessment, VHTs were asked the number of additional trainings they have received. They reported the numbers ranging between 1 and 30. On average, VHTs had generally

received 6 additional trainings after the basic. Whereas these trainings have been carried out, they have not been as regular in some of the districts. In fact, the call for more regular refresher trainings was expressed quite often in the different districts such as Pader, Kamuli, Nakapiripirit, Kaliro, Tororo, Kapchorwa, Mukono, Sembabule, Kalangala, Maracha, Nebbi, Hoima, and Kamwenge among others.

Discussion

Whereas the guidelines and training manuals to support VHT trainings are in place, nearly a third of VHTs have not received initial training. This may have been as a result of a number of factors such as; lack of funds by districts to conduct initial trainings, self-appointed VHT members and selection by local leaders and by IPs, against the guideline. Such tendencies to select VHTs without the community involvement could have been due to lack of supervision by the districts. Consequently, a substantial number of VHTs may lack adequate skills to perform their duties.

The one third VHTs who received initial training in only 1-4 days imply that the training duration according to the guidelines was flouted. This may have therefore lowered the quality of the training conducted, as the training period is too short to equip the VHTs with the necessary knowledge and skills. Though the training period of five days of basic training is in the guidelines, it is however too short for the trainees to comprehend all the content and apply it. Besides, the varying education levels of VHTs affect their ability to comprehend the content of the training.

Programme-specific trainings by IPs are not harmonized in terms of standardized materials, content, duration and methods. This clearly is not in line with the guidelines on refresher training.

4.5.4 Supervision

For the purpose of this assessment, supervision refers to the oversight function of the district and lower local governments over the VHTs to ensure that they execute their roles in the guidelines.

4.5.4.1 Structure of supervision

Only 70% of VHT members reported having been supervised. Health Assistants, In-charges of health centers and Parish VHT supervisors, and some by NGOs and CDOs are reported to have conducted the VHT supervision. However, there were no reports to support this. The quarterly review meetings at the district and health centers are usually viewed as supervision activities.

However, there was reported on-spot supervision conducted by district leaders including the Resident District Commissioners, District LC V Chairmen as well as implementing partners. Routine supervision is also carried out by the in-charges of health centers and health assistants at the health centers and within the community.

> *"We have been having review meetings where the VHTs are met at the health centers and we give them feedback. Then also we have been giving them support supervision where the health worker at the health facility (in-charge) go and supervise them".* **FGD_DHT,Buliisa district**

At the national level, support supervision was found to be inadequate due funding constraints. In some instances, development partners have taken lead in VHT supervision. The districts and Ministry of Health were perceived as less involved in VHT supervision even when they own the VHT programme.

> *"The Ministry of Health has also relaxed towards follow up of VHT activities in that they have left it into the hands of partners",* **KII_ partner_Kiboga district.**
>
> *"When we don't initiate the supervision program, the district does not do it because they claim not to be having resources to conduct monitoring and supervision. This in other words tells me that these VHTs have been left in the hands of the development partners yet it was initiated by the Ministry of health as the government",* **KII_partner,_Kumi district.**

The Ministry of Health recognizes the problem of lack of supervision as stated in the quote below:

> *"Quarterly support supervision- this is not happening. It happens only when funds are available- this was last done three quarters(s) ago",* **KII_MoH**

Supervisors of VHTs according to the MoH (2009) VHT guidelines should come from HC II and HC III to which the VHTs are attached or Community Development Officers (CDOs) or Health Assistants or Health Inspectors.

However, in addition to these listed supervisors, in this study we identified that VHTs are also supervised by other structures that include the DHTs, Local councils, CDOs, VHT Coordinators, Peer Supervisors and IPs deviating from the guidelines. The selection of supervisors largely did not follow the guidelines (table 15)

> *"At grass roots level, we mobilise and actually visit activities that VHTs perform. Our local council III also helps as supervisors. They supervise VHT activities and report to us accordingly",* **KII_ Bukedea District.**

Table 15: Selection of VHT Supervisors

Selection criteria	Frequency	Percent
No criteria	24	22
One Criterion	36	32
Two criteria	27	24
Three criteria	18	16
Four criteria	6	5

Many of the district leaders reported carrying out indirect but not much of direct supervision of the VHT activities. Indirect supervision involves mandating the DHO/DHT to supervise the VHT activities and to report to the top district leaders such as Chief Administrative Officers (CAOs), LC.V and the Resident District Commissioners (RDCs).

> *"Personally, I supervise the VHT activities and even monitor them. As a district, we have our technical people the DHT, the political wing and the people in security all of whom monitor and supervise the activities of VHTs in different ways",* **KII_ Kumi district.**
>
> *"When I go down to the villages, I ask them how they are working and even check their reports and when I go to monitor other partners work like Boreholes, the element of sanitation is common and the VHTs are key, they are always elected as water source committees for the boreholes. So in that way, I supervise the VHT work",* **KII_ Apac district.**

At the community level, VHT supervision has also been undertaken by Peer Supervisors, the local Council I chairpersons and the health assistants. Peer Supervisors are VHT members who support fellow VHTs on writing reports especially due to illiteracy among some of the VHTs.

In Karamoja sub-region where illiteracy is very high among the VHTs, Peer Supervisors have been used to support the VHTs in documentation of the VHT activities such as in report writing.

> *"We created the peer supervisors to help illiterate VHTs to document reports. The peer supervisors work as supervisors to check what VHTs have done on issues of sanitation whether the community members have latrines",* **FGD_DHT, Kotido district.**
>
> *"A Peer supervisor supervises VHTs and the peer supervisors are being supervised by Health Assistants and Health Assistant are being supervised by VHT Focal Person. During support supervision stock taking is done and data management tools are checked",* **KII_Partner, Gulu district.**

Table 16 below indicates that most of the VHTs (46.5%) were supervised by the health assistants and 33.6% were supervised by health centre in-charge. This is line with the guidelines that stipulate that the central figure in supervision is a designated individual from the first referral level who has contact with VHTs on a regular basis. VHTs are directly

supervised and report to the health centres through the Health Assistants as indicated in the MoH (2009) VHT guidelines on supervision where the VHTs are to be supervised by the Health Assistants. In communities where IPs exist, it was found that the IPs conduct VHT activity supervision through the health assistants. However, some VHTs (7.6%, 3.4%) were supervised by NGOs and CDOs respectively which is also not in line with the guidelines.

Table 16: Supervision of VHTs

Supervisor	**Frequency**	**Percent**
Health Assistant	752	46.5
In charge of the health centre	543	33.6
Parish VHT Supervisor	521	32.2
Direct supervision by NGOs	189	11.7
Direct supervision by CDO	87	5.4

Discussion

The assessment revealed that VHTs are supervised at the health center IIs or IIIs or IVs and at district level as stipulated in the guidelines. However, there were no supervision check lists and reports ascertained. Supervision of the VHTs was hampered by lack of resources including funds, transport and technical capacity for supervision.

Supervision was undertaken mainly by Health Assistants, in-charges of health centers and Parish VHT supervisors and LC I Chairpersons as well as by NGOs and CDOs. The selection of VHT Supervisors was not rigorously followed in 95% of the cases. It was however difficult to ascertain whether these various supervisors and the VHT members themselves understood what supervision entails.

Therefore, the lack of supervision tools, reports and apparent understanding of what supervision entails leaves gaps in determining whether the supervision reported to have been carried out was effective. The lack of reports suggests that supervision may not have taken place. The non-adherence to the VHT Supervisors' selection guidelines therefore compromises the quality of VHT supervision.

4.5.5 Reporting by VHTs

The assessment found that VHTs fill in their registers, collate data and share their reports with the health centers where they are attached. This is illustrated in narratives from two focus groups below.

> *"The 5 VHTs at village level sit and compile their monthly report and from there a representative from the village meets the parish supervisor with other representatives*

from other villages in the same parish, they compile the parish report. Then the sub-county supervisor calls the parish supervisors and they sit with their parish reports and compile one report for the sub-county which is later brought to the HMIS focal person at the district. A copy is sent to the partners. So the HMIS person sends the report to the Ministry and this is always done on time", **DHT FGD Namutumba**.

"VHTs make monthly reports to health assistants at the facilities they are attached to then the health assistants take initiative to report to Plan Uganda and sometimes we support the health team during supervision", **KII_Partner, Plan Uganda.**

Although there is a hierarchical reporting mechanism right from the village through the parish (health centre), sub-county to the district level exists , some district such as Otuke, Sheema and Buhweju, there was practically no reporting due to the absence of a reporting format/tool and lack of training. The districts reported that they were awaiting trainings in order to start reporting.

"There are no reports because we are still waiting for a format to train and report", **FGD_DHT, Buhweju.**

The mTrac reporting system is a sms-based reporting system that combines both statistical data and some narrative. It is a government led initiative to digitize the transfer of Health Management Information System (HMIS) data via mobile phones In Gomba district for instance, it is used to accompany the paper-based reporting system.

"They (VHTs) report weekly through MTRAC. They report to the parish co-ordinator in the monthly meetings held at (the) parish headquarter", **FGD_DHT, Gomba district.**

The frequency of reporting varied among IPs contrary to the quarterly reporting required by MoH as stated by Mpigi DHT. The most common frequency of reporting for most VHTs is monthly (as outlined in the guidelines) and quarterly. However, in some few cases, weekly reports are made.

"They report to the programme, let me say, Malaria Consortium. If they say they want to report every month, they bring the reports monthly to the focal person who will have been selected by that programme to do that. Mildmay may be working with them on HIV Clinics and they report weekly. PACE is working with them to mobilise people for the positive living services, they report monthly. So it depends on the programme they are involved in". **FGD_DHT, Mpigi district.**

It was also established that some districts were defaulting on their reporting roles to the Ministry of Health. This is because the VHT focal persons in such districts were failing to submit reports to the Ministry of Health.

“Some focal persons do not share reports with the centre”, **KII_MoH**

4.5.6 Reporting tools for VHTs

A sample of a VHT register, Kabale district, 29-11-2014

The study established that the tools used for reporting by VHTs include registers, summary sheets from HC IIs and districts and computerized data base in which data are entered into a spread sheet by Health centre staff.

Paper-based forms for reporting were found to be the most commonly used in most districts. Reporting tools were mostly found with implementing partners. The tools were tailored to suit the programmatic priorities of each respective implementing partner.

> *“We give VHTs tools to use during field activities and then use the tools to evaluate the programme, for example, the number of mothers referred and tested and then those that have obtained nutrition counselling are obtained from the outreach tool”,* **KII_partner, Namutumba district.**

The assessment revealed that IPs such as World Vision and, districts such as Butambala, Bukomansimbi, Gomba, Moroto, Kyankwanzi, Kiboga and Wakiso have adopted and are using mTrac sms reporting system.

Table 17: Level of VHT Report Submission

Report submitted to:	Frequency	Percent
Health centre II	977	49.9
Health centre III	805	41.1
Health centre IV	123	6.3
District	21	1.1
Partner	32	1.6

The vast majority of VHTs submit their reports to Health center II and III. A few VHTs submit their reports to the districts and implementing partners (table 17).

Discussion

The assessment showed a hierarchical reporting from the village through the parish (health centre), sub-county to the district levels. However, in some districts such as Otuke, Sheema and Buhweju, there was practically no reporting due to various reasons including the lack of tools and lack of training. The study however did not determine whether the hierarchical reporting existed in every district. The absence of reporting tools and training on reporting constrained reporting and suggests the need for capacity development in this area.

Various reporting formats and tools were used including mTrac. However, paper-based forms for reporting were found to be the most commonly used in most districts. Reporting tools were mostly found with implementing partners. This implies that reporting took place based on availability of tools in settings and programmatic priorities of implementing partners. It may also imply that VHT supervisors at health center levels could only exercise limited supervision on VHT reporting. The inadequate reporting tools, existence of various implementing partners and reporting formats coupled with low education level of some VHTs therefore suggest that there was irregularity and poor quality in reporting.

4.5.7 Coordination of VHT programme

The assessment found that the DHOs have the overall mandate for coordinating the VHT programme within the district. They specifically assign a district VHT focal person to be responsible for VHT coordination, training, monitoring and supervision. The District Health Educator (DHE) was designated that role in most districts. However, coordination meetings

and support supervision at lower levels have been irregular. Even at the national level, coordination was recognised as a gap in the VHT programme.

> *"There is a national committee that should meet quarterly but this has not been regular. These meetings incur costs and therefore need funds for the meeting",* **KII_MoH**
> *"Coordination became poor, there was no steering committee in the MoH, we did not know who was training and where, there was weakness at the central level for effective training, monitoring and evaluation; there was no effective leadership at the Ministry of Health",* **KII_MoH**
> "*Coordination is also a problem in some areas; you don't find health assistants who should be in touch with VHTs in terms of supervision",* **KII_Manafa district**

Discussion

There are VHT operational guidelines in place to support coordination mechanisms. However, poor coordination has arisen due to human resource and financial constraints mainly at national and district levels. The irregularity of the quarterly national steering committee meetings could have led to increasing gap in VHT coordination with and within districts. Lack of coordination led to poor supervision of IPs and their activities.

4.5.8 Referrals

For a functional VHT programme, an efficient referral system should be in place to determine when a referral is needed, the logistics plan in place for transport and funds when required and finally a process to document and track referrals. The Ministry of Health guidelines identified two levels of referral.

Routine referrals: non-urgent conditions include:

- All conditions without danger signs for which the VHT has received training/instructions to when and where to refer
- All conditions without danger signs for which the VHT has not received specific training, or if the VHT does not have the necessary medications
- Routine outpatient or outreach referrals for Immunisation, Antenatal Care, Post-natal care (Mother and Infant)
- Referral of children >6months with mid arm circumference (MUAC) yellow.
- All conditions which require rehabilitation e.g. after injury, patients with leprosy.
- Clear guidance must be given to VHTs on where to refer non urgent cases.

Emergency referrals:

This should be to the nearest health facility. These include conditions that require urgent treatment such as:

- All Pregnant women (obstetric emergencies), new-borns or children or other person with danger signs including red on the MUAC strap.
- Anyone with sudden recent loss of visual acuity, or a painful red eye or recent inability to close the eye
- Accidents or injuries.

This assessment established that VHTs have played key roles in identifying and referring under five children and sick community members to the health facilities.

> *"VHTs link communities to health centres through networking and referral systems for diseases like HIV/AIDS, maternal and reproductive health problems, for antenatal (care), immunisation",* **FGD_DHT Namayingo.**
>
> *"They move in the community and give health education thus they come in contact with those who have had cough for like two weeks and refer them. T.B, HIV patients who are on treatment are also referred. They also refer clients with diseases which they have never had prior training on or if he/she doesn't have the necessary medication for that particular disease",* **KII_In-charge HC III, Kisugu.**

VHTs also accompany sick patients to health facilities such as pregnant mothers, youths and dog bite patients as were reported in Bukwo district.

Over all, VHTs have been trained on referral forms and are actively involved in the referral of patients to health facilities. However, in some health facilities, some health workers have had negative attitudes concerning the VHT role of referring patient's as explained in Namutumba district. This concern was voiced in Soroti, Kween, Nebbi, Mubende and Gulu districts.

> *"Some health workers have failed to understand the strategies of VHTs. Some even demotivate them by asking them, 'who are you? What did you study? And even throw away the referral forms",* **FGD_DHT, Namutumba district**.
>
> *"Some health workers think VHTs want to take their work so they do not work hand in hands with VHTs. They do not appreciate VHTs",* **FGD_DHT, Mubende district.**

This negative perception could be due to the lack of sensitization of health workers on VHT roles and or coordination amongst VHTs and health workers. Some community members also have similar negative attitudes towards VHTs.

> "*Some communities don't understand VHT roles and thus chase them away from their homes. Someone says, I know you, what do you also know about health, go away. They lack recognition",* **KII_Bududa district.**

Nearly 9 in 10 VHTs (91.4%) referred clients using the common approaches of filling out the referral forms (77.8%) and writing in the book (22.2%). VHT-members following up of the referral to the health facilities were almost universal (97.2%). The most commonly reported referred conditions were pregnant women (42.5%), under-fives (31.8%) and clients on long-term treatment (17.0%) as shown in table 18. Facilities usually patients where patients are referred were government health (97.4%) or private (2.6%) health.

Table 18: Clients Referred by VHTs in the Last Six Months

Support	Frequency	Percent
Pregnant women	1108	42.5
Post-natal mothers	227	8.7
Clients on long term treatment	444	17.0
Under five	829	31.8

Discussion

The assessment established that most of the VHTs referred clients to health facilities. However, the assessment also found out that Health workers sometimes did not respect referrals made by VHTs. This emanated from the fact that VHTs are considered people of low education who are not competent in disease management as they are not medical personnel.

It was not clear whether referrals made by VHTs were effective as well as recorded by the service providers at the health facilities. In addition, the assessment found that there were other concerns that affected effective referral such as lack of medicines in and transport means to health centers.

4.6 Approaches for Motivation Mechanisms and arrangements (Objective 5)

4.6.1 Volunteerism in the VHT programme

VHTs are known or perceived by the district leaders as volunteers and non-government employees. Thus they are not supposed to receive salary. This concept of volunteerism has been a demotivation factor as the VHTs now think that they should be paid for their services. This has attracted the attention of different stakeholders who think that VHTs should be paid.

> *"The VHTs have been voluntary, voluntarism can't continue forever",* **KII_MoH**
>
> *"They will begin the work very well but they will see themselves not gaining because of volunteerism within the shortest time period. So they will also start comparing themselves with others and the work they do and say we are doing a lot of work for these people for nothing. And then they relax",* ***FGD_DHT, Moyo district.***

"Government should motivate VHTs, they should be given some monthly allowance", **FGD_Community, Hoima district**

"Volunteerism is a problem. It has been over taken by events. It first worked because they first expected to be salaried employees over time, and other incentives such as scholarships and absorption in the civil service", **KII_MoH**.

Due to the ineffective roll out of the minimum package for VHT motivation mentioned above, some of the VHTs have lost enthusiasm and dropped out of the programme. However, their replacement was a problem as districts lacked funds to train the new recruits in their roles.

"Their contribution is fundamental. They are doing a good job and if we had resources, we would pay them. They are doing what we could not do in their villages", **KII_Mbale district.**

4.6.2 Motivation of VHTs

MoH has defined this minimum motivation package for purposes of identity, cultivating a sense of achievement and recognition (MoH, 2009). Motivation entails instituting and reinforcing mechanisms that recognise and appreciate the contribution of VHTs to their communities.

The 2009 Ministry of Health operational guidelines recommend a minimum package for VHT motivation (Box 1).

Box 1. Incentives for VHTs in Uganda

- Basic requirements to carry out VHT function (Standardised VHT uniform, ID, Standardised bag and kit using MoH VHT logo. Lunch and travel allowance whilst carrying out outreach and visits to health centre).
- Health worker supervision and mentoring – technical support
- Activity and performance related incentives
- Recognition by Authorities and their own communities-
- Advocate and support for VHT to access Government programs, income generating schemes and other microfinance and credit schemes
- Community reward – such as community digging, seeds, livestock

To motivate VHTs, the districts and IPs have used a combination of monetary and non-monetary incentives. The most commonly used motivation were provision of allowances, official recognition, capacity building, and provision of supplies, medicines and equipment to facilitate VHT work, certificates and income generation activities.

Monetary Incentives: Financial incentives have been provided in the form of allowances mainly given during activities or events for transport, lunch provision and bicycle maintenance. Partners provided forms of motivation that included transport and feeding allowances.
The allowances ranged from as low as 2,000 Ushs to 25,000 Ushs per activity. On the other hand, some of the allowances are provided on monthly or quarterly basis ranging from between 25,000UGshs to around 100,000 Ushs. However, it was not possible to establish the proportion of VHTs who were getting allowances.

Financial support has also been provided to VHTs in the form of education support to the children of VHTs who cannot continue going to school because of lack of school fees VHTs have been encouraged to form their own SACCOs and VHT associations for income generation. In some districts, VHT associations have been contracted to provide edutainment from which they can earn some payments. Some districts rely on implementing partners to provide financial and other forms of motivation to the VHTs.

> *"The district simply relies on NGO support. But as a district, there is no budget for VHTs which makes it impossible for the district to fund VHT activities. The district cannot even afford to print t-shirts to identify them…NUHITES also uses the VHTs and currently it is the only NGO that actively supports them",* **KII_Nwoya district.**
>
> *"Motivation comes from partners through the district. While Yumbe district is really willing to give their total support to VHTs, the only challenge is lack of fund from the District"* **KII_CAO, Yumbe district.**
>
> **"W***e train VHTs, give them transport refund when they come for any activity, feed them and provide VHTs with accommodation also so that they don't spend their money",* **KII_LC.V, Nwoya district.**

Non-Monetary incentives

Logistical forms of motivation have been provided either through MoH support to the districts or through IPs operating in the districts. The Logistics provided to the VHTs included among others, bicycles, t-shirts, torches, gum boots, rain coats, lunch and transportation as well as hand bags.

> *"The district has no specific budget for the VHTs but we have given them bicycles to facilitate their transport. We also give them t-shirts and small allowances when new projects are brought to the district by the different partners"* **KII, Lamwo district.**

A sample of VHT T-shirt, Kibuku district, 10-12-2014

Gum boots and umbrellas for VHTs in Butalejja district, 26-11-2014

In some districts such as Kaabong and Soroti, the community members reported having provided food to VHTs while conducting community mobilization.

> *"Sometimes, I cook tea for VHTs or roast ground nuts for them as they pass around while on mobilization tours. I have ever given one a hen after making for her orange juice because she was hungry"*. **FGD_Community, Soroti district.**

In practice, the moral support have majorly been in the forms of appreciation by words of mouth, giving titles to VHTs e.g. super VHT, priority in accessing health services, public recognition on mass media or at public events and encouragements.

> *"We always tell them that they are the best at what they do"* **KII_Otuke district.**
>
> *"We recognise them on national occasions such as the Independence Day. We give speeches in honour of what they do for the community and appreciate them",* **FGD_DHT, Pader district.**
>
> *"We give them simple recognition. We appreciate them at the end of the year e.g. we write an appreciation certificate so as to boost their morale. Also we recognize them during public functions and this makes them feel respected",* **KII_Mpigi district.**
>
> *"The district encourages the VHTs to form groups and some of them have benefited from government programs like poverty alleviation fund"* **FGD_DHT, Masindi district.**

DHTs from Nakasongora, Kamuli, and Luwero and Lamwo districts reported that priority is given to patients referred by VHTs at health facilities which motivated the VHTs in their work.

> "*…VHT is the core. For us to improve on maternal child health, we needed really to have functional VHT. And for us to have functional VHT there must be means to motivate them because that is where normally problems will come. So we should have really something in place right from the ministry of health since they are part of the system. To make the whole system function, there must be some budget, much as they are many there must be a budget maybe for monthly meetings. And then, they don't need much then we can get something once in a while maybe like T-shirts yearly to motivate them. Every year you can give them a T-shirt, the way we are doing it to LC1's, like every year they get like 120,000 if we really want to improve the health system",* **FGD_DHT, Kitgum district.**

Other non-monetary forms included:

Capacity Building

Various ways of capacity building were identified. These included:

- Support supervision, Trainings, Mentorship, Exchange visits, meetings, involvement at Health facilities
- Feedback from referrals from health facilities
- Participation in data collection & surveys

"Refresher trainings by the health department, DHI office and district partners. There is also a current support from Amatheone-Agric, an NGO which has come up to support famers but they are interested to link-up with the VHTs to provide health services needed to their potential farmers, mainly in building the capacity of the VHTs to help in the hard to reach areas. Amatheone-Agric support is directly to farmers and may support VHTs with transport but not money", **KII_Nwoya district.**

We note that while these various forms of motivation have been provided to the VHTs, they have largely been irregular and none uniform as have been the case with financial and logistical forms of motivation. The motivation also varies from IP to IP and from district to district.

"Incentives were not well defined. It would depend on the donor or government programme. The incentives were not consistent; the system of distributing incentives was not organized. Turn over became so much and drop outs were very high", **KII _MoH**

"The motivation is lacking, (there are) no standard incentives that are given; they vary", **KII_Partner, Pathfinder.**

"There is Mildmay Uganda, Profam, TASO and also Uganda Care. These IPs work in some regions. But most of the time you find it is the same VHTs that are picked repeatedly, so they are very motivated while others are not. Every partner wants a VHT that is literate and can write a report, not starting from scratch to train them", **FGD_DHT, Masaka**

As such, the irregularity, non-uniformity and variance in form and substance of motivation have been de-motivational other than motivational to some of the VHTs. The result of this has led to drop out and inactiveness as well as poor relations among the VHTs. Thus to some extent, this fragmented way of motivation has to some degree impeded the functionality of VHTs.

"Different rates of facilitation of the VHTs i.e. Strides facilitated them with 12,000 UGX while the Local Government was giving them 6,500 UGX. They tend to run to partners who give better facilitation. Since not all of them are taken on by partners, they end up dropping out of the system", **FGD_DHT, Kasese district.**

"..bicycles given did not go to all VHTs; only one VHT in every village. That also caused a challenge because it demotivated the other VHTs. A coordinator was almost beaten sometime. He had to come up with a list of members who had not got bicycles", **FGD_DHT, Ibanda district.**

While various kinds of logistics were provided to facilitate VHT work such as torches and bicycles, in some instances they were reported to be of poor quality, with no spare parts.

4.6.3 Suggested VHT motivation mechanisms and arrangements

Various VHT motivation mechanisms were suggested by the community members, VHTs, partners, district health teams (DHTs) and district leaders.

1. Establishing a standardized and regular financial way of motivating VHTs
2. Recognition and appreciation of the contribution of VHTs by both the central and local governments
3. Capacity building in the form of educational short courses, trainings and mentorship
4. Provision of a conducive working environment for the VHTs in terms of
    a. Ensuring cordial relationship between VHTs and the formal healthcare workers
    b. Provision of essential supplies such as uniforms, bags, gum boots, umbrellas, identity cards, bicycles, among others
    c. Provision of special rewards for VHT work
5. Provision of planned and well executed regular supervision
6. Engaging the VHTs in economic empowerment activities such as savings and credit cooperative societies (SACCOS)
7. Ensuring safety and security of VHTs especially during epidemic outbreaks such as viral haemorrhagic fevers, e.g., Ebola and Marburg. This includes provision of protective gears
8. Provision of appropriate transport means for hard-to-reach areas such as hilly and island areas
9. Involvement and engagement of VHTs in the national activities e.g. National Immunization Days (NIDs), Child Days Plus (CD+)

Discussion

The provision of monetary and non-monetary incentives to VHTs contributes to motivation and retention of VHTs. While the VHT Operational Guidelines stipulate the various forms of motivation for VHTs, it does not explicitly describe how these should be equitably distributed and who should provide these incentives. For instance, the financial forms of motivation did not have the educational level required and yet government does not pay workers without formal education. The minimum package did not stipulate a salary but a reimbursement of costs for transport or for meals. In addition the MOH guidelines did not provide clarity on what constitutes activity and performance-related incentives.

While there are economic and social benefits of volunteerism, maintaining the VHTs to perform their functions can be eroded over time if some basic needs are not met. Some VHT who volunteered had high monetary expectations and if these were not met, some dropped out of the VHT program. Some of the materials provided were just tools but were not meant for motivation. Although those materials were meant as materials to facilitate VHT activities, they provided motivation to VHTs. The study found that there are certain things beyond what was thought as motivation to VHTs. Qualitative data showed that there is an overwhelming demand for a harmonized and regular financial form of motivation for the VHTs.

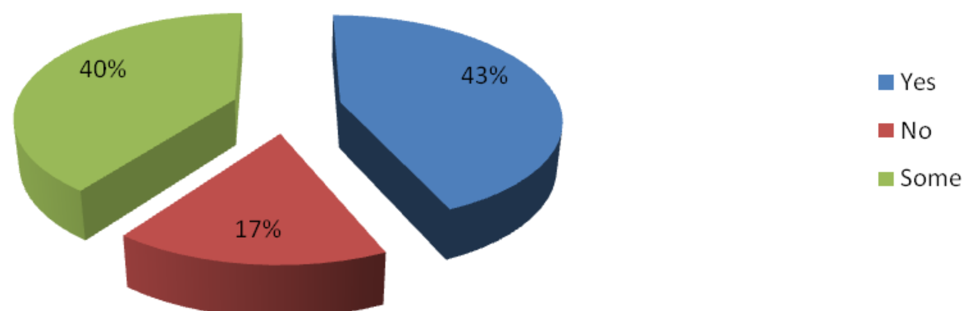
The various ways of motivation are not uniform thus creating disharmony at the district level and among the VHTs hence making coordination ineffective. Although the MoH, Partners and IPs are providing different kinds of motivation, there is no system for tracking the different motivation packages and support for VHTs hence there is need for harmonizing motivation approaches and packages to address these anomalies.

Various ways of motivation of VHT members as seen above were suggested by different stakeholders including VHT members. The proposed idea to establish a standardized and regular form of financial forms of motivation to VHTs calls for the need to undertake a proper planning to prepare for it. Government and its implementing partners will need to consider the sustainability of these forms of motivation and their implications on the number of VHTs in place.

4.6.4 Existing equipment and supplies for VHT

Forty three percent (43%) of VHT members reported possession of supplies and equipment for use in their operations (Fig 5). An almost equal number reported possession of some of the supplies and equipment needed to perform their duties. However, it should be noted that the number of VHTs that reported possessing all the supplies and equipment was less than half of the total sample.

Fig 5: Possession of supplies and equipment



The results of assessment indicate that VHTs possessed more of material supplies and equipment than medicines/drugs (Table 19). Supplies and equipment such as registers, badges, t-shirts, bags and bicycles were possessed by more VHTs compared to drug related supplies such as Coartem, ORS and NTD drugs as well as family planning supplies such as condoms.

Table 19: Supplies and equipment possessed by VHT members interviewed

Supplies and Equipment	Frequency	Percent
Badges, T-shirts, Bags	1401	65.3
Register	1394	65.0
Bicycle	1206	56.2
Report book	770	35.9
Condoms	611	28.5
ORS	418	19.5
Amoxicillin	371	17.3
Zinc	338	15.8
Coartem	316	14.7
NTD drugs	295	13.7
Respiratory timers	199	9.3
RDT kit	186	8.7
Gloves	183	8.5
IEC materials	154	7.2
Mobile phones	129	6.0
Identity cards	57	2.7
Tippy tap materials	32	1.5

Solar chargers	28	1.3
Wrist watches	23	1.1

The majority of the VHT members interviewed kept their supplies in wooden boxes. They reported that this was one of the safest ways to keep the supplies.

Discussion

Whereas a number of equipment and supplies have been availed to VHT members, they appear to have been more focused on the health promotion and community mobilization roles of VHTs but not treatment roles. This situation may imply that some of the treatment needs of the community members cannot be adequately addressed by the VHT members due to stock outs.

4.7 Functionality of the VHT Programme (objective 6)

Functionality of the VHT programme was assessed at four levels: national, district, community and individual VHT members. The study defined VHT programme functionality at national and district levels as the capacity of the Ministry of Health and district health teams to plan, manage and supervise VHT activities at national and district levels. At community level, functionality was defined as the frequency of interaction between the VHT members and the health facility to which they are attached, the existence and knowledge about VHTs by the community members and the benefits that accrue to the community as a result of the VHT programme.

At individual level, functionality was defined as the capacity and practice of the VHTs to perform duties assigned to them in line with the guidelines. Four indicators were used to assess functionality at individual level that includes participation in coordination meetings, reporting, referrals and supervision.

4.7.1 Functionality of the VHT programme at national level.

At the national level, functionality was assessed using six indicators that include; policy environment, investment, governance, coordination, supervision and training.

4.7.1.1 Policy environment

The concept of VHT was conceived and included in the second Health Sector Strategic Plan (HSSP 2000 – 2005). The VHT concept evolved from the WHO Primary Health Care Framework to optimize health services to communities through community health workers.

In the Health Sector Strategic Plan, the VHT constituted the health centre I with no formal physical structure. The role of the VHTs was to mobilize communities and carry out health promotion. The role of the Ministry of Health was to coordinate training and provide guidelines and information. Although some policy instruments refer to community health, there is no clear policy that addresses VHTs. The lack of harmonization in motivation, trainings, and coordination

is a result of the lack of clear policy which explains how each of these aspects should be operationalized.

4.7.1.2 Investment in VHT

The Government of Uganda made some efforts to invest in the VHT programme since its creation. This is reflected in the allocation of funds to the VHT programme. Over time, the Ministry of Health has provided a budget for VHT implementation. However funding for VHT programme has been declining leaving the partners to fund most of the activities.

> *"There is a budget line since the creation of the VHT strategy. However funding kept reducing from about UGX 800 million per year at the start of the programme to less than UGX200 million per year in the last two years. The Central funding allocation is to train VHTs, coordinate and supervise VHTs. The low funding thus constraints these roles", even the little money allocated is never accessed* **KII_MoH.**

The assessment established that the money released by government in a financial year to train VHTs in the country is not sufficient to train VHTs even in one district. As of January 2015, the VHT coordination office had not accessed any money for VHT implementation for the financial year. However, the government has working arrangements that allow partners to contribute to the VHT programme. The partners are supposed to facilitate district staff to conduct VHT activities. Various partners have contributed financial, logistical and technical resources to the VHT programme. These partners include, among others, the UN Agencies such UNFPA, UNICEF, WHO, UNDP, etc., World Bank, Implementing agencies such as Pathfinder International, Plan International, World Vision Uganda, PACE, Marie Stopes, AMREF, AVSI, etc. (Appendix 6.2).

The extent of investments by partners into the VHT programme was reported to be significant. However the total package of partner specific support could not be determined by the assessment. They provide financial support annually to various organizations to implement VHT activities. Such support is used to conduct training, logistical supplies, supervision and motivation.

4.7.1.3 Governance

In 2014, the VHT section of Ministry of Health was separated from health promotion and education division and made answerable directly to the Commissioner of Community Health. A coordinator was put in place to coordinate the strategy at national level. The coordinator reports to the Commissioner, Community Health. The Commissioner reports to the Director Clinical and Community Health. The Director Clinical and Community Health then reports to the Director General. This hierarchy is in place and functioning.

4.7.1.4 Coordination

There is a national VHT coordination committee at the MoH comprising of Ministry of Health staff, UN agencies and the major implementing partners. The committee is mandated to meet quarterly. The functions of the committee include; reviewing of VHT technical guidance, information sharing by implementing partners, and getting to know who is doing what in the VHT strategy.

The assessment indicates that this committee does not meet regularly as mandated. For example, since February 2014, the committee only met once in November 2014. The coordination office is not facilitated in terms of personnel and facilities to ensure regular meetings.

The assessment established that there though there is a revised VHT strategy (2011), it has not been rolled out to the districts and to the partners. The districts still rely on the 2009 draft guidelines.

4.7.1.5 Supervision

The Ministry of Health is mandated to supervise the implementation of the VHT strategy in the country. The Ministry is also required to supervise implementing partners in terms of the activities and how they implement them. However, the assessment results indicate that due to lack of funding and inadequate personnel, such supervision has not been regular. For example, in the financial year 2014/15, no funds have been accessed for supervision.

4.7.1.6 Training

According to the MoH, ToTs have been conducted in all the districts apart from Kampala district. During the ToTs, district trainers are trained who in turn train VHTs. Most of the ToTs were conducted in the first ten years of the programme. However, due to financial contraints, the district trainers have not conducted basic training to all the VHTs. It could also be that those VHTs without basic training are those who were selected outside the selection guidelines.

Discussion

Lack of funding is a major challenge to the VHT activities at national level. As a result, coordination, and supervision of VHT activities have not been adequately done. Training of VHTs has not been completed in all the districts as a result of lack of funding. Lack of personnel in the coordination office has created a huge gap where the national coordinator is expected to do all the coordination work.

The MoH does however have other opportunities for supervision such as the Area Team supervision where VHT activities have been supervised but this is also irregular due to

inadequacy of funding. Area team supervision is integrated health supervision in the Ministry of Health. The team looks broadly at broadly at health service provision and is under the mandate of Quality Assurance Department in the Ministry of Health. Overall, at national level, the VHT national coordination office is poorly facilitated to enable it efficiently implement the strategy as stipulated in the guidelines.

The lack of policy to guide implementation of the VHT strategy has complicated the operations of the programme in terms of adequate funding, supervision and coordination. The lack of coordination has left gaps in the programme. For example, the MoH has failed to roll out the revised strategy (2011) and this has left districts relying on the draft one of 2009.

4.7.2 Functionality of the VHT programme at district level

Functionality of VHT programme at district level was assessed using data generated from the interviews with VHT focal persons. Functionality was based on responses to the core areas of recruitment, training, coordination, supervision, financing and documentation. The core indicators were: guidelines for recruitment of VHTs, availability of active VHT trainers and basic VHT training. In addition, coordination and supervision indicators were weighted more than the other indicators with each having a maximum of four points.

As shown in Table 20, most of the districts (80%) that conducted the initial training for the VHTs were able to follow the guidelines for recruitment of VHT. However, only two-thirds of the districts were able to conduct VHT initial training and had active VHT Trainers. Although 44% of the districts reported supporting VHT activities financially, less than 20% of the district committed funds in the district budget. It was unclear if the funds committed in the budget were later disbursed for VHT activities. Regular and consistent coordination meetings were held in only 40% of the districts.

Table 20: Indicators of VHT Functionality

Indicators of functionality	n	Percent
Selection following guidelines		
Yes	96	84
No	15	13
Missing	3	3
Conducted VHT TOT		
Yes	95	83
No	16	14
Missing	3	3

Have active VHT Trainers		
Yes	72	63
No	35	31
Missing	7	6
Ever conducted Refresher Courses		
Yes	78	68
No	32	28
Missing	4	4
Districts funding VHT implementation		
Yes	50	44
No	59	52
Missing	5	4
District that allocated funds for VHTs in their budget		
In Budget	18	16
No Funds	92	81
District that conducted Coordination Meeting		
Yes	70	61
No	37	32
Missing	7	6
Regularity of Coordination Meetings in the last I year		
None	39	34
1 meeting	15	13
2 meeting	16	14
3 meetings	12	11
4 four or more	32	28

Discussion

Although the majority of the districts followed the guidelines in recruitment (84%), carried out ToTs (83%), has active VHT trainers (63%) and conducted refresher training (68%), the VHT programme is lacking district funding thereby making it less functional in coordination and supervision activities.

4.7.3 Functionality of the VHT Programme at Community Level

A majority of communities interviewed reported the existence of VHTs in their villages with exceptions of urban areas such as Soroti & Mbarara municipalities and Kampala city.

"We do not know the work of VHTs we just see them at the facility and if we want medicine they give us medicine and we go. But we basically do not know what they do there and what they are supposed to do". **FGD_Community, Kampala district**

The communities commonly referred to VHTs as village doctors, community health workers and health promoters arising from the roles and services performed by VHTs such as treating children under five years, immunization, distribution of drugs and promotion of hygiene and sanitation.

"Those community health workers are good. They mobilize us to maintain hygiene, construct toilets, drying lines and rubbish pits and also distribute nets". **FGD_Community, Butaleja district**

Generally, the community perceived VHTs as committed and passionate about their work. In a number of instances, community members reported having provided VHTs with food, transport and free water from bore holes in appreciation of VHT work to the community.

"They are really so committed and helpful because you find them and tell them of the disease affecting your child and they take it as an initiative to come to your home to extend treatment to the child. They really work because they have record books and here at the health center you find our names in those record books and this justifies how they work hard". **FGD_Community, Kyankwanzi district**

"Before we can inform the VHTs trust me they will have known. These people are very good at their work". **FGD_Community, Hoima district**

"VHTs are allowed to get water freely from the community bore holes in appreciation of their good work". **FGD_Community, Moroto district**

To a large extent, the services provided by VHTs were considered commensurate to the needs of community members. Community members reported improvement in hygiene and sanitation, uptake of immunization, antenatal care and HIV services and reduction of illnesses and deaths in the community as direct efforts made by VHTs

*"I used to suffer a lot from typhoid because I never had to boil my water but now I boil my water and I do not fall sick anymore. Even my children do not fall sick of malaria anymore". **FGD_Community Mbale district***

*"What VHTs have done initially, initially children used to suffer from measles and one thought it was witchcraft, however when these people came, they encouraged parents to take their kids for immunization, they have advised pregnant women to go for antenatal services". **FGD_Community Gomba district***

"Even those VHTS the big job I see them doing in the community is that people in the community used to fear to go for HIV Tests because they would stay in the village and fear to disclose their sickness but when the VHTS find out about them they go down to them in the village, counsel them and create for them conducive grounds of which finally the people who have HIV come to the health centre to carry out tests. But now ever since that happened you find that people have gained courage and confidence and come to the health centre to get tested because of the counseling they got from VHTS. You see they are now better people compared to how they were before they came for testing". ***FGD_Community Luwero, district***

Although community members largely considered VHT roles as meeting community needs, there were instances where the services provided did not meet community expectations as cited in the extracts below;

"They used to perform their duties but now these days we don't know if there was change in leadership at the top most because for sure drugs are no longer available at all. And if you go with a child you find they have no medicine and you bring the child to the health center". ***FGD_Community, Kyankwanzi district***

"Some people tell VHTs that "you who did not go to school, how do you teach me about latrine construction, you come here for my wife". ***FGD_Community, Kamuli district***

"In town many people are wiseacres they do not mind about people who come to talk to them about health, they just wait till when their children are sick and they go to hospital so they do not give any attention to VHTs". **FGD_Community, Kampala district**

Lack of drugs and low levels of education of some VHTs have contributed to negative perceptions of community members towards VHTs in communities. In addition, VHTs are largely existent and known in rural settings compared to urban settings.

Discussion

The majority of the rural community members interviewed reported the existence of VHTs in their communities. To a large extent, the services provided by VHTs were considered relevant to the health needs of community members. Community members reported improvement in hygiene and sanitation, uptake of immunization, antenatal care and HIV services and reduction of some illnesses and deaths in the community as direct efforts made by VHTs.

This therefore implies that the VHT programme is perceived to be functional by the rural communities. However in the urban setting, the communities did not know much about the programme since the VHTs do not visit their homes. This brings into question the functionality of the programme in the urban communities.

4.7.4 Functionality of Iindividual VHT Members

The individual VHT member functionality was assessed based on the following criteria: access to equipment and supplies, VHT referral and follow up, supervision and reporting.

Table 21: Functionality of VHT members

Indicator of functionality	n	Percent
VHT referral and follow up		
Conduct referral and follow up	1779	68
No referral or follow-up	831	32
VHTs being Supervised		
Yes	1787	70
No	781	30
VHT submitting Reports		
Yes	2370	91.2
No	228	8.8
VHT Participation in coordination meetings		
Yes	2038	79
No	545	21

Table 21 indicates that majority of VHTs referred clients to health centres (68%), were supervised (70%) and were reporting (91%). The reporting tools were majorly provided by IPs. Less than 50% of the VHTs reported having all the equipment. However, there was no evidence of support supervision reports to the district. The VHTs also reported multiple reporting formats from partners which became a burden to VHTs especially those with low or no education.

Discussion

Although most of the VHTs reported to have been supervised, there was no evidence of support supervision reports to the districts. VHTs reported being supervised by health workers at health center IIs. However, these health workers lack facilitation in terms of transport and may not be adequately trained for this purpose. The quality of supervision may therefore be low. The VHT members also have multiple reporting formats from partners which became a burden to VHTs especially those with low or no education.

4.7.5 VHT drop outs (Attrition)

For a VHT to be considered as a drop out, he/she no longer carries out any role related to the VHT programme in the community where he or she was trained. The assessment found that of

the 56 district VHT Focal Persons who provided information on VHT drop outs, there was about 30% VHTs dropped out (Table 22). As noted, this is a reported figure and we did not have the necessary documentation to verify this. The Northern region had the highest attrition due to camp decongestion and resettlement of former Internally Displaced Persons (IDPs) which led to relocation and eventual drop out of some VHTs. Other causes of the drop out were: change of residence, death, employment, low motivation and marriage.

> *"In other cases, VHTs were trained but they drop out. Others shift to other areas such as Kampala and others die yet they haven't been replaced. We also need more VHTs. The ones we have are not enough. The district does not have funds specifically allocated to the VHT programme and therefore facilitation of VHTs is not easy",* **KII_Rukungiri district.**
>
> ***"****The high attrition rate is due to volunteerism. The VHTs are not seeing this programme as motivating. Some VHTs prefer doing something where they get some money and so others have gone to South Sudan",* ***FGD_VHT, Moyo district.***

Table 22: Number of districts that reported VHT dropout rate region

Region	Frequency	Mean dropout Percentage
Northern	14	38
Karamoja	02	03
Eastern	16	27
Central	14	28
Western	10	26
Total / Mean	**56**	**30**

A 30% drop out rate is high and affects the functionality of the VHT programme in as far as the number of people to conduct community health activities and the costs of recruiting and training other replacements and performance of VHTs are concerned.

4.7.6 Sustainability of the VHT programme

The VHT programme has had a quite significant effect on the improvement of the delivery of primary health care services to the communities in Uganda. Such activities include hygiene and sanitation improvement, immunization, indoor residual spraying, HIV/AIDS, TB and malaria, family planning, maternal and child health and NTD services. These services have been appreciated by the some community members, the district leaders and the healthcare workers. Moreover, the community members participate in the selection of VHT members, thereby creating a sense of ownership in the process hence providing a ground for sustainability.

However, several challenges with sustainability of the VHT programme were reported as illustrated in the excerpts below;

> *"MOH does not have clear harmonized position for financial sustainability of the VHT program",* **KII_MoH.**
> *"Government should encourage partner to use VHT but the VHT should be controlled by the Government",* **KII_MoH.**
> *"Funding is the root cause of all the challenges VHTs are facing because without funds activities like supervision capacity building and motivation would be hard or near impossible to implement",* **KII_Mbarara**

In its current form, the programme is not sustainable as it is highly dependent on IPs. There is need to ensure that the VHT programme is not dependent on volunteerism and financing mechanisms are put in place, harmonized and sustained.

> *"Partners can come together and have a VHT fund. This VHT fund can be put in a basket and then we know that from this district for the VHTs, there is this fund and the districts can break it down to ensure that the whole district is covered, the tools are harmonized and all the VHTs are remunerated depending on how much money is available",* **FGD_DHT, Kamuli district.**

Discussion

Dropout rates

The high dropout in the North (38%) may be due to the fact that the camp situation brought many villages together and the trainings provided to VHTs then may have only benefitted VHTs from some villages and not others. The VHT training started about 15 years ago in northern Uganda compared to other regions. The VHTs may have naturally dropout due to other employment, death and retirement. The high expectation on benefits from the programme may have caused high attrition when the expectations were not fulfilled.

Low drop out in Karamoja region was reported by two districts. VHTs in Karamoja were trained in the last five years and may be a reason why there is low drop out as compared to the Northern region where VHTs were trained over ten years ago.

Secondly, there is more support being provided to VHTs in Karamoja region under ICCM programme by UNICEF. However, this study did not correlate the low drop out in Karamoja region and service delivery or health indices.

Sustainability

The VHT programme seems unsustainable due to heavy dependency of partners. The MoH does not have a clear harmonized position for financial sustainability of the VHT program.

4.0 Discussion

Number and Socio demographics

The assessment revealed that there are a total of 179, 175 village health team members in the 112 districts with only 119,026 who have had the basic training. These are estimates as reported by the District VHT Focal Persons. With 57, 735 villages in Uganda, this translates into 3 VHTs serving a village.

This figure, however, may be inaccurate since there are some districts such as Kibuku, Kampala, among others that have not carried out the basic VHT training. The number of VHTs are as reported by the districts and could not be independently verified. The regional imbalance in VHT distribution in VHT coverage requires government to conduct VHT training in districts that have not yet had their own trainings to ensure equitable delivery of health services.

The assessment found that just over a half (52%) of VHTs were below 40 years of age. They are able to sensitize the communities on health promotion but also do other health related activities. This age bracket may be more susceptible to attrition as they are considered more energetic and mobile. Some of the VHTs were fifty years or older, a factor that may have led to inefficiencies with regards to report writing and swift movement during mobilization activities. For example, administrators in districts such as Kalungu, Butambala and Mpigi expressed dissatisfaction with the manner in which the older VHTs were performing in terms of reporting and drug distribution as well as efficiency in movement during mobilization.

"Some of the VHTs in this area are aged and cannot see well", **FGD_DHT, Butambala district.**

Given the unique challenges of the young ones less than 40 and the old one ones more than 40 years of age, there is need to review the guideline for eligibility and recruitment of people to be trained as VHTs.

While the majority of the VHTs interviewed (54%) were male, the assessment could not establish the sex composition of the VHTs in the Country due to the absence of VHT databases in the districts.

The data shows that more than 50% of the VHTs have attained at least 0-Level education and can therefore read and write. This position was also supported by community data showing preference for people who have attained 0-Level education and above. This would imply that

Government could consider the minimum level of education for a VHT could be 0-Level. This would suit the expanding scope of responsibilities of VHTs such as administering antimalarial drugs, data gathering and reporting, family planning.

However, it should also be pointed out that there is a challenge of identifying people with 0-Level education in some places, more especially in Karamoja region, where about 20% of the VHTs had at least O Level education as compared to the rest of the Country.

VHTs are involved in various activities. The majority of the VHTs (86.2% males) and 85.6% females were engaged in farming. However, the findings indicate that some VHTs are employed by NGOs; some are students while others are LCs. These categories of VHTs may not have sufficient time to do VHT work and it is inconsistent with the VHT selection guidelines. Some of these individuals could have joined VHT work due to high expectations as noted in the interviews. It is therefore observed that the VHT selection guidelines have not been adhered to.

Training of VHTS

The study found that there are no training databases for the VHTs in the districts and at the national level. Some of the VHT Focal Persons in the districts are new and because they lack VHT databases in the district, they therefore may lack information on what has happened in the programme in the previous years. This result may also mean that the number of VHTs may not be accurately known at the national level.

Despite the high number of VHTs in the Eastern region, the majority have not had basic VHT training. The high number of untrained VHTs in Eastern region shows disfunctionality of the VHT programme. People who did not receive basic training were considered VHT members in some districts. For example, in Kampala district where no basic training has taken place, 351 people were reported to be VHTs. These were only trained on programme-specific areas. In such districts, it is apparent that the VHT guidelines have not been followed with respect to training.

It was noted that the content of the basic training reported by VHTs was largely consistent with the content stipulated in the VHT operational guidelines. However, this content may not have been fully covered in the short duration of the training (5-7 days) even when qualified trainers were used. The reduction of the training duration by the Ministry of Health from 10 to 5 days may have led to rushing of the trainings. The trainings may have been inadequate to equip the VHTs with appropriate knowledge and skills. This therefore could affect the quality of services VHTs provide to the community.

At times, trainings are conducted directly by the IPs without notifying and involving the DHTs or using the district trainers. This indicates a problem of VHT programme coordination, streamlining and training.

Since IPs choose where to go and implement their programmes, it creates disparity in the capacity of VHTs since trainings are provided to some VHTs in some areas and not to others. This leads to differences in knowledge and skills levels among the VHTs. Such a situation may lead to demotivation of the VHTs who have missed the training and may result into drop out.

Poor IP coordination creates a problem in supervision of the programme and eventually in sustainability when the partners' projects end. In areas with few or no implementing partners, it implies that the communities may not be benefitting from the VHT activities supported by such partners.

While these multiple trainings can strengthen the capacity of VHTs to deliver services to the community and provide feedback to the health facility staff, it also means that the same VHTs receive multiple trainings which increase their reporting burden. It may also mean there is inadequate time to have quality training given the low level of education of some of the VHTs.

Partners supporting VHT programme and activities the VHTs are implementing

Implementing partners have made significant contributions to the overall implementation of the VHT programme through the provision of financial, technical and logistical support. This support has improved utilization of health care services provided by VHTs in the areas of immuniuzation, sanitation, HIV/AIDS services, antinetal care, deliveries and family planning services.

However, there is inequitable distribution of partners among and within districts. This may be caused by the uncoordinated selection criteria of the districts of operation. This leads to inequitable distribution of skills among VHTs. Districts with many partners may have VHTs who are more skilled than those with few partners or none at all. This has implications on quality of health care services VHTs deliver to the community.

The roles played by the VHTs as indicated by the Community FGD data are reflective of the content of the VHT training. The most common roles played by VHTs are community mobilization and this is consistent with the content and requirement of the basic VHT training guidelines.

The community members are appreciative of the roles played by VHTs in health service delivery especially in hygiene and sanitation, drug distribution, antenatal care, HIV and family planning.

Although the VHT programme is owned by the Government of Uganda, the assessment established that VHTs pay more allegiance to the IPs who provided them with more facilitation than government. This is reflected in the VHTs willingness to participate in IP related projects as opposed to those for the government where there is less or no facilitation.

Extent to which Implementing guidelines are being followed

Selection

The VHT selection guidelines are in place and have largely been used. This is evident in the involvement and participation of the communities in selecting VHTs. However, a small proportion of VHTs were selected not in accordance with the guidelines in place. This included selection by local leaders, self-selection and selection by IPs. This may imply that the quality of VHTs not selected according to the selection guidelines may not meet the selection criteria such as being able to read and write or trusted, committed to working and are permanent residents in the community.

Training

Whereas the guidelines and training manuals to support VHT trainings are in place, nearly a third of VHTs have not received basic training. This may have been as a result of a number of factors such as; lack of funds by districts to conduct basic trainings, self appointment and selection by local leaders and by IPs. Such tendencies to select VHTs without the community involvement could have been due to lack of supervision by the districts. Consequently, a substancial number of VHTs may lack adequate skills to perform their duties.

The one third VHTs who received basic training in only 1-4 days imply that the training duration guidline was flouted. This may have therefore lowered the quality of the training conducted as the training period is too short to equip the VHTs with the necessary knowledge and skills. Though the training period of 5 days of basic training is in the guidelines, it is however too short for the trainees to comprehend all the content and apply it. Besides, the varrying education levels of VHTs affect their ability to comprehend the content of the training.

Programme-specific trainings by IPs are not harmonized in terms of standadized materials, content, duration and methods. This clearly is not in line with the guidelines on refresher training.

Supervision

The assessment revealed that VHTs are supervised at the health center IIs or IIIs or IVs and at district level as stipulated in the guidelines. However, there were no supervision check lists and reports ascertained. Supervision of the VHTs was hampered by lack of resources including funds, transport and technical capacity for supervision.

Supervision was undertaken mainly by Health Assistants, In-charges of health centers and Parish VHT supervisors and LC I Chairpersons as well as by NGOs and CDOs. The selection of VHT Supervisors was not rigorously followed except in only 5% of cases. It was however difficult to ascertain whether these various supervisors and the VHT members themselves understood what supervision entails.

Therefore, the lack of supervision tools, reports and apparent understanding of what supervision entails leaves gaps in determining whether the supervision reported to have been carried out was effective. The lack of reports suggests that supervision may not have taken place. The non-adherence to the VHT Supervisors' selection guidelines therefore compromises the quality of VHT supervision.

Reporting

The assessment showed a hierarchical reporting from the village through the parish (health centre), sub-county to the district levels. However, in some districts such as Otuke, Sheema and Buhweju, there was practically no reporting due to various reasons including the lack of tools and lack of training. The study however did not determine whether the hierarchical reporting existed in every district. The absence of reporting tools and training on reporting constrained reporting and suggests the need for capacity development in this area.

Various reporting formats and tools were used including mTrac. However, paper-based forms for reporting were found to be the most commonly used in most districts. Reporting tools were mostly found with implementing partners. This implies that reporting took place based on availability of tools in settings and programmatic priorities of implementing partners. It may also imply that VHT supervisors at health center levels could only exercise limited supervision on VHT reporting. The inadequate reporting tools, existence of various implementing partners and reporting formats coupled with low education level of some VHTs therefore suggest that there was irregularity and poor quality in reporting.

Coordination

There are VHT operational guidelines in place to support coordination mechanisms. However, poor coordination has arisen due to human resource and financial constraints mainly at national and district levels. The irregularity of the quarterly national steering committee meetings could have led to increasing gap in VHT coordination with and within districts. Lack of coordination led to poor supervision of IPs and their activities.

Referrals

The assessment established that most of the VHTs referred clients to health facilities. However, the assessment also found out that Health workers sometimes did not respect referrals made by VHTs. This emanated from the fact that VHTs are considered people of low education who are not competent in disease management as they are not medical personnel.

It was not clear whether referrals made by VHTs were effetively handled by the service providers at the health facilities. In addition, the assessment found that there were other concerns that affected effective referral such as lack of medicines in and transport means to health centers.

Approaches for Motivation

The provision of monetary and non-monetary incentives to VHTs contributes to motivation and retention of VHTs. While the VHT Operational Guidelines stipulate the various forms of motivation for VHTs, it does not explicitly describe how these should be equitably distributed and who should provide these incentives. For instance, the financial forms of motivation did not have the educational level required and yet government does not pay workers without formal education. The minimum package did not stipulate a salary but a reimbursement of costs for transport or for meals. In addition the MOH guidelines did not provide clarity on what constitutes activity and performance-related incentives.

While there are economic and social benefits of volunteerism, maintaining the VHTs to perform their functions can be eroded over time if some basic needs are not met. Some VHT who volunteered had high monetary expectations and if these were not met, some dropped out of the VHT program. Some of the materials provided were just tools but were not meant for motivation. Although those materials were meant as materials to facilitate VHT activities, they provided motivation to VHTs. The study found that there are certain things beyond what was thought as motivation to VHTs. Qualitative data showed that there is an overwhelming demand for a harmonised and regular financial form of motivation for the VHTs.

The various ways of motivation are not uniform thus creating disharmony at the district level and among the VHTs hence making coordination ineffective. Although the MoH, Partners and IPs are providing different kinds of motivation, there is no system for tracking the different motivation packages and support for VHTs hence there is need for harminizing motivation approaches and packages to address these anomalies.

Functionality of VHT programme and VHTs

National level

Lack of funding is a major challenge to the VHT activities at national level. As a result, coordination, and supervision of VHT activities have not been adequately done. Training of VHTs has not been completed in all the districts as a result of lack of funding. Lack of personnel in the coordination office has created a huge gap where the national coordinator is expected to do all the coordination work.

The MoH does however have other opportunities for supervision such as the Area Team supervision where VHT activities have been supervised but this is also irregular due to inadequacy of funding.

Overall, at national level, the VHT national coordination office is poorly facilitated to enable it efficiently implement the strategy as stipulated in the guidelines.

District level

Although the majority of the districts followed the guidelines in recruitment, carried out ToTs, have VHT trainers and conduct refresher training, the VHT programme is none functional on district funding to the programme, coordination and supervision. This is mainly due to lack of funds to finance these activities in the districts.

Community level

The majority of the rural community members interviewed reported the existence of VHTs in their communities. To a large extent, the services provided by VHTs were considered relevant to the health needs of community members. Community members reported improvement in hygiene and sanitation, uptake of immunization, antenatal care and HIV services and reduction of some illnesses and deaths in the community as direct efforts made by VHTs

This therefore implies that the VHT programme is perceived to be functional by the rural communities. However in the urban setting, the communities did not know much about the

programme since the VHTs do not visit their homes. This brings into question the functionality of the programme in the urban communities.

Individual VHT functionality

Although most of the VHTs reported to have been supervised, there was no evidence of support supervision reports to the districts. VHTs reported being supervised by health workers at health center IIs. However, these health workers lack facilitation in terms of transport and may not be adequately trained for this purpose. The quality of supervision may therefore be low. The VHT members also have multiple reporting formats from partners which became a burden to VHTs especially those with low or no education.

5.0 Recommendations

Numbers and Socio demographics

1. MOH should include stipulation in the selection criteria to Increase the number of VHTs under the age of 35 to more effectively reach young people in the community. Selection criteria should be revised in a way that takes into consideration communities' cultural values while also encouraging a greater number of younger VHTs within the overall selection.
2. The minimum education level for VHTs should be specified at 'O' level. However consideration should be made for the differences in education levels between the regions. In urban centres, there need to recruit VHTs of higher levels of education to match the population that lives in these areas.
3. Engage more female VHTs in recruitment to handle specific female health needs such as reproductive health issues that women feel uncomfortable to share with male VHTs.

Training and Supervision of VHTs

1. Given the increasing expectations of the roles of VHTs, the duration, content, methodology of VHT training should be reviewed and revised with the intention of making it commensurate with the skills to be developed. In addition, inclusion of content around gender and values clarification around serving young people (e.g., addressing myths and misconceptions on family planning use by young people and nulliparous couples) is needed to address VHTs' attitudes and ability to effectively deliver services.

2. The VHT programs should be coherently inserted in the wider health system, and should be explicitly included within the human resources for health (HRH) strategic planning at country and local level.
3. MOH should put in place clear, measurable mechanisms of VHTs role in primary health care, to ensure that a core set of skills and information related to MDGs be provided to VHTs. The proposed revised VHT curriculum should incorporate scientific knowledge about preventive and basic medical care, and how they relate these ideas to local social issues and cultural traditions. They should be trained, as required, on the promotive, preventive, curative and rehabilitative aspects of care related to maternal, newborn and child health, malaria, tuberculosis, HIV/AIDs as well as other communicable and non-communicable diseases.
4. There is need to establish a VHT database at the district level to track all district level VHT trainings and other activities. However, this needs control and coordination of all district level VHT trainings and other activities by MOH and the District Local Governments.
5. The MOH should ensure that all VHTs in the districts should undergo VHT basic training, especially in Kampala and the newly created districts.
6. There should be coordination of refresher training by the MOH and the District Health Teams and IPs to ensure uniformity of the VHT training with regard to standardized materials, content, duration and methods based on VHT roles and functions and fair coverage and should be more inclusive of the content of the basic training since the current training is more programme-driven. The refresher training should only target VHT who have completed the basic training.
7. Considering the ever changing roles of VHTs it is recommended their roles and responsibilities be reviewed and updated thus stipulating suitable duration of days for training. There is need to identify other innovative ways of training to ensure content is covered and skills are.
8. MOH and districts in close collaboration with IPs should ensure reliable provision of transport, drug supplies and equipment for VHT effectiveness in implementing their activities. Supplies' of drugs and related commodities should be brought to the Health Center IIs for the VHTs to easily access them.
9. MOH and Districts should revise the training curriculum for supervisors and ensure that VHT supervision checklists exist and are put to use by VHT supervisors. MOH and DHTs should revise supervision tools, report formats/tools for VHTs and checklists for understanding of what supervision entails to ensure effective supervision of VHTs as well as harmony with IPs expectations. MOH and districts should enforce adherence to the set criteria for selection of VHT supervisors and build their capacity to perform that role. MOH should ensure that VHT supervision checklists are developed and disseminated to the districts. The districts should

ensure that VHT supervision checklists are put to use by the VHT superviors. Reports of VHT supervision should be written and submitted by supervisors to appropriate offices as stipulated in the VHT operational guidelines. MOH and districts should revise the training and support supervision activities to ensure positive attitudes of health workers towards VHTs.

10. MOH and districts should ensure that VHTs have appropriate tools for regular reporting feeding into respective district HMIS. MOH and districts should ensure that VHTs have the right skills and tools to undertake effective data collection, report writing and timely report submission.
11. Indicators that specifically track VHT interventions e.g VHT trainings should be developed in the HMIS so as to track effectiveness and performance of VHT member's work. The VHTs should be oriented on the importance of tracking, collecting and reporting of these indicators using the revised VHT reporting formats during the VHT trainings.

Partners supporting VHT programme

1. MOH and the district leadership should play a role to ensure a more equitable distribution of implementing partners among and within districts. In addition, MOH should regulate partners working within the same district but working in the same programme area.

2. MOH should use district based VHT and IPs mapping to coordinate and harmonize the VHT activities in the districts. This will improve the inequity of VHT coverage and service delivery. It will also strengthen government leadership and ownership of the programme.

Implementation of the guidelines

1. The DHT and district leaders should ensure through supervision a clear selection and deployment procedure for VHTs and their Supervisors. Ideally they should engage community in planning, selecting, implementing, and monitoring that reassures appointing those who certify the course completion and pass the writing or verbal exam at the end of training. MOH and local leadership should take responsibility in making a transparent system for selection and deployment and further quality assurance of the regulated set system.
2. MOH and districts should streamline reporting structure to ensure compliance to the VHT operational guidelines on reporting
3. Government should provide adequate funding for the Ministry of Health to have an efficient national steering committee and for coordination of VHT activities nationally and at district level as well as at the community level.

4. There is need to sensitize health workers in the health centres and the communities at large about the mandate of the VHTs. This will create harmony and good working relationship between the VHTs and the health workers.
5. MOH should advocate/lobby Parliament to provide adequate funding and annual budgets for VHT activities nationally, at district level as well as community.
6. MOH in the revision of training and support supervision guidelines should develop an effective tracking system to ensure that patient referrals are effective and can be evaluated.
7. MOH should develop and use effective checklists on attitudes of health workers and communities towards VHTs'work.

Motivation mechanisms

1. There is need to provide a standardized and harmonized regular and equitable financial form of motivation to VHT and to ensure equitable distribution of non-monetary incentives to all VHTs.

2. MOH should lobby Parliament to establish Performance Based Financing system (PBF model) in which a base salary is paid for core activities, and an additional bonus can be earned for excellent performance for additional activities.
3. Non- monetary recognition of VHTs as a formal cadre of health worker, integrated into the public health system, with all that that entails (payment, rights, supervision and assessment).
4. Government should review the number and level of education of VHTs if a standardized remuneration systems is introduced such as wages or salaries.
5. MOH should develop career path development plans for VHTs as a motivational function.
6. Government should take lead in clarification and provision of the motivations and incentives mentioned in the VHT operational guideline.
7. Revise HMIS to include household data on basic public health indicators collected by VHT system.
8. Establish use of mhealth tools such as the routine messaging tool for household health data collection that feeds into district HMIS, and for monitoring VHT performance.
9. For motivation to be effective there is need to have a database of VHTs with their full names and photographs. This helps in tracking the existence of the VHTs and the Authenticity of these VHTs if they have to be introduced to a remuneration payment system.
10. Government and IPs need to undertake proper planning on the proposed financial mechanisms of VHT motivation prior to adopting such suggestions. Government and IPs should take a cost-benefit analysis of these suggested motivation mechanisms to come

up with the most suitable mechanisms that are within government means to motivate the VHT members

Functionality

1. A VHT Policy should be formulated which should guide the Strategy development which should be costed and funded.
2. MOH should advocate/lobby Parliament to provide adequate funding for VHT activities nationally and at district level as well as at the community level.
3. MOH and the district health offices should coordinate the IPs in terms of activities implemented and geographical coverage in order to reduce the concentration of IPs in some areas.
4. There is need to empower the VHT department at the MOH with adequate funding and increase personnel to enable them to efficiently implement the strategy
5. A national basket fund should be established to which donors contribute and which can be used to pay VHT salaries and any other additional costs such as training, supervision, supplies etc. that will be covered.
6. MOH should routinely monitor district based databases for VHTs and their activities to ensure coordination of all IPs targeting VHTs. This will help in equity geographical distribution of service delivery as well as skills and knowledge among VHTs.
7. The districts should include in their annual workplans and budgets VHT activities and MOH should ensure timely disbursement of funds.
8. MOH should develop an **urban- specific strategy** that prioritize by parish or villages with the worst public health indicators such as slum areas, and the lowest service provider to population ratios. The most underserved parts of the cities/towns should be addressed first with later expansion to the rest of the city as budget permits.

6. 0 Appendices

Appendix 6.1 Number of VHTs in the districts

District	Number of VHTs
ABIM	718
Adjumani	826
AGAGO	1969
Alebtong	1210
Amolatar	870
AMURU	720
Apac	3500
Arua	200
Dokolo	958
Gulu	1561
Kitgum	1534
Kole	1114
Lamwo	1198
Lira	210
Maracha	1184
Moyo	1642
Nebbi	879
Nwoya	874
Otuke	790
Oyam	4976
Pader	1300
Yumbe	1272
Zombo	1669
Koboko	120
AMUDAT	244
Kaabong	920
KOTIDO	365
Moroto	365
Nakapiripirit	343
Napak	60
Amuria	3630
Budaka	798
Bududa	1902

Bugiri	2285
Bukedea	682
Bukwo	1054
Bulambuli	2820
Busia	1710
Butaleja	1000
Buyende	1615
Iganga	715
Jinja	1930
Kaberamaido	82
Kaliro	1465
Kamuli	3456
Kapchorwa	1484
Katakwir	1540
Kibuku	492
Kumi	871
Kween	968
Luuka	1275
Manafa	3031
Mayuge	2500
Mbale	3214
Namayingo	1250
Namutumba	1815
Ngora	665
Palisa	1712
Serere	1480
Sironko	2570
Soroti	1398
TORORO	4375
Buikwe	1870
bukomansimbi	1016
BUTAMBALA	640
Buvuma	300
GOMBA	1018
kalangala	480
kalungu	1140
Kayunga	1875

Kiboga	1143
kyakwanzi	62
Luwero	2980
lwengo	1802
lyantonde	150
masaka	1400
MITYANA	150
MPIGI	1354
MUBENDE	309
Mukono	2547
Nakaseke	656
Nakasongola	1405
rakai	4500
sembabule	1500
WAKISO	2880
Buhweju	1235
BULIISA	418
Bundibunjo	2548
Bushenyi	1713
Hoima	1124
ibanda	1750
Isingiro	3325
kabale	4437
Kabarole	3000
Kamwenge	2560
Kanungu	1760
Kasese	1023
Kibaale	7620
kiruhura	3408
KIRYANDONGO	412
Kisoro	2200
Kyegegwa	1430
Kyenjojo	5246
MASINDI	1328
Mbarara	2582
Mitooma	1198
Ntoroko	1312

Ntungamo	3695
Rubirizi	1020
Rukunguri	1119
Sheema	1160

Appendix 6.2 National Partners for interview

PARTNER	**KEY INFORMANT**	**COMMENTS**
PACE	Amon	Done
World Vision	Geofrey Babugirana	Done
UNFPA	Roseline Achola	Done
Pathfinder International Uganda	Karamagi Charles	Done
Marie Stopes Uganda	Dr. Herbert Muhumuza	Done
AMREF	Dr. Kagurusi	Done
UNICEF	Charles Loada	Done
Malaria consortium	Denis Mubiru	Done
Reproductive Health Uganda	Kansiime Doreen	Done
Uganda Health Marketing Group	Eva Kaggwa	Done
FHI 360		Done
POPSEC		Done

Appendix 6.3 List of partners working with VHTs in districts

DISTRICT	**PARTNER**	**AREA OF OPERATION**
KARAMOJA REGION		
Moroto	UNICEF	Nutrition
	UNFPA	Malaria
	International Rescue Committee	PMTCT
	CAUMM	ICCM
Nakapiripirit		
	UNICEF	Nutrition
	International Rescue Committee	HIV
	CAUMM	ICCM
	WAP	

	CONCERN	
Amudat		
	International Rescue Committee	PMTCT
	Vision Care	ICCM
	FOREF	HIV
	UNICEF	Nutrition
	Pilgrim Uganda	Malaria, HIV, diarrhea
	Marie Stopes	Maternal health
	CAUMM	ICCM
Napak		
	UNICEF	Nutrition
	International Rescue Committee	PMTCT
	CAUMM	ICCM
	Sight Savers	
	Samaritan purse	Sanitation and hygiene
Katakwi		
	Baylor Uganda	HIV, Malaria
	UNFPA	Malaria
	LWF	
	TASO	HIV/AIDS
Kaabong		
	World vision	Nutrition
	UNICEF	Nutrition
	International Rescue Committee	PMTCT
	Community action for health	Nutrition
Abim		
	UNICEF	Nutrition, support review meetings
	World vision	Nutrition
	Community action for health	Nutrition
	Baylor Uganda	HIV reporting
	GOAL	
Kotido	Community Action For Health	Nutrition

	World vision	HIV
	International Rescue Committee	PMTCT
	UNICEF	Nutrition
Amuria		
	World vision	Nutrition
	TASO	HIV/AIDS
	Baylor Uganda	HIV/AIDS
	Pilgrim	Malaria, HIV, diarrhea
	Uganda cares	HIV
Eastern		
Soroti	World vision	Malaria
	AMREF	TB
	AIC	Malaria
	Uganda Cares	HIV
	Baylor Uganda	HIV/AIDS
	Mental Health Project	
Serere		
	Baylor Uganda	HIV/AIDS
	AMREF	Reproductive Health
	Partners For Children World Wide	Livelihood And Sanitation And Reproductive Health
	Staying Alive	Fistula and supporting households with equipments
	Health Need	Reproductive sanitation
	HOW Uganda	Reproductive Health
	Hope for OVC Uganda	
	Pentecostal Assembly of God	
	Pilgrim	Management of malaria
	SORUDA Uganda	Reproductive health and sanitation
Ngora		
	Baylor Uganda	HIV/AIDS
	Pilgrim	Malaria, HIV, diarrhea
	THETA	PMTCT
	PACE	Malaria
	Uganda sanitation fund	Hygiene and Sanitation

Bukwo		
	PACE	HIV,TB,PMTCT
	CARITAS	HIV and AIDS,TB
	Star Ec	HIV/AIDS,TB
	Strengthening Decentralization Systems(SDS)	Health system strengthening
Kween		
	PACE	HIV/AIDS, Malaria, TB
	Star E	HIV/AIDS,TB
Kapchorwa		
	PACE	Malaria
	Star E	HIV, TB
Bukedea		
	Pilgrim	Management of malaria
	Baylor Uganda	Referral, community linkage, HIV/AIDS, sanitation
	Maritza international	
Bulambuli		
	PACE	Malaria control and prevention
	Salvation army	Reproductive health
Manafwa		
	TASO	HIV/AIDS, Referrals, maternal health
	PACE	Family planning, malaria and nutrition
	Salvation Army	Family planning
	Mbale Cap	Maternal health
Kumi		
	Baylor Uganda	HIV/AIDS, maternal health
	Pilgrim	Reproductive health and family planning
	PACE	malaria and nutrition
	Strides	Maternal, Newborn and Child Health
	Star E	HIV/AIDS
	Friends of Kumi	

	Private Sector Training	
Sironko		
	PACE	Malaria, HIV/AIDS and Reproductive health
	Buyobo Development Association	Micro finance and soft loans
	Salvation army	Family planning
	Star E	HIV/AIDS,TB
Mbale		
	PACE	HIV/AIDS
	World vision	Girl child and Child upbringing
	Malaria consortium	Malaria prevention and control
	SPOT LIGHT ON AFRICA	Water source treatment, H/C construction
Bududa		
	PACE	Malaria, HIV/AIDS and TB
	UMODA	HIV/AIDS
	SCORE	Family planning
	DATA	Maternal health
	PATH	Family planning
	PONT Uganda	Capacity building
Tororo		
	Plan Uganda	ICCM
	World vision	Nutrition
East Central		
Mayuge	Star EC	TB/HIV
	Strides	Maternal, Newborn and Child Health
	Family life education program	family planning
	Makerere SPH	New born care
Paliisa		
	MANIFEST	Maternal and Newborn Health
	Star ec	TB, HIV
	Kagum development organization	Maternal health

Kibuku		
	Uganda Sanitation Fund	Hygiene and Sanitation
	MANIFEST	Maternal and Neonatal Health
	Kagum development organization	Maternal Health
	Kadama widows association	HIV/AIDS
	Star EC	TB, HIV
	TASO	HIV/AIDS
Budaka		
	KADO	Maternal Health
	Salvation Army	Reproductive Health
	Child fund	Maternal, Newborn and Child Health
	Star e	HIV/AIDS
	Strengthening Decentralization Systems(SDS)	Health system strengthening
Butaleja		
	World vision	Maternal, Newborn and Child Health
	Child fund	Child Health
	Salvation Army	Reproductive health
Namutumba		
	Star ec	HIV/AIDS and TB
	Marie Stopes	Family planning
	Spring	Nutrition
	Kagum Development Organization	Malaria, TB, HIV
	Envision	
	Accelerating Nutrition Intervention(ANI)	Nutrition
Busia		
	World vision	Maternal, neonatal and child health
	PACE	Malaria
	Salvation army	Family planning
	Child fund	Livelihood and child health
	Star ec	TB

	Family health international(FHI)	Family planning
Namayingo		
	Star ec	HIV/TB
	PACE	Malaria
	GOAL	WASH
	Mother To Mothers	HIV in pregnancies and lactating mothers
Bugiri		
	Star EC	HIV, TB
	World vision	MNCH
	Strides	MNCH
	PACE	Malaria
	Link up project	
	ACCORD	
Luuka		
	Star EC	HIV and TB
	Kagum development organization	Long lasting nets, pregnant mothers and children
	PACE	Malaria
Buyende		
	Star EC	TB, HIV and Malaria
	MANIFEST	Maternal and child health
	Community vision	Livelihood
	Kagum Development Organization	HIV, TB Malaria
Kamuli		
	Plan Uganda	ICCM
	MANIFEST	MNCH
	Star EC	TB, HIV, Malaria
	Strides	MNCH
Kaliro		
	Strengthening Decentralization Systems(SDS)	Health System strengthening
	Star EC	TB, HIV
	PACE	Malaria
	Strides	MNCH

	Kagum Development Organization	HIV, TB, Malaria
Central 2		
Nakasongola	AMREF	Malaria
	Save the children	Reproductive health
	PREFA	Prevention of transmission from mother to child
	World vision	Nutrition and sanitation
	Strides	MNCH
	Save foundation	
	UNICEF	Family health days
Nakaseke		
	Busoga Trust	HIV and malaria
	Mild may	HIV
Kiboga		
	Malaria consortium	Drug distribution
	World Vision	Nutrition and sanitation
Kyakwanzi		
	Malaria consortium	ICCMs
	World vision	Nutrition and Sanitation
	AMREF	Malaria
Luwero		
	PLAN	ICCM
	UNHCO	
	CORDI	
	Busoga trust	HIV and malaria
	AMREF	Malaria
	PACE	Malaria
	Caritas	
	Health Wine	
	Mbuya Outreach	
	Abagala Uganda	
Kayunga		
	FHI 360	Family planning
	PACE	HIV and TB
	Strides	MNCH
	Joint Action for Health	

Buvuma		
	PACE	Health communication and education
	Makerere University Walter Reed Project	Export clients from communities
	Envision	Train in mass treatment of bilharzia
Jinja		
	TASO	HIV/AIDS
	PACE	HIV and TB
	Sustain project	Data collection for health information
Mukono		
	Omni-med	Training VHTs
	PACE	HIV and TB
	World vision	Nutrition and sanitation
Buikwe		
	World vision	HIV testing
	UNICEF	Family health days
	Walter reed project	
	PACE	Malaria
	THETHA	
Iganga		
	PACE	Malaria
	Star EC	TB, HIV, Malaria
South Western		
Kisoro	SPRING	Nutrition
	AMREF	Maternal and family based health care
	Muhabura	HIV/ Sanitation
	Mayanja memorial hospital	HIV, Malaria
	Water School Project Kisoro	
	Doctors of Global Health	
Mitooma		
	Global fund	Distribution of mosquito nets
	Star SW	HIV and TB
	Church of Uganda	HIV

Buhweju		
	Star SW	HIV, TB
	Malaria Consortium	ICCM
	UNICEF	Registration
Ntungamo		
	Star SW	HIV
	UNICEF	Immunization
	Health child	Maternal health
Kabale		
	PACE	HIV
	World Vision	AIM project
	Mayanja Memorial Hospital	HIV, Malaria
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management,
	Star SW	HIV
	Community Connector	Nutrition
Kanungu		
	UNFPA	Family planning
	ACLAIM	Nutrition
	Star SW	HIV
	UNICEF	Nutrition
Bushenyi		
	Health Child Uganda	Maternal health
	Star SW	HIV and TB
	UNICEF	Nutrition
	TASO	HIV/AIDS
	Uganda Sanitation Fund	Sanitation
Sheema	UNICEF	Immunization
	Star sw	HIV
	Marie stopes	Family planning
	TASO	HIV/AIDS
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management
	Church Of Uganda	tuberculosis and HIV
	UNHCO	

	ICOB	HIV
Mbarara	Health child	Maternal health
	TASO	HIV testing and counseling
	Uganda Sanitation Fund	sanitation
	Coin Uganda	
	ICOB	HIV
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management
Isingiro	UNHCR	Child health
	Mayanja Memorial Hospital	HIV, Malaria
	PACE	ICCM
	Church Of Uganda	tuberculosis and HIV
	Aids Information Center	HIV/AIDS
	Medical Teams Association	
	Star Sw	HIV
	ICOB	HIV
Rukungiri	AMREF	Saving lives at birth
	PACE	HIV
	Star sw	HIV
	Agape	
	RUGADA	Capacity building
	MCSP	
	RODNET	
kiruhura		
	UNICEF	ICCM
	Star SW	HIV and tuberculosis
	African Evangelism Enterprise	malaria, tuberculosis and HIV
Ibanda		
	Star SW	HIV and tuberculosis
	community connector	
	Mayanja Memorial	HIV, Malaria
	African Evangelical Enterprise(COU)	malaria, tuberculosis and HIV

Western		
Hoima	Malaria Consortium	Malaria
	World Vision	Immunization
	Care Uganda	HIV
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management
	Infectious Disease Institute	Safe deliveries
Kyegegwa	UNICEF	HIV
	Baylor Uganda	Immunization
	Church of Uganda	HIV
Kabarole		
	Baylor Uganda	HIV
	International Development Initiative	
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management
	PACE	Malaria
	Church Of Uganda	Malaria, tuberculosis and HIV
	Community based ARV DOTS project	HIV/AIDS
Kibaale		
	World Vision	HIV
	Malaria Consortium	Malaria
	Save Foundation	
	Infectious Disease Institute	Safe deliveries
	Uganda Rural Development Program	
	EMESCO	
Kyenjojo		
	Baylor Uganda	HIV
	Strides	Family planning
	UNICEF	Child health program
	Samaritan Purse	Sanitation and hygiene
	NGO Forum	Capacity building

	PACE	Malaria
	Marie Stopes	Maternal health
	Kind Uganda	
	Malaria Consortium	Malaria
	Church Of Uganda	tuberculosis and HIV
	NGO-CBO	
Bundibugyo		
	Baylor Uganda	HIV
	World Vision	Child survival
	Save The Children	Maternal/child health
	PACE	HIV
	World Health Organization	Reproductive health and family planning and nutrition
	Belgian Technical Cooperation	Capacity Buliding
	UNICEF	Immunization, Nutrition
Ntoroko		
	Baylor Uganda	HIV
	UNICEF	Family health days and immunization
	Save The Children	Mother child health
	Save Foundation	
	Ride Africa	
	Rwebisengo Post Test Association	
	Karugutu people living with HIV/AIDS	HIV/AIDS
Rubirizi		
	Health Child Uganda	Maternal health
	Church Of Uganda	TB
	Mayanja Memorial Hospital	HIV, Malaria
	COVOID	
Kamwenge		
	World Vision	Capacity building for VHTs
	Strides	Capacity building
	Mild May	Capacity building
	UNICEF	Immunization, Nutrition
	Carter Centre	

	PACE	Malaria
Kasese	UNICEF	Immunization, Nutrition
North		
Kaberamaido	Pilgrim Africa	Malaria,
	Baylor Uganda	TB, HIV/AIDS
	PACE	Malaria
Oyam		
	Communication For Development Foundation Uganda	Reproductive health
	Uganda Health Marketing Group	Condom distribution
	Family Health International	Reproductive health and family planning
	Nu-Hites	HIV/AIDS and community mobilization
	Marie Stopes	Family planning
	World Vision	Nutrition
	Transparency International	
	Global Refugee International	HIV
	Plan Uganda	Malaria
	UNHCO	
	GHN	
	THETA	
Kole	Nu-Hites	Safe male circumcision, immunization, malaria
	Crane Health Services	HIV, Malaria and TB
	World Vision	HIV/AIDS, Sanitation, immunization, family planning
	UNICEF	Immunization
	ABT associates	
Alebtong		
	Plan Uganda	Malaria
	Nu-Hites	Malaria, TB, HIV
	Divine Waters Uganda	
	PACE	Malaria

Dokolo	Uganda Health Marketing Group	Malaria
	Crane Health Services	NTDs
	Nu-hites	Malaria, TB, HIV
	PACE	Malaria
	Uganda sanitation fund	Sanitation and hygiene
	Community connector	Nutrition
	ABT associates	
Apac		
	Nu-Hites	Malaria, TB, HIV
	LICODA	HIV/ Family planning
Lira		
	Plan Uganda	Adolescent
	Nu-Hites	HIV, Malaria and TB
	Marie Stopes	Reproductive health
	TASO	HIV/AIDS
	PACE	Malaria
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management
Otuke		
	Crane Health Services	Malaria, TB, HIV
	UNICEF	Immunization
	Marie Stopes	Reproductive health
Amolatar		
	CEPA	
	JCRC	HIV
	Lango Samaritan Initiative	HIV/AIDS
	Nuhites	Malaria, TB, HIV
Agago		
	AVSI	ICCM
	PACE	ICCM
Kitgum	AVSI	ICCM
	International Rescue Committee	PMTCT

	Nuhites	Malaria, TB, HIV
	UNICEF	
	Child fund	Maternal health
	AMREF	Malaria and HIV
	World Vision	Nutrition
Pader		
	AVSI	ICCM
	SAVE The Children	ICCM
	Nuhites	Malaria, TB, HIV
	Carter Centre	
	AMREF	Malaria and HIV
Lamwo	International Rescue Committee	ICCM
	AVSI	ICCM
KAMPALA		
Gomba	Malaria Consortium	Malaria
	Mild May	HIV/AIDS
	Uganda health marketing group	Family planning
Bulisa		
	Infectious Disease Institute	HIV/AIDS
	Malaria Consortium	ICCMs
	World Vision	Reproductive health, nutrition and sanitation
Masindi		
	Malaria Consortium	Malaria, diarrhea, Pneumonia
	SCIPHA	HIV/AIDS
	TASO	HIV/AIDS
	International Health Net Work	
	Sight Savers	
	CEDO	
Mubende		
	World Vision	Water and sanitation
	PACE	Reproductive health
	UNFPA	Reproductive health
	PATH	Family planning
	SNV	

	UNICEF	Nutrition
	Mild may	HIV/AIDS
Mityana		
	FHI 360	Reproductive health
	SCIPHA	HIV/AIDS
	Marie Stopes	Reproductive health
	Mild May	HIV/AIDS
	Strides	Nutrition, child health
	Uganda Health Marketing Group	Reproductive health
	Reproductive Health Uganda	Reproductive health, Maternal health, HIV management
Kiryandongo		
	Child Fund	Water/ sanitation
	Action Against Hunger	Nutrition
	International Rescue Committee	Water and sanitation, reproductive health
	UNICEF	Nutrition
	PACE	HIV/AIDS
Butambala		
	Malaria Consortium	Malaria prevention
	Mild May	HIV/AIDS
	World Vision	Nutrition
Wakiso		
	UNICEF	Total funding
	Malaria consortium	implementation
	Mild may	HIV/AIDS
	AMREF	Circumcision
	PACE	Malaria
Mpigi		
	PACE	Malaria
	Malaria Consortium	ICCM
	Strides	Reproductive health
	World vision	Nutrition
	Mild May	HIV/AIDS
	SCIPHA	HIV/AIDS

	STOP MALARIA	Malaria control
WEST NILE		
Gulu	Nu-hites	Malaria, TB, HIV
	AVSI	ICCM
	AMREF	
	World vision	Nutrition
Nwoya	AVSI	ICCM
	PACE	Malaria
Amuru	AVSI	ICCM
	World Vision	MCH
	Nuhites	Health facility based VHT meeting
Koboko	UNHCR	Supports refugee VHTs
Yumbe	UNFPA	Reproductive health
Adjumani	Baylor Uganda	Nutrition assessment
	-	Immunization
Moyo	New Life	-
Zombo	Baylor Uganda	HIV/AIDS
Nebbi	Baylor Uganda	HIV/AIDS
	RTI	
Arua	UNICEF	Nutrition
	PREFA	HIV/AIDS
	Baylor	HIV/AIDS
	Care International	Refugee settlement
	Concern	Nutrition
Maracha	Baylor Uganda	HIV/AIDS
	SNV(WASH)	
	RICE(Agriculture)	Nutrition

CENTRAL 1		
Rakai	World Vision	Nutrition
Kalangala	Strides	Reproductive health
	Kalangala Comprehensive Health Service	Malaria
Masaka		
	Uganda Cares	HIV
	PREFA	PMTCT
	Mild May	HIV
	Red cross	Reproductive health
Kalungu	Malaria Consortium	All VHT activities
	TASO	HIV/AIDS
	Mild may	HIV
	Uganda cares	HIV
Lwengo		
	PACE	Malaria
	CDC	
	TASO	HIV/AIDS
	Malaria consortium	Supply of drugs
Bukomanasimbi		
	PACE	Malaria
	Malaria Consortium	Malaria
	Mild May	HIV/AIDS
	Uganda Cares	HIV
	Villa Maria	
	Karitas MADDO	
Ssembabule	-	-
Lyantonde	PACE	Malaria
	Mild may	HIV/AIDS
	Care Uganda	HIV

Appendix 6.4 List of partners interviewed at district level

District	Partner
Arua	Baylor
Adjumani	Baylor
Bududa.	PONT (PERTENERSHIP OVERSEAS NETWORK TRUST
Bukedea	BAYLOR
Bulambuli	PACE
Bundibugyo	Save the Children International
Hoima	WORLD VISION
Kibaale	Infectious Diseases Institute
Ntoroko	RIDE AFRICA
Rubiriizi	Health Child Uganda
Kaliro	Envision
Oyam	World Vision Uganda
Kitgum	AVSI
Kumi	BAYLOR UGANDA
Kyegegwa	Humura Archdeaconry ....Church Of Uganda
Maracha	Baylor
Masaka	Uganda Cares
Mbale	MALARIA CONSORTIUM
Mbarara	Healthy Child Uganda
Mityana	REPRODUCTIVE HEALTH UGANDA(RHU) MITYANA OFFICE

Moyo	Baylor
Dokolo	NU-HITES
Kiryandongo	CHILD FUND
Kamuli	PLAN Uganda
Butaleja	Mazimasa Community Development Association (Implementing for Child Fund)
Gomba	Gomba Aids Support and counseling organization {GASCO}
Abim	Community action for Health (CAFH)
Amudat	Friends of Christ Revival Ministry(FOCREV)
Amuria	Partners for Children WORLD WIDE
Kaabong	CUAAM (INGO
Katakwi	LWF (Lutheran World Federation)
Kotido	International Rescue Commission (INGO
Moroto	UNICEF MOROTO
Nakapiripirit	Doctors With Africa- CUAAM (INGO)
Napak	International rescue committee (IRC)
Kibuku	Kagum Development Organization (KADO)
BUSIA	World Vision Uganda
Kiboga	World Vision
Luwero	Plan Uganda
Palisa	Maternal and Neonatal Implementation for Equitable Systems
Nakaseke	BUSOGA TRUST
Nakasongola	World Vision

Kaberamaido	Baylor Uganda
Lira	Marie Stopes
Buyende	STAR EC
Budaka	Child Fund (Kadenge Children's Project)
Kibuku	Kadama Widows Association
Namutumba	USAID SPRING
Sheema	ICOBI (Integrated Community Based Initiatives)
Mpigi	Mild May
Kabale	AMREF
Ntungamo	Uganda Red Cross Society
Mubende	PACE(Program For Accessible Health Communication And Education)
Alebtong	Plan International
Sironko	Buyobo Community Development Association
Soroti	WORLD VISION
Kamwenge	World Vision
Kabarole	Baylor
Kapchorwa	Kapchorwa Integrated Community
Serere	BAYLOR UGANDA
MANAFA	TASO

Appendix 6.5 Ministry of health KIIs

1. Director General
2. Assistant commissioner, Health Promotion and Education
3. Assistant commissioner, Community Health
4. Assistant Commissioner, Reproductive Health
5. VHT Coordinator
6. Director, Clinical and Community Health

Appendix 6.6 VHT Questionnaire

General information		
1.	Date of interview (dd/mm/yyyy)	
2.	District	
3.	Sub-county	
4.	Parish	
5.	Village	
6.	Name of interviewer & contact	
7.	Name of the VHT member and contact	
8.	Age	
9.	Sex	1) Male 2) Female
10.	Highest level of education attained (including vocational skills)	1)P.7 2) 0-Level 3) A-level 4)Tertiary 5)University
1.	Marital status	1)Single 2)Married 3)Divorced 4)Widowed
2.	Occupation (other than VHT work)	1)Farmer 2)Business 3)Employed by Govt 4)Employed by NGO 5)Student 6)Other specify ___________________________
3.	Name and level of Health facility the VHT is attached to	
4.	How were you selected to become a VHT member?	
5.	Have you been trained as a VHT member?	
6.	When were you trained as a VHT member?	
7.	How many times have you received training?	

8.	How long was the training?	
9.	Who conducted the training?	
10.	What was covered in the training	1)Disease prevention 2)Community mapping 3)Community registers 4)Home visits 5)Community mobilization 6)Health education 7)Referrals 8) Others (specify) ____________________________
11.	How was the training done	1)Brain storming 2)Group discussions on specific issues 3)Role plays 4)Games 5)Field visits 6)Sharing experiences 7)Practicing what has been learned 8)Refresher sessions after training to strengthen weaknesses found during supervision
12.	How long have you served as a VHT member?	1) 6 months to 1 year 2) 1 year to 2 years 3) 2-5 year 4) More than 5 years (specify)……………..
13.	What has kept you active?	
14.	What were your expectations as a VHT member?	

15.	Have the above expectations been met?	
16.	If no, suggest areas of improvement	
17.	What are your roles as a VHT member?	1) Mobilize the community for health action 2) Promote health to prevent disease 3) Treat simple illness at home 4) Checks for danger signs in the community 5) Report and refers community sickness to health workers 6) Keep village records up to date 7) Others specify ____________________________
18.	What activities have you done as a VHT member?	1) Disease prevention 2) Community mapping 3) Community registers 4) Home visits 5) Community mobilization 6) Health education 7) Referrals 8) Treat simple illness at home 9) Checks for danger signs in the community Others (specify) ____________________________

19.	How many other VHT members are in your Village	
20.	In how many village(s) do you work?	
21.	Have you received any additional training following the basic training? YES/NO If yes, specify………………………..	1)Yes 2)No Specify___________________ __________________________ __________________________
22.	Have you been supervised in the last 6 months? If yes, by who? Specify……………………….	1)Yes 2)No
23.	What support did you get from your supervisor?	1) Observation of service delivery (use of Job Aids, RDT 2) Coaching and skill development 3) Hygienic practice 4) Trouble shooting (this is technical advice) 5) Problem solving (non technical) 6) Home visit 7) Record review (Register, stock cards) 8) Supply check (Medicines,) Others (specify)………
24.	During your activities, have you ever received any assistance from the Local Council?	1)Yes 2)No
25.	If yes, which assistance?	1) Inform communites about VHT 2) Advocacy for health at home 3) Mobilize communities for health 4) Supervision of VHT activities 5) Give financial support 6) Planning for VHT in district

		and village health plans 7) Attend and support health events 8) Others (specify) ___________________________
26.	Do you have the supplies and equipment you need to provide the services you are expected to deliver?	1) Yes 2) No 3) Some
27.	If yes which supplies and equipments do you have? (Please verify)	1) Condoms 2) Register 3) Report book 4) Badges, t-shirts, bags 5) Job Aids (flip charts, counseling cards, VHT manual, e.t.c.) 6) IEC materials 7) Identity cards 8) Bicycle 9) Others (specify)……….
		ADDITIONAL Amoxacilin Coartem ORS Zinc Lectoatersunate RDT kit Gloves Respiratory timers Mobile phones Solar chargers Wrist watch Tippy tap materials
28.	How do you keep the supplies/medicines?	1. Wooden box 2. Plastic bag

		3. Others (please specify)
29.	What additional logistical support have you received as a VHT member to facilitate your activities?	
30.	Who provided these supplies/equipment/medicines? Specify	

31.	In the last six months, have you participated in a VHT review meeting?	1) Yes 2) No
32.	Have you ever had a meeting/dialogue with the community to give you feed back on your services?	1) Yes 2) No
33.	If yes, who participated in the feed back meeting?	1) LC 1 2) Parish leaders 3) Health workers 4) Community members 5) Partners
34.	29. How does your community support you in work as a VHT? (please tick appropriately)	For example 1) Feed back 2) Support (financial or gifts in kind) 3) Guidance on your work 4) Formal recognition/ appreciation 5) Others (specify)
Referral of patients		
35.	What do you do when you get clients who need health services that you can not provide?	1) Referral 2) Others (specify)…… ……………………… ………………………
36.	If the answer above is referral how do you refer?	1) Fill out form 2) Write in the book 3) Other (specify) ………………………. …………….
37.	Do you have referral forms? If yes, verify availability of referral forms	1) Yes 2) no

38.	If yes, are they Ministry of Health referral forms?	1) Yes 2) No
39.	In the last one month did you refer any client to the health facility?	1) Yes 2) No
40.	If yes, where was the client referred?	1) Government health facility 2) Private health facility 3) Others (specify)……….
41.	Did you follow up any of the referred clients?	1) Yes 2) No
42.	What category of clients did you follow up?	1) pregnant women 2) post natal mothers 3) clients on long term treatment 4) new borne 5) Under fives 6) others (specify) ………………………… ……………………….
43.	What challenges do you face during referral? (Health facility related)	
44.	What challenges do you face during referral? (Client related)	
45.	Do you have a VHT/ICCM register?	1) Yes 2) No
46.	What do you record in the register? **(please verify)**	……………………………. ……………………………. …………………………….
47.	How do you use the information you collect?	……………………………. ……………………………. …………………………….
48.	Where do you submit your monthly and quarterly reports?	……………………………. …………………………….
49.	Are these reports shared with the community?	1) Yes 2) No
50.	If yes in which ways do you share the reports	……………………………. …………………………….

51.	If no, why?	
52.	What challenges do you find in the course of your work?	
53.	How do you think these challenges can be rectified?	

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS INTERVIEW.

Appendix 6.7 Questionnaire for Ministry of Health officials

1. **DEMONSTRATION OF MOH COMMITMENT TO IMPLEMENT VHT STRATEGY**
    - Does the Ministry have a budget line to implement the VHT strategy?
    - In the last two quarters what has the Ministry done with VHT allocation?
    - What plans are in place for resource mobilization for VHT strategy?
    - What advocacy activities have been carried out to promote the roll out of the VHT strategy? (Influence policy, resource allocation, integration etc)
    - What are the supervision mechanisms in place?
    - What Quality control measures are in place and how is it done?

2. **COORDINATION**
    - How are the VHT activities coordinated from national to community level?
    - Are there any reports on coordination in the last two quarters?
    - Who is the focal person for VHTs at the Ministry?
    - What is the linkage between MoH and the districts in coordinating VHT interventions?
    - Does VHT working group exist? If yes, explain its functionality.
    - How can the coordination be strengthened?
    - How does MOH work with other partners in supporting VHTs

3. **POLICY FRAME WORK**
    - What policies and guidelines are in place to guide the VHT implementation? Are they available?
    - Has there been any review of policies and guidelines to meet new challenges and innovations?
    - Have policies and guidelines been disseminated to districts and partners?

4. **SUSTAINABILITY**
    - What mechanisms are in place to ensure continuity of established VHTs? - How often are the VHT kits, tools, registers, T-shirts replenished?
        - Are there planned refresher courses for VHTs? If yes, verify.
    - How has the Ministry utilized lessons and best practices learnt from other countries and other partners?

5. MOTIVATION

- Are there guidelines that define standard package for VHT motivation?
- Are these guidelines being adhered to by partners?
- What needs to be improved /harmonized to increase the morale of the VHTs to serve their community's health needs?

6. DATABASE ON VHTS

- Does the MOH have a data base for VHTs?
- If no, what are the plans for establishing the database?
- If yes, when was it last updated?
- Is the existing database adequate?
- What plans do you have to improve/update the database?

7. CHALLENGES

- What challenges have you encountered in implementing the VHT strategy? (consider political, Technology, economics, social, legal, environment)
- What are the possible solutions to overcome these challenges?

8. RECOMMENDATIONS

- Suggest ways of improving the VHT implementation framework?

What suggestions do have for improvement of VHT functionality?

What suggestions do you have for sustainability of VHTs functionality?

Appendix 6.8 Partner interview guide

General information

Name of Organisation…………………………………………………………………………
Name of respondent……………………………………………………………………………
Position of respondent…………………………………………………………………………
Phone number of respondent…………………………………………………………………
Name of interviewer……………………………………………………………………………

1. What activities does this organization do?..
   ………
   ………
   ………
   ……………………………….
2. When did you start supporting VHTs in Uganda?...

3. How have you been supporting VHTs in Uganda?

a) Strengthening the national capacity to provide quality VHT strategy implementation
b) Providing technical advice
c) Funding for core activities
d) Drugs and other supplies and logistics
e) Advocacy
f) Training VHTs
g) Others (specify)…………………………………………………………………………
   ………
   …………………………………………………

4. If funding, how much funds have you so far spent in regard to VHT support?...................
   ....

5. How do you know how your resources have been utilized?.................................
   ………
   ………
   ………
   ………
   …………………………………………..

6. How are you involved in the planning and evaluation processes?..................

………
………
………
………
……………………

7. Has this organization been involved in training of VHTs? a) Yes b) No
8. In which districts has this organisation carried out the training?..........................
   ………
   ………
   ………
9. What areas did you train on?
   a) Provide appropriate information about disease prevention and health promotion Correctly classify simple illnesses and give simple treatment
   b) Referring cases they cannot manage
   c) Referring cases with danger signs or complications
   d) Maintaining simple, village register and reporting
   e) Recognizing community members in need of rehabilitation and refer them to the appropriate services
   f) Skills such as direct observation of therapy or community case management (Fever, pneumonia ,malnutrition
   g) Others (Specify)…………………………………………………………………
      ……
      ……
      ………………………….
10. What methods did you use to train the VHTs?
    a) Brain storming
    b) Group discussions on specific issues
    c) Role-plays
    d) Games
    e) Field visits
    f) Sharing of experiences.
    g) Practicing what has been learned
    h) Refresher sessions after training to strengthen weaknesses found during supervision
    i) Additional topics according to new developments or health needs of the community.
    j) Others (Specify)…………………………………………………………………

………
………
…………

11. How many trainings has this organization so far offered?.....................................
12. What challenges do you think face VHT implementation in Uganda? ……………………
………
………
………
13. What do you think can be done to improve VHT operations?

Appendix 6.9 Health Centre interview guide

General information

District……………………………………………………………………………………..

Subcounty……………………………………………………………………………………

Parish………………………………………………………………………………………

Village………………………………………………………………………………………

Name of health centre………………………………………………………………………

Name of respondent…………………………………………………………………………

Position of respondent………………………………………………………………………

Phone number of respondent…………………………………………………………………

Name of interviewer…………………………………………………………………………

1. How long have you been working here?..Years
2. How many villages does this health centre cover?...
3. How many households does this health centre cover?...
4. How many VHTs operate under this health centre?...
5. What are the functions of VHTs
   a) Community Information management,
   b) Health Promotion and Education
   c) Mobilization of communities for utilization of health services and health action
   d) Simple community case management and follow up of major killer diseases (Malaria, Diarrhoea, Pneumonia) and emergencies
   e) Care of the newborn
   f) Distribution of health commodities
6. What diseases do the VHTs treat in the communities? 1) Malaria 2) Diarrhea, 3)Pneumonia, 4)Malnutrition
7. Do VHTs usually refer community members to this health centre? 1) Yes 2) No.
8. Under what circumstances do the VHTs refer community members to a health centre?
   a) ALL Pregnant women, newborns or children or other person with danger signs including red on the MUAC strap.
   b) Anyone with sudden recent loss of visual acuity, or a painful red eye or recent inability to close the eye
   c) Accidents or injuries.
   d) ALL conditions without danger signs for which the VHT has not received specific training, or if the VHT does not have the necessary medications
   e) Routine outpatient or outreach referrals for Immunisation, Antenatal Care, Post natal care (Mother and Infant)

f) Referral of children >6months with mid arm circumference (MUAC) yellow.
g) All conditions which require rehabilitation e.g after injury, patients with leprosy.
h) Others (specify)………………………………………………………………
………
……………………………………………….

9. What roles do VHTs play at this health centre?
a) VHTs refer patients to HC II/III/IV.
b) VHTs follow-up patients discharged from the health centres.
c) VHT members can serve as health management committee of Health Centre II.
d) VHTs assist at clinics and outreach

10. How does this health facility help VHTs to perform their duties?
   a) The VHT benefit from the training facilities of HCII/III/IV
   b) The VHT receives training, support and supervision from Health Centres.
   c) Commodities e.g kits for use at community level are stored
   d) Supervision of the VHTs

11. What constraints do you think face VHT operations in communities around this health centre?..
....
....
....
....

12. How do you think VHT operations can be improved?...
………
………
………
………
……………………

Appendix 6.10 Community interview guide

General information

District……………………………………………………………………………………………..

Subcounty……………………………………………………………………………………….

Parish…………………………………………………………………………………………….

Village……………………………………………………………………………………………

1. How many households are in this village?
2. How many VHT members do you have in this village?
3. How were VHTs formed in this community (Guiding principles)?
4. What is the composition of the VHTs as regards to gender (how many men vs women)
5. Do you know the functions of VHTs?
6. What are they?
7. What diseases do VHTs usually work treat?
8. How do VHTs relate to LCs (what activities do they do together, how do LCs help VHTs to do their work?)
9. How do VHTs relate to health centres (what activities do they do together, how do health centres help VHTs to do their work?)
10. How do VHTs relate to households and communities (what activities do they do together, how do households and the communities help VHTs to do their work?)
11. Who monitors VHTs in this community? How is monitoring done?
12. Have you benefited from the existence of VHTs in this community? How?
13. How do you think VHTs can be improved to perform better?

Appendix 6.11 District key informant Guide (LCV Chairman, CAO, RDC)

Name of the Key informant___________________________

Title of the key informant______________________________

Contact of the key informant---

1. What do you know about VHT?
2. Is there any mobilization of district leadership about VHT program?
3. How is the district supporting VHT activities?
4. Do you sometimes supervise VHT activities? How?
5. What does the district do to motivate VHTs?
6. What do you feel about the contribution of VHTs in promoting health services
7. What challenges does the district find in implementing the VHT program?
8. Suggestions to improve the VHT program

7.0 References

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