MINISTRY OF HEALTH

VHT

Village Health Team

Strategy and Operational Guidelines

VHT

Health Education and Promotion Division

March 2010

Contents

FOREWORD

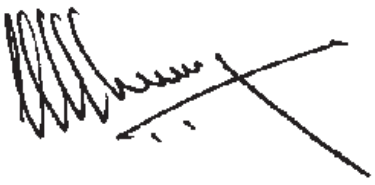
Village Health Teams (VHTs) were established by the Ministry of Health to empower communities to take part in the decisions that affect their health; mobilize communities for health programs, and strengthen the delivery of health services at house-hold level.

The Primary Health Care principle recognizes that health services should be accessible, cost-effective, tailored to local needs, characterized by inter – sectoral co-operation and delivered with the participation of the people. It is envisaged that the VHT strategy will enable the realisation the Alma Ata Declaration, and the recent 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa to which Uganda subscribes.

According to the HSSP 2000/01 – 2005/06, the key challenge to the health care system is to extend basic health care service to the entire population especially in rural areas where access to healthcare is limited. It is in this regard that HSSP I recommended establishment of VHTs, HSSP II and HSSP III called for roll out and consolidation of the VHT strategy.

This Village Health Team (VHT) Strategy and Operational Guidelines therefore incorporates lessons learned during the nine years since the publication of the first Strategy and Plan in September 2001. It has been updated following a long consultation process with stakeholders and Partners.

This document is intended to facilitate a good understanding of the VHTs strategy. This is the official guide to individuals and organisations that plan to or are implementing community-based health activities in Uganda. The important point to note is that all health activities and interventions must be coordinated through the VHT structure. The Ministry of Health will not allow creation of parallel or competing community structures apart from the VHTs. It is our policy and guiding document which we hope all stakeholders and partners will follow and support as we strive for better health for all Ugandans.



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For: Director General Health Services

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Particular mention is made of the following persons whose input and participation in various meetings enabled drafting to this document. Mr. Godfrey Kaggwa, Mr. Arsen Nzabakurikiza, Mr. Benjamin Sensasi, Dr. Geoffrey Bisoborwa, Mr. Collins Mwesigye, Dr. Charles Katureebe, Dr Claudia Hudspeth, Dr. Francine Kimanuka, Dr. Deo Sekimpi, Mr. Solomon Onyango and Ms. Rita Mwagale.

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1. BACKGROUND

Over the years, the Government of Uganda has been striving to improve the socio-economic standards of living through strategies such as the Poverty Eradication Action Plan (PEAP) and Vision 2020. These reforms, encapsulated in the Economic Recovery Program (ERP 1987) have aptly noted the significant role of health care delivery in development. Therefore, one of the fundamental missions of government has been improvement of health care for all in terms of provision, accessibility and utilization. Several studies in Uganda indicate unacceptably high morbidity and mortality rates from preventable diseases. Other studies have indicated that only about 49% of the population lives within five kilometres from a health facility.

In Uganda, over 75% of the diseases are preventable if only people changed and adopted appropriate and well known behaviors geared towards better health (MoH, 2005). Positive behaviors focusing on personal hygiene, sanitation, nutrition, sexual practices among others would improve the well being of many people and thus avert the high morbidity and mortality due to preventable diseases such as malaria, tuberculosis, upper respiratory infections, HIV/AIDS and childhood vaccine preventable diseases.

Implementation of health promotion and basic disease prevention measures at personal, family and community levels can turn the situation round and help the country make big strides toward the Millennium Development Goals and thus achieve better health and development for the people. Unfortunately, Uganda, like many African countries suffers from serious shortage of health human resources who would oversee and guide the people to implement these basic health interventions.

Community participation and empowerment is a strategy that enables communities to take responsibility for their own health and wellbeing and to participate actively in the management of their local health services. In the Uganda context, this will take the form of the Village Health Team (VHT).

The VHT will help to engender community participation in health and link the communities to the formal health service delivery system. This will also help bridge the current health human resource gap especially in rural or peripheral areas where the majority of the people live.

Establishment and utilization of VHTs demonstrates the commitment of Uganda to the aspirations and principles of the 1978 Alma Ata declaration and the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. These historic declarations emphasize fostering full community involvement in health and health care delivery in accordance with the primary health care approach. Inspiration for the VHT is also drawn from the 1986 Ottawa Charter on Health Promotion that calls for formulation of public health

policies, creation supportive environments, strengthening community action, developing personal skills and re-orienting health services all geared towards appropriate health care development and delivery.

According to the HSSP 2000/01 – 2005/06, the key challenge to the health care system is to extend basic health care service to the entire population especially in rural areas where almost thirty percent of the people live below the poverty line. It is in this regard that HSSP I recommended establishment of VHTs, HSSP II and HSSP III called for roll out and consolidation of the VHT strategy Village Heath Teams (VHTs) strategy was therefore conceived as a vehicle that could potentially help deliver much needed basic health care services direct to households and communities in Uganda.

2. JUSTIFICATION FOR THE VHT STRATEGY

Health is recognised as one of the fundamental pillars of human and national development and this is not only consistent with Uganda's development priorities but is also a commitment to achieving health related Millennium Development Goals (MoH, 2005). There is therefore a direct link between development and health outcomes at individual, community and national levels (MoFPED, 2001). Consequently, it is critical to foster an integrated approach to development tackling health from a development perspective. It is envisaged that engendering community participation and ownership through community-based structures such as VHTs will increase individual and community control over the determinants of health thereby contributing significantly to social-economic development of a country (WHO, 1986).

In Uganda as in other African countries, there is an acute shortage of health workers especially in rural and peripheral areas due to attrition, HIV/AIDS, migration or search for greener pastures (Lehmann and Sanders, 2007). This realisation makes initiation and widespread implementation of VHTs even more critical in order to reduce the workload on the few health workers or as a stop-gap measure in places where there is none.

Besides, in Uganda, more than 75% of the diseases are preventable (MoH, 2000) which can only be achieved through increased awareness, behavioural change and adoption of positive health practices. According to the National Health Policy, Health Sector Plans I, II and III the most effective way to achieve this is through interpersonal and group communication that VHTs can effectively perform in the villages where they live and are well known.

In addition, Uganda's poor health indicators such as, low latrine coverage, falling immunization coverage, inadequate and inappropriate ITN use, malnutrition or the high total fertility rate can be partly tackled through constant dialogue with the community members using VHTs. Moreover, in Uganda geographical access to health care facilities is limited to only 49% of households due to long distance or other natural features such as marshes, rivers, hills, forests or mountains (MoH, 2000). VHTs will help bridge the gap that exists between the un-served households and the formal health system. In that sense, VHTs will be the first contact with the health system or indeed as health centre I and this is consistent with the "task-shifting" approach.

In the past, MoH programmes undertook community activities in a vertical manner leading to fragmentation, duplication, wastage of resources and dissemination of conflicting messages. The table below shows some examples of the community based interventions that have been implemented vertically by MoH programmes vertically.

Programme	Resource persons trained for community work
UCBHCA	District and sub-county trainers Parish Development committees Community Health Workers
IMCI	Community Owned Resource Persons Community Based Growth Promoters
MCP	District and sub-county trainers Parish Mobilisers Drug distributors
UNEPI	Parish Mobilisers
RH	Community Based Distributors for OCP TBAs
ACP	Counselling Aides Home care providers Condom Distributors
EH&S	Water Source Committees Sanitation Aides (civil servants)

The VHT strategy is therefore meant to harmonise this arrangement so that MoH and partners approach the communities in an organised fashion that will increase efficiency and effectiveness of our programmes thus making them relevant to the communities.

The VHTs will also facilitate data collection at community level which will greatly assist in health planning and response in addition to undertaking disease surveillance and reporting especially in epidemic prone areas. There are also community resources that the VHTs can identify and harmonise to supplement the meagre district resources available for community activities.

3. VILLAGE HEALTH TEAM (VHT)

The Village Health Team is a community based (village) structure whose members are selected by the people themselves to promote health and wellbeing of the people in their areas of residence/jurisdiction. It is the lowest health delivery structure and serves as a Health Centre I.

1. Criteria for selection

At the end of the village sensitisation meetings, the Village/Local Council I with the help of the trainer maps all households in the village and from every 25-30 households they select one member of the VHT, through a popular vote. VHTs must be selected by the community itself and not imposed by political structures. The number should on average be five members per team. Selection should be gender sensitive. Political leaders such as the LC I chairperson, vice chairperson and secretary are not be eligible for membership for purposes of ensuring checks and balances.

Potential VHT members may already be Community Health Workers, Traditional Birth Attendants, Drug distributors or similar if acceptable to the community. If a VHT member drops out, a new member will be identified from the community during the quarterly review meetings. The new member will acquire knowledge and skills from on-job training.

2. Qualities of a VHT Member

After successful sensitization of the community leaders, community members and other key stake holders on the importance of VHTs, the following criteria shall be used for selection:

- Should be exemplary, honest, trustworthy and respected
- 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 mobilizer and communicator
- Ideally should be able to read and write at least the local language
- Should be dependable and approachable
- Should be a good listener
- Should be 18 years and above

3. Composition of the VHT

The size of the team depends on the number of households in a given village. On average it should be one team member per 25-30 households. The more sparsely populated area is, the less the number of households per member. However in areas where people live in close proximity, the number of households per VHT member can be more than 30. The team selected per village must be gender balanced with at least a third of the members women. Each Village should have an average of five VHT members.

4. Objectives of VHT

The overall objective of the VHT strategy is to promote health at individual, family and community levels. Specific Objectives are:

1. To promote community participation and involvement in health
2. To promote positive health behaviour and practices
3. To promote health care seeking behaviour
4. To strengthen timely health service delivery at community and household levels
5. To promote community based health information system
6. To foster coordinated delivery of integrated services at community level

5. The major roles and responsibilities of a Village Health Team

These shall include the following:

- Home visiting
- Mobilization of communities for utilization of health services
- Health Promotion and Education
- Community based case management of common ill health conditions
- Follow up of the mothers during pregnancy and afterbirth and the newborns for provision of advice, recognition of danger signs and referral
- Follow up of people who have been discharged from health facility and those on long term treatment
- Distribution of health commodities
- Community information management
- Disease surveillance

4. GUIDING PRINCIPLES FOR VHT STRATEGY

The guiding principles for the VHT strategy will be the following:

1. Community Ownership

The community is responsible for selection, supervision and support of the VHT. The VHTs are fully accountable to the communities in which they operate and their services/ responsibilities are community driven**.**

2. Equity and Access

VHT services are meant to o benefit all members of the community especially those in rural peripheral areas or marginalised communities.

3. Community Support

While performing their roles and responsibilities, the VHTs shall be supported by their own communities, local health facilities and local political structures.

5. IMPLEMENTATION STRATEGIES

The following Strategies are recommended to facilitate implementation of VHT strategy:

1. Advocacy, social mobilisation and communication

This aims at creating awareness, building consensus, and gaining political commitment and support (e.g. resource allocation). Standardized communication strategies and materials for advocacy, and social mobilisation and communication coordinated by the Ministry of Health will be used for different target groups.

2. Networking and Partnerships

This will be between households, communities, VHTs, the health system, the political structure, community based organisations, development partners, community structures such as churches, schools and extension workers.

3. Capacity Building

Training sessions will be conducted guided by the Ministry of Health for district facilitators and DHT members. The Ministry of Health and district health teams will ensure provision of Health Promotion materials, HMIS data collection tools and availability of basic VHT Kits. They will also build supervisory capacity at all levels in addition to improving the logistical distribution system to reach the VHTs.

4. Resource Mobilisation

Functioning of VHTs requires continuous, harmonised pooled financial support, planning, and monitoring and well coordinated resource allocation. At all levels, there should a clear allocation of funds for integrated community level interventions through the VHT.

6. VHT CO-ORDINATION

The Ministry of Health is the central player, leader and driving force of the Village Health Team Strategy. The Ministry shall coordinate advocacy and fund raising activities and also ensure that effective interventions are selected at district and local levels according to local needs but in conformity with national policy. All actors shall work within a common framework with standardised key messages, harmonised training and communication materials, and using the VHT as conduit for service delivery. Below is how the VHT will be coordinated at different levels.

1. National level

Stakeholders Forum

There shall be a Stakeholders Forum whose membership includes; key Technical and Health Development Partners, Key Implementing Partners and Key funding Partners. The forum shall be responsible for coordination, VHT consensus building and experience sharing. The Stakeholders Forum shall be convened at least once a year. The health policy advisory committee shall steer this forum.

National Coordination Committee

The National Coordination Committee will work through the Basic Package Working Group. It will comprise of membership from the basic package Technical Working Group and shall meet quarterly.

Some of the membership shall include among others:

a. Ministry of Health programmes i.e.

- Malaria Control Programme
- Reproductive Health Division
- Child Health Division
- Uganda National Expanded Programme on Immunization (UNEPI)
- Environmental Health Division
- Health Management Information System
- Nutrition Section
- National Tuberculosis and Leprosy Programme
- Health Planning Department
- AIDS Control Programme
- Neglected Tropical Diseases
- Support to Health Sector Strategic Plan 11 (SHSSPP2)

b. Other Government Ministries and Institutions

c. Development Partners

- UNICEF
- World Health Organisation
- UNFPA
- USAID
- World Bank
- DANIDA
- SIDA
- ADB
- NGOs/CSOs (International and National)

The functions of the National Coordination Committee shall be:

- Leadership and stewardship
- Policy guidance
- Oversee progress
- Technical guidance
- Mobilise funding for VHT implementation

The Secretariat

There shall be a Secretariat headed by the Assistant Commissioner for Health Promotion and Education. Health Promotion and Education shall be responsible for overseeing and coordinating the implementation of VHT at all levels. The Health Promotion and Education Division shall be the VHT National Coordination Office. The Roles of the secretariat shall include:

- Harmonising of community based interventions of different programme and streamlining them into the National VHT plan
- Guide activities of development partners to ensure effective coverage and logical synchronization of community based interventions
- Documenting all the VHTs operations and activities

2. District Level

At district level, the District Health Officer (DHO) shall be responsible for overall planning, implementation and monitoring of VHT activities. He can delegate a member of the district health team to be responsible for the VHT activities. Through the Chief Administrative Officer, all other departments will be required to utilise and support the VHT structure to implement their health related community activities.

VHT activities shall be fully integrated into the District Health Development and Operational Plans and it will be the guiding document for community-level health interventions in the district.

All stakeholders and implementers are coordinated by the DHO and all community level health interventions coordinated through VHT.

Health Sub-District

The in-charge of the Health Sub-District with the assistance of the Assistant Health Education office shall be responsible for overall planning and coordination VHT activities at the Health Sub-District level. VHT activities shall be integrated into the Health Sub-District work plan which is developed from Health centre level. The in-charge shall be responsible for sensitisation of sub-county leaders and will ensure that activities of partners working at sub-county level are included in the sub-county and health facility work plans which are eventually amalgamated into a Health Sub-district work plan. The in-charge and the Assistant Health Education Office will be the custodians of supplies and commodities that are used by the VHT

Sub-County

The In-charge of HCIII with assistance of other sub county VHT Trainers will be responsible for planning, implementation and monitoring of VHT activities in the sub county. The In-charge may delegate some of the responsibilities to an active and competent Health worker in-charge of the sub-county. The in-charge in collaboration with the sub-county chief shall ensure that the health activities of NGO's are implemented through the VHTs.

Health Facility

Health facilities of all levels shall be responsible for coordination, implementation, monitoring and evaluation of VHT activities within their areas of responsibility. Health Centres shall provide technical guidance to the VHTs, replenish

commodities and health supplies, hold regular meetings with VHT members, encourage them to participate in health unit activities and give them support supervision.

Community (Parish and LC 1Levels)

This is the implementation level of VHT activities. The Community leaders (LC1 and Parish chief) will be responsible for coordination, overseeing and administrative (non-technical) supervision of VHT activities in their areas. The VHTs will be accountable to the community leaders. For proper function VHT members will select a team leader, a secretary and treasurer from amongst themselves and coordinator at parish level.

7. MOTIVATION AND SUSTAINABILITY

VHT Members are expected to perform their roles and responsibilities on Voluntary basis, and yet they are expected to achieve the set objectives for the VHT strategy. The Ministry of Health therefore proposes some incentive mechanisms that may be used to reward and motivate the VHT members and thereby sustain the programme**.**

1. Initial Incentives

The following shall be provided to the VHT as incentives to accept the assignment and begin work**:**

- Good quality training
- Award of certificates
- Commissioning ceremony
- Badges, T-shirts, bags
- Job aides
- IEC materials
- Registers

2. Continuous/consistent use of the VHTs

These will be required to sustain the services of the VHT and minimize attrition hence they should be provided on a continuous basis.

VHT is a government policy and it stipulates that all health activities at community level by the government, NGOs and or Partners targeting communities shall be coordinated through VHTs. This includes health promotion activities, campaigns and other health events and functions. This will keep VHT members engaged, will feel useful and benefit from the benefits of the programs' activities including allowances. VHTs can also be assigned tasks like distribution of IEC materials. This in turn makes the community value and continue demanding and utilising their services.

3. Health Promotion Activities

VHTs will be supported to initiate and organise health promotion initiatives like drama with health messages. This will serve as entertainment or recreation as well as education for community from which VHT members earn recognition.

4. Budgetary provision

As a priority area in health service delivery, VHT activities should be planned and budgeted for at all levels from national to the village level. Local councils should put in place innovative financing mechanisms to support VHT. Areas for budgeting include but not limited to the following:

- ❖ Support supervision
- ❖ Facilitation for regular meetings between VHT, health workers and trainers
- ❖ Allowances for VHTs. The Ministry of Health and District Local Government shall advise on the rates from time to time to guide actors for purposes of harmonisation. A minimum monthly stipend of $5 (UGX 10000) which can be paid quarterly during the Quarterly Review and planning meetings)
- ❖ Monitoring

5. Task Specific Allowances

Government, NGO's and Partners will facilitate VHTs in the performance of specific extraordinary tasks. Such allowances will cover items like transport and lunch.

6. Refresher Training of VHTs

The VHTs shall undergo continuous refresher and update training organized by Government, NGO's and Partners using standardized VHT materials, additional modules for specific services and other specific areas like: Malaria, Reproductive Health, Child Health and others. This will improve their knowledge and skills and also motivate them to keep serving as VHT members.

7. Logistics and Supplies

There should be a constant supply of medicines and supplies and other logistical support to enable VHTs provide services to their clients including their own families all the time. Once there is shortage of these supplies the VHTs may be demeaned by the community which may lead to frustration.

8. Follow up, support Supervision and mentoring

VHTs will receive regular follow up and supervision from their trainers and health workers. During supervision VHTs will be supported to improve their skills. Where necessary, VHTs will be offered apprenticeship training at the health facility to get hands on training.

9. Recognition and appreciation by health workers, leaders and community

Leaders at all levels shall be oriented to recognize and show appreciation of the services of VHTs in public. This works as a marketing strategy for the services of the VHTs and also makes them feel important and that their services are valued and hence keep serving.

10. Preferential treatment

Aside from the medical criteria for priority treatments, VHT shall be given preferential treatment at health facilities and other services in the community

11. Functional linkages between VHTs and health facilities

VHTs will be closely linked to the health facilities. They will receive apprentiship training at health facilities. Health facilities will be oriented to honor referrals from VHTs and refer discharged patients where necessary for follow up in the community.

12. Regular meetings between trainers, health workers and VHTs (Including community leaders)

There will be quarterly meetings between VHTs, Health facility staff including the trainers/supervisors and LC I chairpersons, Parish Chiefs and LC II Chairperson. During the meetings, VHTs will be able will share experiences, present their reports and obtain feedback. The meetings will also be used as opportunity to provide refresher trainings to VHTs. At the end of the meeting, all those attending will get a transport refund of UGX 5000. In addition, VHTs will be given their monthly stipend for the previous quarter.

13. Study tours and exchange visits

Government and Partners shall from time to time organize study tours and exchange visits for VHTs. This will enable VHTs to learn through observation of best practices within and outside their own districts. Travel and its associated fun and allowances will serve as a motivation for the VHTs.

8. ROLES AND RESPONSIBILITIES OF DIFFERENT STAKEHOLDERS

1. Ministry of Health

To provide policy framework for the establishment, functioning, monitoring and evaluation of the VHTs. The Ministry will specifically:

- Define minimum package of services and standards to be provided by VHT
- Provide guidelines on recruitment, retention, facilitation and motivation of VHTs
- Policies to link VHTs with health and health related interventions
- To ensure availability of medicines and supplies as provided for in the package
- MOH to take lead in resource mobilization for VHTs
- To provide overall coordination and supervision in VHT implementation
- To link up with relevant ministries to harmonise policy frameworks in support of VHTs.

2. Local Governments

- To integrate VHT strategy into their development and operational plans
- To allocate and avail resources for implementation of activities
- To formulate, pass and enforce by-laws in support of VHT functions
- To promote intersectoral collaboration in the local government
- To ensure harmonised and integrated implementation of health activities at community level using VHTs.
- To ensure that all those delivering community based health care interventions do so through VHTs and avoid creating other parallel structures

3. Development Partners

- To contribute to policy development, monitoring and evaluation
- To provide technical, financial and logistical support for the operationalization of the VHT strategy
- To support documentation and sharing of best practices

4. Non Government Organization and Civil Society Organisations

- Participate in joint planning with Government Health planning authority at all levels
- Facilitate functioning of VHTs in accordance with the National Strategy Guidelines
- Integrate their community based health programmes into the district VHT plan
- Promote and raise the profile of the VHT strategy
- Sensitize communities on the roles of VHTs

5. Health Facilities

- To take overall technical responsibility for all VHT activities within their areas of responsibility
- Conduct training and supervision of VHTs
- Support management of medicines and supplies for VHTs
- To regularly organize planning, review meetings and refresher programmes with VHTs in their catchment areas
- To receive, analyze, utilize VHT data and provide feedback

6. Local Council 1 Executive

- To advocate for VHTs
- Sensitize communities on the roles of VHTs
- Provide time for VHTs to talk about health issues at community meetings and other public gatherings
- Enforce implementation of advice based on recommendations given by VHTs on health issues
- Initiate and implement motivation schemes for VHTs
- Participate and also mobilise communities to participate in VHT initiated activities

7. Communities

- Volunteer for VHT work
- Select VHT according to the national guidelines
- Seek and utilize and the services of the VHT
- Recognize and appreciate the services of VHT
- Help VHTs to collect medicines and supplies from heath centres
- Report health incidences in the community to VHTs
- Respond to the call for community activities initiated by VHTs

9. VHT IMPLEMENTATION GUIDELINES

The VHT Operation Guidelines provide a benchmark for VHT implementation at different levels and identifies roles and responsibilities for each party at the following levels:-

- National Level
- District Level
- Health Sub-District Level
- Sub-county Level
- Parish Level
- Community Level

The Guidelines specify in detail what activities that needs to be done at each level and how each activity will be done. It also identifies the responsible person or officer for a particular activity, source of funding and the indicators to show that that a particular activity has been accomplished.

Coordination and Networking

At all levels Government will be the lead and coordinating agency for VHT implementation, but all other stakeholders willing to work towards the common goal will be free to participate in a coordinated way. With Ministry of Health and District Health Offices in the lead, all stakeholders need to be brought on board, but in a coordinated way.

At national level all stakeholders supporting the VHT Strategy must do so through Ministry of Health.

At District level all stakeholders must support the VHT Strategy through the District Health Office, similarly at HSD and SC levels.

Lastly, all community level health interventions will be coordinated through the VHT.

Advocacy

Taking into account the issues in the Background to VHT strategy, advocacy will remain a key intervention for the acceptance, adequate resourcing and successful implementation of the VHT Strategy.

Capacity Building

Capacity building shall include the clarifying of the rationale/justification of the VHT Strategy. The information and training for district level sensitisation, Training of Trainers and Initial Training of VHT shall have standard materials approved by Ministry of Health.

The VHT members should have continuous capacity building after the initial training. This should involve refresher training, hands-on work at the nearest Health Unit and regular supervision by the VHT Trainers/Supervisors.

Supervision

VHT Supervision is one of the main determinants for the SUSTAINABILITY of the VHT Strategy. The most critical supervision is that of VHT members by their VHT Trainers/ Supervisors. Adequate thought and resources need to be allocated to this.

Reporting and Feed back

Reports need to be timely so as to be useful for planning and decision making. Reports should be discussed by all key stakeholders so that they form the basis for continuous improvement of health. The Quarterly VHT Meetings should discuss reports from the previous three months.

Monitoring and Evaluation

There must be a mechanism to find out whether VHT activities are implemented according to the set guidelines, monitor the activities of the VHT and eventually evaluate the VHT impact on health.

Planning and Budgeting

The main mobiliser of financing for the VHT Strategy is Government on behalf of the people of Uganda. Partners should continue to support where necessary. Districts are also encouraged to include VHT activities in their work plans and budget for them especially supervision of VHTs.

MATRIX FOR VHT OPERATIONAL GUIDELINES

NATIONAL LEVEL					
Area of focus	**What will be done**	**How it will be done**	**Person Responsible**	**Source of Funding**	**Indicators**
Coordination and Networking	Establish and operationalize national coordinating committee and secretariat	• Develop strategy, guidelines and standards • Hold quarterly meetings • Disseminate guidelines • Develop a scale-up plan for VHT implementation.	• MOH specifically DHS (C&C), Secretariat (ACHS-HP&E Office)	• Ministry of Health • Partners	• Minutes of meetings • National Coordination Committee in place • Secretariat in place
Advocacy	Raise profile of VHT developing consensus about the need for VHT and Mobilizing support including financial support	• Lobbying for resources • Orientation of partners, political leaders, line ministries and district authorities, religious organisations, Traditional leaders and other national stakeholders. • Have in place standardised advocacy tools	The Secretariat	• Ministry of Health • Partners	• Number of times stakeholders' forum has met • Participation of stakeholders in VHT activities
Capacity building	• Develop training plan, • Develop training materials • Technical support to districts for VHT capacity building • Conduct district level orientation for leaders • Conduct district training of trainers • Monitor training at lower levels • Develop and avail implementation guidelines to be adhered to by the MOH, Partners, districts and NGOs	• Training • Sensitisations • Field trips • Seminars • workshops	• The Secretariat • National Trainers	• Ministry of Health • Partners	• National Coordination Committee • A VHT training plan in place, • VHT training materials in place • Technical Support Team to assist districts with VHT capacity building

Supervision	• Conduct support supervision to the district health team	• Include VHT supervision in the quarterly Area Team visits • Review district VHT reports • Conduct technical support supervision	• Secretariat • Trainers • National Co-ordinating Committee	• Ministry of Health • Partners	• Reports of quarterly area team visits • Support supervision reports to districts
Reporting and feedback	• Develop a district reporting format • Design a computer program to capture all data • Produce quarterly and annual reports	• Receive reports from districts about, training, activities, funding agencies and others • Compile information into a data base • Receive queries and inquiries about VHT and respond accordingly • Make feed-back reports to all districts about VHT activities countrywide • Provide a comprehensive report for the Annual National Health Assembly	• The Secretariat • MoH Resource Centre	• Ministry of Health • Partners	• Reports • NHA report • Database
Monitoring and evaluation	<u>Monitoring</u> • Checklist for Develop and avail implementation guidelines to be adhered to by the MOH, Partners, districts and NGOs • Reviewing district reports • Conducting support supervision <u>Evaluation</u> • Conduct a mid-term review every two years • Conduct a comprehensive evaluation every five years • Conduct field research		• The secretariat • Development Partners • MOH Programmes • Resource Centre • Universities/ research institutions	• Ministry of Health • Partners	• Have a functional M&E Programme in place • (Develop indicators from activities) • Evaluation report

Planning and budgeting	• Ensure there is a VHT Budget line supported by MOFPED at national and district levels • Develop budgets and proposals	• Project financial requirements for VHT • Mobilise funding to support VHT • Advocate for funds	• Planning Secretariat	• Ministry of Health • Partners	Stakeholders forum

DISTRICT LEVEL					
Area of focus	**What will be done**	**How it will be done**	**Person Responsible**	**Source of Funding**	**Indicators**
Coordination/ Linkages	• Build Multisectoral partnerships and linkages in support of the VHT Strategy in the District • Build Multisectoral partnerships and linkages in support of the VHT Strategy in the District	• Orientation leaders and partners in key stakeholders implementing activities at community level • Maintain DHT cohesion on issues of VHT Strategy implementation • Define and maintain linkages with other District Departments, DPs, NGOs, CBOs and any other defined stakeholders • Define and maintain linkages with HSDs and SCs on VHT issues • Orientation leaders and partners in key stakeholders implementing activities at community level • Maintain DHT cohesion on issues of VHT Strategy implementation • Define and maintain linkages with other District Departments, DPs, NGOs, CBOs and any other defined stakeholders • Define and maintain linkages with HSDs and SCs on VHT issues	• DHO assisted by the DHE or other named person in the • District serving as VHT Coordinator • CAO to chair the District VHT Coordination meeting	• Ministry of Health • Ministry of Local Government, • Other Partners	Inter-sectoral District VHT Coordination Committee Minutes and reports of meetings

Advocacy	• Raise profile of VHT • Developing consensus about the need for VHT and Mobilizing support including financial for VHT • Enlist collaboration and support of partners • Identify the stakeholders	• Organise District VHT Advocacy forums • Use and disseminate VHT advocacy tools • Sensitising and lobbying district political leaders, district departments and constituency and sub-county leaders, religious leaders, traditional leaders and other district stakeholders. • Translate standardised advocacy tools into local language(s) • Map the VHT partners and their VHT activities in the district • Coordinate the dissemination of VHT materials • Lobby stakeholders/partners to buy in all key areas of collaborations • Develop a three to five year District VHT master plan • Ensure that all VHTs materials are collected from Ministry of Health and are distributed to all Health Sub-Districts and Sub-Counties. • District Technical Planning committee • Through budget conference meeting	• District Health Officer	• Ministry of Health / • Ministry of Local Government • Other Partners	VHT incorporated in district plan and budget plan

Capacity building	• Conduct HSD/SC level VHT sensitisation • Carry out District Training of VHT Trainers with back up of MOH • Supervise, back up and Monitor training of VHTs at lower levels (HSD/SC) • Technical support to HSDs/ SCs for continuous VHT capacity building • Train HSD/SC Trainers for supervision of VHT activities	• A District VHT training plan, • Collect from MOH VHT training materials and if necessary translate them into the local language(s) • Provide technical support to HSDs and Sub-Counties for VHT capacity building • Develop District VHT supervision Plan • Develop District VHT M & E Plan	• DHT	• MoH • District Local Government • Other Partners	Inter-sectoral District VHT Coordination Committee Training plan Training reports
Supervision	• Monitor supervision carried out by HSDs and SCs • Collate supervision reports • Include VHT supervision in all DHT field/supervision visits • DHT members to attend a specified number of Quarterly Sub-County VHT Meetings in different HSDs/ SCs every quarter • Use standard check list and or supervision forms • The secretariat members to attend a specified number of Quarterly Sub-County VHT Meetings in different districts every quarter • Use standard check list • and or supervision forms • Provide a check list and or supervision forms to HSD and SC VHT Trainers	Conduct support supervision to the HSDs and sub county levels	• DHE or other named District VHT Coordinator	• Ministry of Health / MOLG/Other Partners	Inter-sectoral District VHT Coordination Committee

Reporting and feedback	• Adopt national format and content of VHT Reports from HSDs and SCs • Ensure reporting compatible with HMIS • Receive VHT reports from HSDs and SCs • about all VHT training and field, activities • Compile information into a District VHT data base • Provide a comprehensive report for MOH Resource Centre and l VHT Secretariat • Compile an Annual VHT Report for the District Technical and Planning Committee • Provide feed-back of all aggregated reports to all HSDs and SCs about VHT activities and Community Based Health Indicators	• Develop a district reporting format compatible with HMIS • Establish a District Data base for VHT activities • Produce quarterly reports documenting zero reporting • Produce annual report	• DHO	• Ministry of Health • District • LG/Other • Partners	Inter-sectoral District VHT Coordination Committee District VHT database in place
Monitoring and evaluation	• Adopt and use the national monitoring and evaluation checklist.	• Monitor to ensure that guidelines are adhered to by the districts and NGOs during implementation • Conduct a mid-term review comprehensive evaluation of all District VHT activities • Reviewing HSD/SC VHT reports • Conduct operational field research	• DHO	• Ministry of Health • District • LG/Other • Partners	Checklist adopted Mid-term review Reports available

Planning and budgeting	• Budget and mobilise funds • Rational allocation of funds for VHT activities in the District	• Develop plans and budgets based on defined VHT activities in the district • Advocacy and lobbying for VHT funding • Ensure there is a VHT Budget line at District, HSD and SC levels • Mobilise funds for VHT from MOH, other GOU Ministries and Agencies, Development Partners, private sector, NGOs and other legitimate sources	• DHO's Office	• Ministry of Health • MOLG/Other Partners	Plans Budget allocation

HEALTH SUB DISTRICT					
Area of focus	**What will be done**	**How it will be done**	**Person Responsible**	**Source of Funding**	**Indicators**
Coordination	• Incorporate all VHT activities in the HSD plan • Develop HSD VHT Implementation Plan • Coordinate all HSD and SC efforts towards implementing the VHT Strategy in the HSD	• Identifying all VHT stakeholders in the HSD • Organising quarterly VHT Coordination meetings in the HSD	• HSD in-charge	• Ministry of Health/DLG/ DPs/NGOs/ CBOs • Other partners	Minutes Quarterly Reports
Supervision	• Develop VHT Training supervision Plan • Orient Sub-County VHT trainers on supervision skills for VHTs • Conduct support supervision to the Sub-Counties, Parishes and Village in the HSD	• Carry out support supervision to lower health units • Monitor VHT implementation activities • Monitor supervision carried out by Sub-County VHT Trainers • Conduct Sub-County level sensitisation together with Sub-County VHT Trainers • Participate in district training of Sub-County VHT trainers • Supervise and Monitor training at Sub-County and Parish levels • Technical support to Sub-County VHT trainers for VHT capacity building	• Assistant Health Educator or named HSD VHT Coordinator	• Ministry of Health/DLG/ DPs/NGOs/ CBOs • Other partners	Supervision reports

Reporting and feedback	• Update the area MP on VHT implementation • Ensure VHT reporting from all VHT members and SC VHT Trainers in the HSD is compatible with MOH HMIS format	• Collate SC VHT supervision reports into HSD supervision report • Adopt an HSD VHT reporting format compatible with MOH HMIS • Receive monthly/quarterly VHT reports from SC VHT Trainers about all VHT activities in the HSD • Compile information into a monthly/quarterly and annual HSD VHT report , accumulated to a computer based HSD VHT data base • Make feed-back reports to all SCs about aggregated VHT activities in the HSD • Provide a comprehensive HSD VHT report to DHO	• HSD In-charge	• Ministry of Health/DLG/ DPs/NGOs/ CBOs • Other partners	Reports
Monitoring and evaluation	• Develop and implement HSD VHT Monitoring and Evaluation Plan Make sure implementation guidelines are adhered to by the sub-counties • Conducting Monitoring visits	• Participate in midterm reviews and 5 year evaluation • Review SC VHT reports • Conduct operational field research • Acquire and use VHT implementation guidelines and standards developed by MOH	• HSD In-charge	• Ministry of Health/DLG/ DPs/NGOs/ CBOs • Other partners	Monitoring reports Research reports
Planning and budgeting	• Incorporate VHT activities in HSD plan	• Conduct planning meetings	• HSD In-charge	• Ministry of Health/DLG/ DPs/NGOs/ CBOs • Other partners	VHT activities included in HSD plans

SUB COUNTY					
Area of focus	**What will be done**	**How it will be done**	**Person Responsible**	**Source of Funding**	**Indicators**
Coordination	• Coordinate all VHT activities in the sub county and make sure that all community level health interventions are implemented through the VHTs • Linking VHTs to the health facilities	• Pass enabling by-laws • Organise a health forum for all stakeholders in the sub county	• HC III In-charge is the coordinator • Sub county chief chairs the meeting	• MOH • District • Sub county • Partners	By-laws in place Minutes from the Stakeholders forum
Advocacy	• Sensitisation of sub-county leaders on VHT implementation	• Hold sensitisation meetings • Sub county council meetings	• HC III In-charge is the coordinator	• MOH • District • Sub county • Partners	Meeting reports
Capacity building	• Plan for VHT training • Conduct VHT training • Provide logistics • Orientation of health workers on VHT strategy	• Organise selection meetings • Order, store and distribute commodities and supplies • Meetings /workshops	• HC III In-charge , CDO, HA	• MOH • District • Sub county • Partners	Reports of VHT selection meetings Inventory of logistics Database of VHTs in the Sub county Training reports
Supervision	• Follow up VHT members in their communities. • Conduct monthly VHT meetings • Conduct quarterly VHT meetings	• Conduct Support supervision • Schedule meetings	• Sub County VHT trainers	• MOH • District • Sub-county • Partners	Reports of VHT selection meetings Receiving monthly reports

Reporting and feedback	• Submit VHT activity reports to HSD • Have a VHT performance monitoring • Receive reports from VHTS • Make consolidated VHT report to the HSD • Give VHTs comments on the reports they submitted	• Meetings with VHT members	• Sub County VHT trainers	• MOH • District • Sub-county • Partners	Reports of VHT selection meetings
Monitoring and evaluation	• Monitoring VHT member activities	• Following up VHT members in their communities	• Health Assistant • Community Development officer	• MOH • District • Sub-county • Partners	Reports
Planning and budgeting	• Prepare a plan and budget for VHT activities and Incorporate it in sub-county health plans	• Sub-county technical planning meetings	• In- Charge • Health Assistant • CDO	• MOH • District • Sub-county • Partners	Availability of workplan VHT activities incorporated into sub county health plan

HEALTH CENTRE II LEVEL					
Area of focus	**What will be done**	**How will it be done**	**Person Responsible**	**Source of Funding**	**Indicators**
Coordination and reporting	• Organise Quarterly meetings with VHTs • Receiving new information • Sharing experiences • Review of reports • Review and update of key messages • Re planning	• Quarterly meetings	• In charge HC11 • VHT focal person • Health Assistants	• Ministry of Health • DLG • SCLG, Communities and • Partners	Quarterly meeting reports and registers available
Logistics and Supplies	• Receiving and accounting for medicines, supplies and commodities	• Use Stock cards to account and requisition for more supplies	• In charge HC11 • Parish chief	• N/A	Logistical reports
Supervision and mentoring of VHTs	• Follow up and support VHT members in the field on a monthly basis	• Community visits • Home visits	• Health Assistant • VHT trainers	• DLG • SCLG	Activity reports

VILLAGE LEVEL					
Area of focus	**What will be done**	**How will it be done**	**Person Responsible**	**Source of Funding**	**Indicators**
Coordination and reporting	• Establish a VHT leadership to coordinate VHT members • Monthly village health team meetings chaired by the LC I • Village level Data collection, use and reporting of findings • Submit summary reports to health facility	• In each village, the VHT members select amongst themselves a Team leader, Secretary and Treasurer • Use of VHT household register and summary forms • Organising VHT meetings with LCI chairperson	• VHT Leadership and • LCI chairperson		VHT team leadership available Reports available Meetings take place
Capacity building	• Build the health and development capacity of community members • Community empowerment • Distribution of health commodities and medicines • Educate people about life skills and community health practices	• Regular contact with household members • Community dialogues at formal or informal meetings • Interpersonal communication • Home visits • Community functions e.g. weddings, burials, football matches etc • Organise drama sessions • During outreaches e.g. child days plus • Apprenticeship (hands on training)	• VHT members		Reports of home visits Number of functions addressed Number of commodities received and distributed Number of community dialogues held
Activities to be Implemented by VHT Members					**Indicators**
Be a role model		• All VHTs must keep a model home • Availability of safe drinking water • A Clean usable latrine with hand washing facility with soap • Separate accommodation for animals • Availability and use of Long Lasting Insecticide Net(s)	• VHTs		Number of VHTs with model homes

Implement Social mobilisation activities	• Distribute IEC materials • Inter Personal Communication • Drama • Organise sports activities • Use media e.g. radios	• VHTs		Number and types of IEC materials disseminated Number of recipient homes of IEC materials
Home visiting	• Check for the presence and advise on the use of sanitation facilities • Check for the existence of a pregnant or new mother and advise on the importance of antenatal /Post natal • Check on the availability and care of newborns and other vulnerable children • Check for availability of people with disabilities • Check for availability of chronic illnesses • Check for the presence and utilisation of ITNs • Check on and advise on any other relevant health issues.	• VHTs		Number of homes visited Number of home visits made
Saving lives	• Identify danger signs especially among women, children and PWDs • refer cases to health facility • Mobilise for immunisation • Advise pregnant women to go for ANC and Postnatal for mothers and their newborns • Give simple treatment for malaria, diarrhoea, pneumonia and others	• VHT		No of cases referred No of cases treated No of immunisation sessions supported Number of women counselled for ANC and PNC Number of newborns visited at home

Support	• Support people on long term treatment and those in need of special attention e.g. victims of Gender Based Violence, HIV, CB-DOTs • Advise on food security and nutrition in homes • Advise on education of children especially the Girl Child up to 18 years			No of people with special needs / on long term treatment supported No of homes advised on food security and nutrition No of families counselled on the importance of education esp. of the girl child
Linking community to formal health sector	• Referral of patients • Participate in meetings at the health centre • Following up discharged patients from health facility • Data collection and reporting			No of referrals No of meetings participated in No of discharged patients followed up Report
Data collection, record keeping, reporting and feedback	• Draw a community map • Fill in and update the VHT household register • Report notifiable diseases and other unusual health occurrences • Collect compile, use data and give feedback to community • Report data to relevant authorities			Community map Completed VHT household register Notifiable diseases reported Reports and feed back to authorities

10. STANDARDS FOR VHT IMPLEMENTATION

Standards for VHT (Showing a good example)
All VHTs must keep a model home
A clean usable latrine with hand washing facility with soap
Availability of safe drinking water
Separate accommodation for animals
Availability and use of Long Lasting Insecticide Net(s) (LLINs)
Standards for VHT Kit
All VHT members will be equipped with a standard Kit and certificate
ALL Partners will supply the same minimum kit
Composition of the VHT Kit: Badge, Bag , Register , VHT Participant Manual, Health Promotion Flip charts, Standardised IEC materials and Job Aids
Availability of essential drugs
Community Case Management
Medicines used at community level in accordance with national guidelines
The defined Essential drugs are available in the VHT drug Kit and Drugs are not expired and all strengths present
All any stock out will be documented and counted
Standards for ICCM Kit
The ICCM kit will include: Pre-packed medicines for malaria, pneumonia and diarrhea: Amoxicillin for non severe pneumonia, ACTs for uncomplicated malaria, Low Osmolarity ORS for diarrhea, Zinc for diarrhea, rectal Artesunate for pre-referral patients, diagnostic commodities e.g. respiratory timers, MUAC tape, user items e.g. Job Aid cards.
Standards for VHT Training
• All VHTs will have 5 day standard training in health promotion, which conforms to agreed norms and standards content, duration and ratios of VHTs to facilitators
• Additional modular training will be given to every VHT member.
• Quality assurance will be applied for norms and standards of additional training • Certificate • Training will be conducted using standardised materials • Quarterly meetings should include refresher trainings
• VHTs will select amongst themselves two people but the selection of these members should be guided by geographical location to ease access. • Thirty people should be trained as VHT members in a single training for a course of five days.

Minimal skills required by VHTs for Core Functions
Knows roles and responsibilities
Able to fill out VHT register
Knows Key Messages (Key Family practices)
Ability to communicate effectively
Observational skills
Mobilisation skills
Knows diseases to report
Knows how to read MUAC tape
Availability of essential Equipment and work Aides
• Every VHT has a Job Aid for identifying children, newborns and women with danger signs available and immediately accessible in VHT kit.
• Every VHT will have a standardised colour coded MUAC tape/strap with standardised MoH/WHO cut offs for Malnutrition and severe malnutrition
• Every VHT carrying out CCM has a means of counting respiratory rate which is immediately available (respiratory timer, watch with second hand, mobile phone with timer function)
VHT Core Activities
(refer to the VHT handbook on VHT responsibilities Pg.6) • Ability to conduct Home visits • Ability to organise and conduct village meetings • Ability to carry out individual counselling • Ability to mobilise people for health service • Ability to communicate
REPORTING
Reporting By VHTs
• Ability to report Diseases under surveillance and other unusual health events to the health unit • Ability to give monthly reports to the health unit
Supervision
All VHTs will be supervised by HCII at **monthly** meeting when registers and reports will be checked and on job training and supervision will be carried out
All VHTs will attend **quarterly** supervision meeting
VHTs will receive supportive supervision in the community at least **once per year**
Community Case Management For VHTs
Only VHTs who have completed basic health promotion training followed by Case Management training will treat members of the community.
A pregnant woman, newborn or child with a danger sign has any referral treatment given and referral letter written and immediately referred.

NOTES

Ministry of Health Policy and Guideline on how to engage and utilize Village Health Teams in Community-based health services delivery in Uganda