

THE VILLAGE HEALTH TEAM STRATEGY IS A 'MOST INNOVATIVE COMMUNITY PRACTICE' AWARD WINNER: THE EXPERIENCE OF A VILLAGE VOLUNTEER PROGRAMME IN YUMBE DISTRICT, UGANDA

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Abstract

Community participation in health has been an elusive concept since the days of the Alma Ata Declaration. Many faltering steps have been taken towards genuine community participation only to be retraced because the programmes were either ill-conceived or derailed by the loss of the spirit of voluntarism. In Yumbe District of north-western Uganda, Village Health Teams (VHT) have been established in line with the national strategy for community involvement in health. The Yumbe VHT programme has won an award for innovative support to strengthening decentralisation. This paper reviews aspects of the programme outlining its successes and challenges. Its success has been mainly due to integration of pre-existing volunteer cadres, intersectoral approach to the monitoring of the teams and involvement of the community in the selection of the top-up team members. Its challenges include the relatively young age of the majority of the volunteers and the likely loss of financial support for the activities of the volunteers. The paper concludes that the VHT programme is a delicate venture requiring both programme support through intersectoral inputs to the Community Action Plans developed by communities and sociological approaches to educate the communities to support the VHT for its sustainability.

Introduction

The economic hardships and global shifts in health management philosophy of the 1970s have continued to influence health care financing in Uganda to the extent of determining the implementation strategies adopted in the ministries. With long-standing criticism about meaningful community participation in health, the village health team (VHT) is one of the latest approaches adopted to interest communities to be concerned about the improvement of their own health and to address hardships of health care financing. At Alma Ata in September 1978, 110 health ministers and other stakeholders in health made a commitment to fight all forms of social injustice which hinder the attainment of a good standard of health by all people of the world by the year 2000. The individuals who are faced with much of the social injustices which resulted into a situation described as a 'crisis to healthy living' at the conference were, however, not in attendance or at best not well represented. This meant that both the 'demand' and 'supply' sides of the

understanding of the problem of social injustice were represented by people who did not have first hand personal experience of the problem – 'expert planning for expert syndrome'. And whereas some of the large partners a few years later thought delivering a comprehensive PHC was next to impossible, most of the members were still satisfied that effective community participation was a way forward. Since then, health ministries around the world have been muddling through with several different approaches to elicit full participation of the community, registering only very few if any successes and, even in those few, sustaining it has been problematic. Most times, community participation in health services has been attempted through their democratically elected community representatives; the cohort of names for the participation varies widely but the common point is that the persons involved live in their area of operation, those who can read and write are preferred and most are young and male (Jancloes, 1984). Most

agencies involved offered a formal training and logistics depending on their programme. Village volunteers are expected to be motivated through the feeling that they are able to do good to their community or the rare community incentives.

Where did we come from?

History has it that community participation is not new in the African tradition. Communal field clearing for victims of labour and food shortages is common across communities in Africa (Hyden, 1980). In the former Aringa County (now Yumbe district) Community participation initiatives were practiced in the post war days of late 1980s. The Arua District/ British programme – School Completion Grant (SCG) initiated a community participation programme to restore social services to the people who had been displaced by war. Social infrastructure; schools, health facilities, mosques, churches etc were quickly built with the participation of returnees from Sudan and DR Congo. The community mobilized by their local leaders (mainly the councilors) ferried building stones and grass and made burnt bricks. Most of the schools and health units that had been destroyed during the prolonged conflict in the area were constructed through this effort. The community mobilized locally available construction materials like bricks, river sand and stones and other essentials for construction; the British government, through Arua District, funded other construction materials like cement, Iron sheets and timber in addition to paying for the labour costs to do the construction work. The construction works covered a significant number of schools and health units like those in Odravu, Ariwa, Geya, Yumbe and Nyoko. Ariwa and Kulikulinga health Units that were later on supported by UNHCR also had similar community participation at the initiation. Further the community made bricks and assisted in building Odravu sub-county headquarters knowing that this would become a major revenue collection centre. They divided the tasks among the villages and ensured they were completed in few days. The district authorities inspected and approved the significant community contribution and delivered the needed items shortly. The School Facility Grant (SFG) and others followed. Subsequently, a Dutch-funded programme (Netherlands Trust Fund) which promoted decentralization in the district came after the British project. Under this latter programme, buildings were constructed by the project from foundation to the roof, all costs being borne by the project. The community only identified the site of the school building and contributed land. Thereafter, attempts to mobilize the community to contribute in kind to community projects have become difficult. Some of the health

units constructed lately have no staff housing, a structure which, previously, the community could have done to an acceptable level for occupancy within 1 week. School facilitation grants are still being provided to the district but the past innovation of active contribution by the community to the development of infrastructure in their own area is now looked at as a bitter history. Had such an initiative have been preserved, studied, encouraged and supported, systematic introduction of community participatory programmes in health services could have been easier.

In this same Aringa County, which later became Yumbe district, a group of youth that had been in exile for 10 years in the DRC & Sudan upon return in late 1980s organized themselves in a Martial Arts group. Physical exercises and self defense training for the members were the prime activities before reverting to other community programmes. The Meningitis outbreak of 1988 and early 1989 was a threat to crowding and therefore the group's routine gathering habits. Now that the epidemic prohibited exercising together, the youths decided to, instead, provide voluntary Community Service through provision of manual ambulatory service on stretchers for victims of meningitis in this community. The activities improved cohesiveness among members and the community's attitudes towards the group. Earlier suspicion was that the group mobilized the youth for violent political activity. Besides lifting meningitis patients by stretcher to the health units, the youths also participated in awareness creation and promotion of community networks. After the epidemic, the group was recognized by Yumbe district, registered as a Community Based Organisation (CBO) under the names of Kuru Youth Effort for Healthy Life and Environmental Protection (KYEHLPEP) and, with backing from the district authorities, got funding from other NGOs.

Where are we in community participation?

In Uganda several village volunteer groups have been attempted; the community health workers (CHWs), change agents, the peer educators etc are some of the examples. Vertical programmes created these groups with each serving a separate set of interests. Health sector reforms of the 90s paved way for integration of all health activities including integration of village volunteers. The Village Health Team (VHT) strategy is currently being implemented in Uganda. A VHT is an embracing group for all former community health volunteer categories. It is a team of 9-10 members in a village (HSSP, 2000), comprising mainly of these former volunteer cadres, topped up by a number of other people selected by the community

using specified selection criteria if the village does not have the required number of volunteers. One VHT member oversees the health status and health activities in 25 households on absolute voluntary basis. VHT members identify community needs and take appropriate measures, mobilize resources and monitor their utilization including in the health units, mobilize the community for preventive and promotive health activities and select community health workers. Their other roles are overseeing the activities of the community health workers, maintaining a register of household members and their health status and providing a link between the community and the health providers (HSSP, 2000). Malaria drug distributors named 'Community Drug Distributor' (CDD) are selected and trained from among the Village Health Team for each village. Basic communicable disease and environmental hygiene topics are covered during their trainings.

Yumbe, a district created in September 2000 now with an estimated population of 316,158 people is geographically located in West Nile region of Uganda. Here the implementation of VHT programme is in high gear despite questions at national level on the overall programme like: is the VHT programme working? If yes, what is making it to work? With whom is it working and under what circumstances? How do we know that a particular VHT programme is succeeding or failing? Some questions are a demand for accountability of the programme. The concern that little is published to guide practitioners and decision makers regarding practical aspects of programmes for adoption or replication has been a debate for years now (Barry et al, 2005). Since the academic year 2003/04, Makerere University, under its Innovations at Makerere (I@Mak) project for building capacity for decentralisation, has been inviting selected districts in Uganda to document their best innovative programmes for a competitive annual award. The participants are the districts of Arua, Mbarara, Rakai, Mbale, Sironko, and the municipal councils of Mbale, Mbarara and Arua in addition to Itojo sub-county in Ntungamo District. The incentive to receive scholarships for the civil servants to study at the Uganda's leading university (Makerere University) quickened documentation of the innovative programmes. In 2005 Yumbe emerged winner (Luboobi, 2005) with the best innovation for the programme "Performance of the Village Health Team in Community Health Care" attracting a cash prize of US \$ 15,000 (out of this 85% is to strengthen the VHT structure while 15% is for capacity building of staff to support the programme) from the university. A certificate of recognition was also awarded by the University for

the Team Leader of the VHT in the winning sub-county. The district planning unit and Directorate of Health Services selected the programme with the best practices and documented them..

The VHT programme in Yumbe district was operationalized with involvement of many actors at district, Sub-county, parish and village level. The District Health Team, Community Service Department, the Health Sub-District and the local Health Unit play key roles in VHT programme activities. Other key players are the Sub-county Technical Planning committee, Parish Development Committees, the Village Health Teams, Local Council members (1 to 5), and the Communities themselves. The main objectives of VHT as a community practice were to empower the communities to take responsibilities for their own health and mobilize them for health services at the Household levels; to increase accessibility of both preventive and curative health information and services to the household members and improve on the Health seeking behaviour at household level through massive Health Education and promotion. It was also thought that the VHTs would increase Community based surveillance of diseases of epidemic potential; and strengthen the community based Health Management Information System. The VHT programme has shown strong potential to strengthen intersectoral collaboration in community based service delivery.

Getting started

The initial implementation of the VHT programme involved intensive mapping of the villages in the sub counties. The Villages were clustered into units of between 25 and 30 households to be overseen by one Village Health Team member. At this stage, the district's 42,000 households were mapped. Mapping of the villages allowed intense sensitization of all stakeholders at District, Health Sub District and Sub-county on the concept of the VHT. All village volunteers formerly trained by other programmes were eligible to be members of VHTs. Because each village had to select between 9 & 10 members; others village members had to be selected to fill the gaps with due consideration for gender representation, literacy level, residency in the village and the community's trust in the individual. Selection was done by consensus in a community gathering called by the political head of the village (Local Council I chairman). Upon selection by the community, all team members were taken through a 5-day training conducted by health workers at a community venue selected by sub-county authorities. The trainers had earlier attended a 5 days training-of-trainers course facilitated by the central

Ministry of Health staff, with special inclination to the village health team programme. The trainers were mainly members of the District and Health Sub-District teams. The class size varied between 40 and 45 per training group. Most training took place in primary school classrooms (the pupils being on holidays) and sub-county halls. On completion of this 5 day training 2 members per village were selected and given an additional 3 days of training on anti malarial drug (Homapak, a combination of chloroquine and sulphadoxine /pyrimethamine) dispensing techniques and related record keeping/reporting requirements in the villages. Other areas such as identification of sick children and Mother/caretaker education are also discussed with the drug distributors (CDDs). A total 1,917 VHT members and 642 CDDs were trained in this period. The VHT members also received further training in TB case identification and referral and one member per Parish also received training in Community Integrated Management of Childhood Illness (IMCI) several months later. The VHT members were then clustered into groups attached to each of the 13 health units to facilitate their supervision and reporting. Each health unit oversees between 29 and 341 (mean 148) VHT members in the catchment area. Periodic inventory of the VHTs to update their membership and monitor their performance is done through the monthly parish level supervision conducted by Community Service staff at district and sub-county level.

The VHTs have been active in mobilization of the community for mass and routine immunizations; the Sub-National immunization days, Vitamin A supplementation and Child days in May and October of every year and monitoring the Maternal and Neonatal Tetanus situation in their areas. Their activities are monitored in a multisectoral pattern with good involvement by the sub-county authorities. Monthly meetings are held at every health unit with the Community Drugs Distributors to receive and provide feed back on drug distribution activities, to estimate community drug consumption and submission of reports. Each Community Drug Distributor is supervised at their own home by health workers from the reporting health units on monthly basis using a standardized checklist.

The VHTs were clustered by parishes and, through democratic elections, the teams elected a chairperson, secretary and treasurer to coordinate the teams. These three are referred to the Executive Committees and are the administrators of the teams at parish level. There is a possibility that these executive committees could be organized into a Parish health committee

together with other stakeholders like parish chiefs, Parish Development Committee (PDC) members and political representatives. The Committees hold monthly meetings and are supervised by the Department of Community Service. The support supervision is done on monthly basis by the office of the Community Service Department at parish level. This is to monitor progress and identify gaps in the implementation of the VHT programme. The Community Service department has a set of indicators developed in consultation with the Directorate of Health Services to guide their supervision and reporting. The reports of the supervision by the Community Service Department are discussed in a monthly meeting with the district health team (DHT). At Health Sub-district level, and sub-county levels there are quarterly review meetings meant to discuss the performance of the VHTs and design appropriate remedies for successful implementation for the subsequent quarter. All concerns generated during the four quarters are later discussed during the annual District Health Assembly in which all the stakeholders in Health Care are called in a bid to design and disseminate improvement measures for the next Financial Year.

Sustainability of the Village health Teams in Yumbe

Village volunteer programmes have many disturbing sustainability records world wide. Most community based PHC groups rarely outlasted their founding leaders, being often stopped by overexpansion of the population served or so many services introduced that exceed their financial and management capacity (Rohde, 2002). In Yumbe district several approaches are in the pipeline to ensure continuity when the Unicef, UPHOLD and MOH - Support to the Health Sector Strategic Plan (SHSSP) funded projects wind up possibly in June 2006, about 2 years after initiation of the village health team programme. Currently focus is on support for the elected VHT executive committees and strengthening VHT functionality as a community structure. The executives of the various VHTs will be formalized into a Sub-county Health Team (SHT) together with the heads of health units in the sub-county, some sub-county authorities and the political health leader at sub-county level (secretary for Health); to contribute to technical health planning at sub-county level. This team and the sub-county health committee will vet annual health unit work plans submitted to the HSD and district health office. All the village health team members will be trained in Participatory Rural Appraisal (PRA) to enable them to facilitate the community identify their own health needs and plan ways to act to meet those needs. On completion of the PRA, VHTs develop community

action plan for their villages. The action plan is expected to be multi-sectoral in scope. The health sector is expected to lobby through the Technical Planning committee, the technical arm of district local government for the items in the community action plan identified by the VHTs to be included in the annual work plans of the other sectors in the district for funding in the next financial year. The vision is to have the community identify their own needs and to plan ways to solve them either alone or with technical and other support from the appropriate arms of the local government. Unless intersectoral collaboration becomes practically operational at community level, the dream discussed during Alma Ata in 1978 will remain far and utopian. It is expected that the VHTs will in the near future be transformed through effective capacity building in to Community Based Organizations. The Community Service department of the district is expected to legitimize their status as fully registered CBOs upon the teams passing accreditation requirements of the department particular to these committees. Non governmental organizations (NGOs) will be encouraged to fund and deliver community-based services through these CBOs. The Directorate of Health Services will also, on annual basis, fund some of the items in the Community Action Plan through the Poverty Action Fund provided by the government or other donor funding. Additional support by the directorate will centre on supervision and logistical supplies for anti malarial and other medical goods. The Community Service department will maintain their monthly interactions and will oversee other community activities to be implemented through the teams. The strong political will initiated by the great demand of the community for anti-malarial drugs is a good sustainability factor. The Sub-counties of Odravu and Midigo included items in their budgets to support VHT activities; the others should be encouraged. The Directorate of Health Services and the Community Service department are advocating endlessly for resources to the VHTs. Effective targeting of funds from other sister programmes and empowering the communities in resource mobilization is another method of sustaining the resources for the practice.

Other programme support to VHTs at district/HSD level

The VHTs received programme support from activities implemented and coordinated by the DHT and HSD. Video shows in 2 venues for all the 42 parishes provided the community with messages on Malaria and role of Homapak distributors in malaria treatment and control in the community. In addition, VHTs were trained in TB case identification and

referral, recording of vital statistics related to child health and selected maternal indicators. The initial data obtained are encouraging; the exercise is unveiling the health sector's progress to becoming a complete health system; a system that is multi-structured, fully involving the community, with a good community-based information system, well coordinated at all levels and with intersectoral contributions.

Managing the communication chain in the VHT programme

Managing rumors and politicking messages is an activity in a VHT programme. The district Directorate of Health Services has taken a gate-keeper role; screening all persons intending to utilize VHTs for programmes. This has enabled uniformity in approach and allowances during training and meetings which has contributed to reducing dissatisfaction and attrition. It has also protected the VHTs from exploitation in addition to improving intersectoral collaboration. Information flow to and from the VHTs should be managed well to avoid misinterpretation or distortion resulting from several characters in the information chain. Whenever possible, messages are delivered directly to the VHTs in appropriate gatherings. Sensitive information especially financial messages are provided in a transparent, clear and open manner without being defensive. Sometimes, showing available documents is more satisfying and supportive to information provided especially about money. In case VHTs were required for meetings at the Sub-county or health units, the sub-county authorities were asked to invite the members; the objectives of the discussions were clearly spelt out. The sub-county leaders especially chairperson LC III, Sub-county chief and secretary for health were allowed to attend all meetings involving the VHTs even on health matters. In case of non performance of a village health team member or CDD, the LC 1 chairpersons of the village where the VHT/CDD member comes from were met at an appropriate venue usually in their own home and the matter was tabled to them. This allowed the LCs/community to take responsibility for the under-performance of the volunteer and for the community to find a solution. It also allowed the LCs to think through with the other members of the village who could serve in the position in the future.

Financial aspects of the Yumbe VHT programme:

Since 2003 financial support was received from the SHSSP project, Unicef and lately by the Global Fund and UPHOLD. Below is the funding commitment so far.

Agency	Amount spent for VHT/CDD in Uganda Shillings)	Comments
Unicef	16,864,500*	Covered 3 out of 8 sub counties but not overlapping SHSSP
SHSSP	33,000,000*	Covered 5 out of 8 sub counties
UPHOLD	28,825,800 **	Covered all 8 sub counties; funding covers programme support activities as well
Global Fund	400,000*	
Total	79,090,000 (about \$43,938.9)	*first year of the programme* *second year of the programme

The VHT members did not receive routine regular allowances except transport refund and participants' allowances a sum of Uganda Shillings 4,000 (about \$ 2.2) per day during training sessions or review meetings. Their monthly parish meetings, village data collection and drug distribution is done free of charge. The attrition rate in most teams is still acceptable as evidenced in the records collected by health workers during individual supervision of each VHT/CDDs in their own homes. The VHT agrees with the health workers and programme managers at district level that the community requires support which needs collective efforts that surpass the financial availability. Temptation to provide a regular loose pay to Village volunteers have been avoided because this is likely to make the programme to costly to run and unaffordable. Instead, the community should be assisted to be able to support and/or put pressure on their elected village volunteers to offer services that the community needs. Failures of VHT members should be tabled to the community/their leaders but this requires selection not dubiously done otherwise programme managers and local leaders could fetch huge blames. The health Unit management committees carry out quarterly dialogue with the community with a focus on VHT/CDD and other health programmes. This is expected to contribute towards mobilizing support from the community for the VHT/CDDs activities. The Health Unit Management Committee (HUMC) members having been trained for 5 days and with younger members will likely contribute towards putting the VHT programme and generally health on the household agenda.

Where do we want to go?

Community participation was never described in any greater details during the Alma Ata conference. The conference acknowledged the varying levels of social development within countries and between communities in the same country and thought that

this could influence community participation in health care interventions at community level. Countries were expected to do good situational analysis of their communities and work out ways to actively engage their community to participate in health services. Community participation was as a result misinterpreted by many countries (Skeet, 1984). For most countries including Uganda, the participation was misinterpreted to be a political process; 'involvement through elected representatives'. The representation of the community by village volunteers introduced a group of people with responsibilities but no authority and influence in community affairs initiating power turbulence within the community. The power turbulence, lack of financial incentives from programmes/community and the heavy opportunity costs resulting from long absence from traditional activities that weakens the ability of the community volunteers to sustain their activities in community interventions. Originally community participation was expected to encourage the community to express their needs and to take responsibility in considering how they can be met (Skeet, 1984). The community residents were therefore expected to be helped to decide on which of the health needs in the community can be met without external inputs and those requiring external inputs. Programmes were expected to analyze activities proposed by the community and intervene on their request on those aspects that the community feels needed external inputs. It is the role of programmes to set the impulse for the community to put health issues on their agendas and to only provide top up resources to strengthen initiatives of the communities and/or other resources where a greater investment beyond the community capacity was identified by the community. By this VHTs needed to facilitate the community to identify their health needs at village level, assist the communities decide which of those needs can be met at village level through wider participation of the villagers or individually by households and those

requiring health sub district support. The health unit serving the villagers should then be able to pick up the village health needs inform of a community action plan. Relevant items could be incorporated into the health unit work plan that is aggregated with those of other units into the district comprehensive annual health sector work plan. But, will the community open up to this young group of people who were in some instances dubiously selected? Do the VHTs have the capacity to effectively guide and facilitate their communities to identify their needs? Can the community identify their needs? Are the health units willing to include the concerns of the villagers into their work plans at health unit level? Are there guidelines for helping the community in identifying their needs? What about the needs that lie outside the health sector but influence the health status of the villagers; who will fund those needs? Are the other sectors like education, agriculture, water and sanitation, housing, engineering, environment, finance and planning, Community Services department willing to commit resources for community interventions?

Challenges

The VHT/CDD programme in the district is still facing some challenges. Coordination and political problems of organizing mass village health team training marred initial stages necessitating additional day for screening the village selected volunteers. Females, few being able to read and write, were under represented. Other challenges that is encountered to date in the programme includes reporting problems, difficulties in storing Homapak, donor fatigue, support logistics and drug stock outs in the community. There is also controversy over national performance in the league table when OPD utilization is reduced through strengthening the Home Based Management of Fever at village level. Some of the performance indicators currently used in the league table have been a point of concern in the recent past.

Conclusion

Village health team programme is still a delicate venture. Its sustainability relies on both programme support through intersectoral inputs to the Community Action Plans and sociological approaches to encourage the communities into supporting the structure.

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