ADVANCING PARTNERS & COMMUNITIES

COUNTRY PROFILE: UGANDA

UGANDA COMMUNITY HEALTH PROGRAMS
DECEMBER 2013

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* Adapted from the Health Care Improvement Project's *Assessment and Improvement Matrix* for community health worker programs, and PATH's Country Assessments of Community-based Distribution programs.

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ACRONYMS

ACT	artemisinin-based combination therapy
AIDS	acquired immunodeficiency syndrome
CHW	community health workers
DHO	district health officer
DMPA (IM)	Intramuscular Depo-Provera
FAM	fertility awareness methods
FP	family planning
HC	health center
HIV	human immunodeficiency virus
HMIS	health management information system
IRS	indoor residual spraying
IUD	intrauterine devices
LAPM	long-acting and permanent methods
MCH	maternal and child health
MOH	Ministry of Health
NGO	nongovernmental organization
ORS	oral rehydration solution
PMTCT	prevention of mother-to-child transmission (of HIV)
PPH	postpartum hemorrhage
SDM	standard days method
SP	sulphadoxine-pyrimethamine (for treatment of uncomplicated malaria)
UHMG	Uganda Health Marketing Group
VCT	voluntary counseling and testing (HIV)
VHT	Village Health Team
WASH	water, sanitation, and hygiene

I. INTRODUCTION

This Country Profile is the outcome of a landscape assessment conducted by Advancing Partners & Communities (APC) staff and colleagues. The landscape assessment focused on the United States Agency for International Development (USAID) Population and Reproductive Health priority countries, and includes specific attention to family planning as that is the core focus of the APC project. The purpose of the landscape assessment was to collect the most up to date information available on the community health system, community health workers, and community health services in each country. This profile is intended to reflect the information collected. Where possible, the information presented is supported by national policies and other relevant documents; however, much of the information is the result of institutional knowledge and personal interviews due to the relative lack of publicly available information on national community health systems. As a result, gaps and inconsistencies may exist in this profile. If you have information to contribute, please submit comments to info@advancingpartners.org. APC intends to update these profiles regularly, and welcomes input from our colleagues.

II. GENERAL INFORMATION

1	What is the name of this program*, and who supervises it (Government, NGOs, combination, etc.)? *Please list all that you are aware of.* **If there are multiple programs, please add additional columns to the right to answer the following questions according to each community health program.*	The **Village Health Team** (VHT) program is the community-level health program in Uganda. Each VHT is made up of an average of five community health workers known as VHT members. VHTs act as a Health Center I, or the lowest level health unit of the formal health system. The program is overseen by the Ministry of Health (MOH) and implemented by many nongovernmental organization (NGO) partners across the country.[1]

[1] NGO partners include Uganda Child Spacing Project (UCSP), Wellshare International, Uganda Malaria Communities Partnership (UMCP), Scaling up Community-based Distribution of DMPA (Depo) in Uganda, Marie Stopes Uganda (MSU), Strides for Family Health, Management Sciences for Health (MSH), FHI 360, Pathfinder International, Conservation Through Public Health (CTPH), Northern Uganda-Health Integration to Enhance Services (NU-HITES), Plan International, and Intrahealth International.

2	How long has this program been in operation? What is its current status (pilot, scaling up, nationalized, non-operational)?	The initial development of the VHT strategy by the MOH began in 2003. The MOH launched a coordinated VHT approach in 2009 where village-level health workers provide multiple health care services, including family planning (FP) information and some services and referrals. As of 2009, 62 out of 94 districts had VHTs. VHTs are meant to be implemented nationally, and the MOH has asked partners to focus on districts where the program has not yet been implemented.
3	Where does this program operate? Please note whether these areas are urban, peri-urban, rural, or pastoral. Is there a focus on any particular region or setting? *Please note specific districts/regions, if known.*	The VHT program aims to increase access to health services among people in rural settings who cannot readily reach health facilitates. The program has a nationwide scope.
4	If there are plans to scale up the community health program, please note the scope of the scale-up (more districts, regional, national, etc.) as well as location(s) of the planned future implementation sites.	Overall, the VHT program is scaling up to cover areas where there are no current community-based activities. Since the program is primarily implemented by partner NGOs, specific scale-up activities are particular to NGO programs.
5	Please list the health services delivered by community health workers (CHWs[2]) under this program. Are these services part of a defined package? Do these services vary by region?	The standard roles and responsibilities of VHTs include: • Home visits • Community mobilization for utilization of health services • Health promotion and education • Community-based case management of common illnesses • Follow-up of mothers during pregnancy and after birth for provision of advice, recognition of dangers signs, and referrals • Follow-up of clients discharged from health facilities and those on long-term treatment • Distribution of health commodities • Community information management • Disease surveillance • Family planning Specialized trainings include FP commodity provision; counseling for HIV testing; malaria prevention; and water, sanitation, and hygiene (WASH). These specialized services are dependent on the partner NGO.

[2] The term "CHW" is used as a generic reference for community health workers for the purposes of this landscaping exercise. Country-appropriate terminology for community health workers is noted in the response column.

6	Are FP services included in the defined package, if one exists?	Yes, family planning is part of the standard responsibilities of the VHT program.
7	Please list the family planning services and methods delivered by CHWs.	The program provides counseling; distribution of condoms, oral pills, and injectable contraception; and referrals for long-acting and permanent methods (LAPMs).
8	What is the general service delivery system (e.g. how are services provided? Door-to-door, via health posts/other facilities, combination)?	Services are delivered in various ways including door-to-door, in the VHTs' home, district health campaigns, and sometimes at health centers (Health Center (HC) II or III).

III. COMMUNITY HEALTH WORKERS

9	Are there multiple cadre(s) of health workers providing services at the community level? If so, please list them by name and note hierarchy.	There is one cadre of health workers in the VHT program: the **Village Health Team** and its members. VHTs, on average, are made up of five members. However, the size of the VHT is dependent on the size of the village; there should be one VHT member per 25-30 households. Additionally, the team must have a gender balance and be at least one-third female. There is no system of hierarchy among VHT members.
10	Do tasks/responsibilities vary among CHWs? How so (by cadre, experience, age, etc.)?	VHTs have different responsibilities depending on the implementing partner NGO they are working with. Some partners may divide responsibilities within the VHT.
11	Total number of CHWs in program? *Please break this down by cadre, if known, and provide goal and estimated actual numbers. Please note how many are active/inactive, if known.*	As of 2009 there were close to 85,000 VHT members nationwide.
12	Criteria for CHWs (e.g. age, gender, education level, etc.)? *Please break this down by cadre, if known.*	The communities usually nominate and select the VHTs for training. Across all communities VHTs must be a resident of the community; should be exemplary, honest, trustworthy, and respected; be available to perform the specified VHT tasks; be a good mobilizer and communicator; be literate in the local language; and be at least 18 years of age. Additionally, the VHT should be at least one-third female.
13	How are the CHWs trained? Please note the length, frequency, and requirements of training. *Please break this down by cadre, if known.*	VHT members participate in an MOH-approved two-week basic training on topics such as healthy timing and spacing of pregnancy, FP basics, infection prevention, malaria, WASH, childhood illnesses, and record keeping. Following this training, implementing partners are expected to provide specialized trainings which can last one to three weeks.
14	Do the CHWs receive comprehensive training for all of their responsibilities at once, or is training conducted over time? How does this impact their ability to deliver services?	Yes, the MOH-approved training is comprehensive. With training, VHTs are able to implement the program at the community level.

15	Please note the health services provided by the various cadre(s) of CHW, as applicable (i.e. who can provide what service).	The VHT provides health services based on the implementing NGO partner. Thus, services can vary across NGO partners and within villages and districts. All VHTs provide services on healthy timing and spacing of pregnancy; FP basics; basic infection prevention including HIV and AIDS, malaria, childhood illnesses, and WASH.
16	Please list which family planning services are provided by which cadre(s), as applicable.	Specific service delivery can differ based on implementing NGO partner. The below represents services provided by most VHTs.

	VHTs
Information/ education	Standard days method (SDM), condoms, oral pills, injectables, intrauterine devices (IUDs), implants, permanent methods, and emergency contraception
Method counseling	SDM, condoms, oral pills, and injectables
Method provision	SDM, condoms, oral pills, and injectables
Referrals	IUDs, implants, permanent methods, and emergency contraception

17	Do CHWs distribute commodities in their communities (zinc tablets, FP methods, etc.)? Which programs/products?	VHTs distribute condoms, oral pills, and injectables for FP, as well as simple treatment for malaria, diarrhea, and pneumonia. The type of treatment can differ based on implementing NGO partner, but may include amoxicillin for non-severe pneumonia, artemisinin-based combination therapy (ACTs) for uncomplicated malaria, oral rehydration solution (ORS) for diarrhea, zinc for diarrhea, and rectal artesunate for pre-referral patients.
18	Are CHWs paid, are incentives provided, or are they volunteers? *Please differentiate by cadre, as applicable.*	VHT members are volunteers. However, the *VHT Strategy and Operational Guidelines (March 2010)* stipulate that a minimum monthly stipend of 10,000 Uganda Shillings (about US$4) should be budgeted. However, in most areas this stipend is not provided. VHTs are reimbursed for travel expenses. NGOs typically reimburse VHTs 8,000-11,000 Uganda Shillings/month for travel expenses. VHTs are used as mobilizers for health campaigns by districts who have stipends available in their budgets. Non-monetary incentives typically include certificates for completion of training, an introduction ceremony to the community, project bags, umbrellas, rain boots, badges, t-shirts, job aides, information and education materials, and community registers. Additionally, VHTs providing injectable contraception have a package of materials for this service: lockable contraceptive storage box, waterproof bags, calendars, registers, tally sheets, contraceptives, and a sharps disposal container.

19	Who is responsible for these incentives (MOH, NGO, municipality, combination)?	Implementing NGO partners are responsible for the provision of all incentives a VHT receives.
20	Do CHWs work in urban and/or rural areas?	VHTs work in rural areas.
21	Are CHWs residents of the communities they serve? Were they residents before becoming CHWs (i.e. are they required to be a member of the community they serve)?	VHT members are residents of the communities they serve.
22	Describe the geographic coverage/catchment area for each CHW.	Ideally, community members select one VHT member for every 25-30 households in the village by popular vote. On average each VHT has five members. There are on average 10 VHTs reporting to the midwife at each Health Center II and Health Center III level.
23	How do CHWs get to their clients (walk, bike, public transport, etc.)?	VHTs reach their clients through various means including, walking, biking, and taking public transport.
24	Describe the CHW role in data collection and monitoring.	VHT have registers that they submit to the midwife/supervisor at the health center they are associated with. The data collected at the community-level is incorporated into the national health management information system (HMIS).

IV. MANAGEMENT AND ORGANIZATION

25	Does the community health program have a decentralized management system? If so, what are the levels (state government, local government, etc.)?	Yes, the VHT program has a decentralized management system. The levels are: • National • District • Subdistrict • Health facility
26	Is the MOH responsible for the program, overall?	Yes, the MOH is responsible for the overall program. The MOH works closely with NGO partners to ensure appropriate program implementation.
27	What level of responsibility do regional, state, or local governments have for the program, if any? *Please note responsibility by level of municipality.*	The national level monitors the program through two main bodies: the Stakeholders Forum and the National Coordination Committee. The Stakeholders Forum is made up of key technical and health development partners, key implementing partners, and key funding partners. The National Coordination Committee works through the Basic Package Working Group of the MOH and meets quarterly to discuss the services provided by the program. The district level is responsible for the overall implementation of the program. The district health officer (DHO) is responsible for overall planning, implementation, and monitoring of VHTs at the health subdistrict level. The health sub-district level is responsible for overall planning and coordination of VHT activities. This is completed by the in-charge and assistant health education officer. The health facility level (Health Center II and Health Center III) are responsible for coordination, implementation, monitoring, and evaluation of VHT activities, including the supervision of VHT members.
28	What level of responsibility do international and local NGOs have for the program, if any?	Implementing partners have responsibilities across all levels from national to health facility level. At the national level, NGOs provide assistance through the Stakeholders Forum. In subsequent levels, NGOs provide training, direct supervision, financial support, and incentives to VHTs and district and subdistrict health levels.
29	Are CHWs linked to the health system? Please describe the mechanism.	Yes, they are linked to the formal health system. VHTs are considered the lowest level health facility and refer to Health Center II or III. Additionally, VHTs are supervised by MOH staff at the health facility level. In addition, VHTs are integrated into health center activities. They provide health information and education, register patients, and observe clinic interactions to improve skills.

30	Who supervises CHWs? What is the supervision process? Does the government share supervision with an NGO/NGOs? If so, please describe how they share supervision responsibilities.	VHTs are usually supervised by the midwife at the Health Center II or III level; midwives typically supervise 10 VHTs, or approximately 50 VHT members. Sometimes a health assistant at the health center provides supervision and record keeping in the absence of a nurse midwife. Midwives/supervisors receive initial supervision training. The midwife (or health assistant) meets the VHT monthly to: • Distribute supplies • Discuss issues or problems that may have arisen • Follow-up on referrals • Provide short refresher training sessions.
31	Where do CHWs refer clients for the next tier of services? Do lower-level cadres refer to the next cadre up (of CHW) at all?	VHTs refer to the Health Center II or III that they report to.
32	Where do CHWs refer clients specifically for FP services? *Please note by method.* To HC II and/or III. In addition, MSU visits the HC III every two months to provide LAPMs where they have outreach teams.	

	VHTs
Standard Days Method/Fertility Awareness Methods (SDM/FAM)	Not applicable
Condoms	Not applicable
Oral pills	Not applicable
Intramuscular Depo-Provera (DMPA (IM))	Health Center II or III (if not provided by VHTs)
Implants	Health Center II or III and MSU mobile clinic
IUDs	Health Center II or III and MSU mobile clinic
Permanent methods	Health Center II or III and MSU mobile clinic
Emergency contraception	Health Center II or III and MSU mobile clinic

33	Are CHWs linked to other community outreach programs?	Yes, they are involved with other health campaigns such as district-wide immunization campaigns, and refer to the MSU mobile services.
34	What mechanisms exist for knowledge sharing among CHWs/supervisors?	VHT members meet at monthly meetings with the midwife or health assistant at the health center. Additionally, knowledge sharing occurs during supervision and monitoring visits made by the midwife or health assistant.
35	What links exist to other institutions (schools, churches, associations, etc.)?	Information unavailable
36	Do vertical programs have separate CHWs or "share/integrated"?	The VHT program delivers integrated health services.
37	Do they have data collection/reporting systems?	Yes, VHTs have registers that they submit to the midwife or health assistant at the health center they are associated with. This data collected at the community-level is incorporated into the HMIS.
38	Describe any financing schemes that may be in place for the program (e.g. donor funding/MOH budget/municipal budget/health center user fees/direct user fees).	Donor funding is the current financing scheme supporting the program. However, there are ongoing discussions at the national level to make VHTs a formal aspect of MOH or Ministry of Community Development jurisdiction so that they receive full government recognition and a standardized package of materials and financial support. Currently, financial support and materials are provided by partner NGOs, rather than the MOH.
39	How and where do CHWs access the supplies they provide to clients (medicines, FP products, etc.)?	The midwife or health assistant is responsible for providing commodities to VHTs through the MOH commodity distribution system. However, stock outs are a major challenge. To alleviate this, health centers are able to access commodities from other health centers, and both health centers and NGOs can access commodities directly from the Uganda Health Marketing Group (UHMG), a private sector social marketing organization, instead of the National Medical Stores. The UHMG offers a parallel supply chain to the National Medical Stores. This has reduced stockouts at the community level, as commodities can be obtained through sources other than the national system.
40	How and where do CHWs dispose of medical waste generated through their services (used needles, etc.)?	VHT members use a sharps box and bring it to the health center for incineration.

V. POLICIES

41	Is there a stand-alone community health policy? If not, is one underway or under discussion? *Please provide a link if available online.*	There is not a standalone community health policy.
42	Is the community health policy integrated within overall health policy?	The VHT program is included in the *Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development*, MOH, July 2010. Additionally, the *Health Sector Strategic Plan (HSSP) III (2010-2015)* was released in 2010. This plan set the target to establish, sustain, and train VHTs in all villages in Uganda. *Village Health Team Strategy and Operational Guidelines*, Health Education and Promotion Division, MOH (March 2010) also describes the VHT approach and roles and responsibilities across all levels.
43	When was the last time the community health policy was updated? (months/years?)	There is no community health program policy; the National Health Policy was updated in 2010.
44	What is the proposed geographic scope of the program, according to the policy? (Nationwide? Select regions?)	Nationwide
45	Does the policy specify which services can be provided by CHWs, and which cannot?	The policy does not specifically state which services the VHTs can provide. However, the *Village Health Team Strategy and Operational Guidelines* provide an overview of what types of general services VHTs should provide.
46	Are there any policies specific to FP service provision (e.g. CHWs allowed to inject contraceptives)?	All current reproductive health policies support the delivery of FP services at the community level. The *2006 National Policy Guidelines and Service Delivery Standards for Sexual and Reproductive Health and Rights* allows VHT members to provide SDM, condoms, combined oral contraceptive pills, and progesterone-only contraceptive pills. VHT members also raise awareness of and counsel clients on LAPM and refer clients for these methods. A 2010 addendum to the 2006 policy document allows VHT members to provide injectable contraception. In addition, FP services are provided free of charge to clients in accordance with MOH policy.

VI. INFORMATION SOURCES

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VII. AT-A-GLANCE GUIDE TO UGANDA COMMUNITY HEALTH SERVICE PROVISION

Intervention		Village Health Team			
Family Planning	*Services/Products*	*Information/education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM	X	X	X	
	Condoms	X	X	X	
	Oral pills	X	X	X	
	DMPA (IM)	X	X	X	
	Implants	X			X
	IUDs	X			X
	Permanent methods	X			X
	Emergency contraception	X			X
HIV/AIDS	Voluntary counseling and testing (VCT)	X	X		X
	Prevention of mother-to-child transmission (of HIV) (PMTCT)	X	X		X

Maternal and Child Health (MCH)	Misoprostol (for prevention of postpartum hemorrhage - PPH)	X			
	Zinc	X	X	X	X
	ORS	X	X	X	X
	Immunizations	X	X		X
Malaria	Bed nets	X	X		
	Indoor residual spraying (IRS)	X			
	Sulphadoxine-pyrimethamine (SP)	X	X	X	
WASH	WASH	X			

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