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Village Health Team Functionality in Post Conflict Amuru District, Uganda: Contribution from the Implementation of World Vision Uganda Amuru-Lamogi Maternal Newborn and Child Health Project



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ABSTRACT

The Village Health Team (VHT) is a non-statutory community structure selected by the people themselves to manage all matters related to health. The VHT are chosen by their own communities to promote health and wellbeing of all village health members (MoH, 2009). Many factors have been identified to affect the functionality of VHT. Data collection and functionality scoring was done at the district level with the involvement of district leaders, district health teams, partners working with VHTs and VHTs themselves. Data from the assessment areas was pooled into one district data set and aggregated to provide an aggregate representation of the district VHT functionality situation. Although VHT functionality components were greatly impacted, functionality for equipment and supplies (46.7%), individual VHT performance evaluation (40%), community involvement (46.7%), the opportunity for VHT advancement (53.3%) and documentation (53.3%) are still low. As Amuru district looks towards re-engineering its health system past the conflict and prepares to contribute towards achieving the sustainable development goals, sufficient attention must be paid to strategies that improve areas of weakness for VHT and sustaining the components that are doing extremely well. Special attention must be given to sub-counties of Pabbo and Atiak where VHT functionality is still very low.

1.0 INTRODUCTION

Amuru District is bordered by Adjumani District to the north, South Sudan and Lamwo District to the northeast, Gulu District to the east, Nwoya District to the south, Nebbi District to the southwest and Arua District to the west. Amuru district suffered two decades of insurgency which caused loss of life, massive abductions, infrastructural destruction and health service delivery breakdown among others. The long conflict had crippling effects on the major determinants of health such as levels of income, education systems, housing conditions, access to sanitation and safe water, and access to quality health services. This subsequently affected negatively the key maternal newborn and child health indicators. While national health indicators are still poor, rural areas especially North and North-Eastern Uganda have the poorest regional indicators. (Geoffrey Kimbugwe *et al*, 2014)

The reproductive maternal newborn and child health sharpened plan for Uganda (2013-2017) proposes five strategic shifts; as the priority for a forward-looking, compelling and integrated sustainable RMNCH agenda for keeping the promise of the MDGs and remain beyond 2015. The five shifts will form the focus for action and introduce a paradigm shift that will overcome the obstacles to prevent avoidable death. These are implemented through various strategies such as the VHT model that has revolutionized healthcare by overcoming key challenges in health service delivery at community levels. VHTs are community volunteers trained to provide accurate health information and improve access to health services. They have been instrumental in providing a critical link and breaking barriers between the community and the health facilities and have been incorporated by the MOH into the health system as Health Centre I level. The village health worker in Uganda is equivalent to a community health worker cadre defined by WHO as a member of the community who is selected by and accountable to the communities where they work; is supported by the health system; and receives less training than formally trained health workers with the aim of improving health for the communities (MoH, 2009). In Uganda, although many interventions have been put in place by both the government and development partners that are geared towards the strengthening of community health workers WHO (1989), utilization of VHT services is still low in the different parts of the country, thus the need for more interventions in systems strengthening for VHTs to perform their roles effectively and efficiently.

In line with the reproductive maternal newborn and child health sharpened plan for Uganda (2013-2017) Health Sector Strategic Plan II for 2005-2010, the Government of Uganda and partners have committed to prioritization of high impact interventions to accelerate progress towards achieving MDG 4 and 5 targets and beyond through an effective, comprehensive and responsive health system to reach all newborns and their mothers, in order to reduce unnecessary deaths and improve newborn health within a continuum of care. The RMNCH plan recognizes the VHT structure as important in delivering effective health services at community and household level especially addressing the supply and demand side bottlenecks for RMNCH. It recommends recruitment, capacity building and providing VHTs with equipment and supplies as well as effective monitoring and supervision if Uganda is to achieve her RMNCH sharpened plan. In line with this, World Vision Uganda Amuru Lamogi Maternal Newborn and Child Health project made a strategic investment in building an effective and functional VHT system that can fit this role. From 2013 to 2016, VHTs were trained and facilitated to conduct up to thirteen visits to caregivers from the time they report pregnancy until the children are 24 months. VHTs provided integrated messages to community members and or caregivers including but not limited to attendance of at least four antenatal care (ANC) visits; birth preparedness; prevention of mother to child transmission of HIV; safe delivery at the health facility; essential newborn care; postnatal care (PNC); immunization; appropriate maternal infant and young child feeding practices; healthy timing and spacing of pregnancy (HTSP); use of mosquito nets. VHTs did not only counsel caregivers on appropriate care seeking behaviour but also referred community members or caregivers to service points and followed them up to sustain desirable practices.

The project through the ministry of health built capacity of trainers of trainers (ToTs) who were strategically selected as part of the district health team (DHT) and health facility health workers. These were supported routinely to conduct VHT trainings, support supervision, mentoring and coaching. VHTs also received capacity enhancements in health promotion models including integrated community case management, essential nutrition actions, engaged in Radio Distance Learning aimed at retooling them and supported integrated outreaches to underserved communities. The project further supported performance appraisal meetings for VHTs through monthly and quarterly meetings with health facility staff as well as information management and reporting systems for VHTs. In addition, the VHTs were formed into two sub-county associations (Amuru and Lamogi) based at respective health

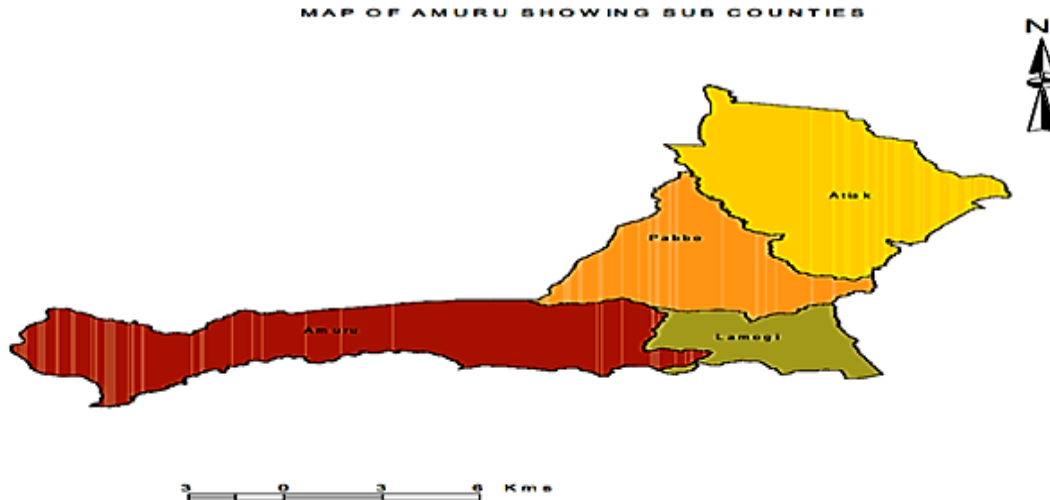
facilities as a measure of ensuring sustainability and linkage to livelihood and development programs in the district.

To be able to effectively implement the Amuru-Lamogi MNCH project interventions as stated above, it was a requirement for the project to facilitate and implement a quality improvement processes for the VHT system. In this regard, the project took a strategic choice to utilize the HCI protocol called the community health worker assessment and improvement matrix (CHW-AIM). Through the system's strengthening approach, the project management committee that was set up at the District recommended that the CHW AIM should be used thought out project implementation period to critically highlight the capacity gaps, progress and strength of the VHT system to guide community MNCH implementation in the district. In addition, the assessment was meant to guide implementation of World Vision Timed and Targeted Counselling (ttC) model in the sub-counties of Amuru and Lamogi.

The assessment was done as part of the end of project evaluation to determine project contribution to VHT functionality in Amuru district. We hope that the results of the assessment will provide guidance to the Ministry of Health, the district health office, the stakeholders and World Vision at large in their current and future community-based MNCH interventions.

2.0 Methodology

2.1 Study Area



The VHT functionality assessment was conducted in 4 sub counties of Amuru, Lamogi, Atiak and Pabbo, Amuru district.

2.2 Study population

The key populations for the study included the following:

- Village health team members
- District Health team member;
- Health facility workers;
- Partners engaged in Health programming.

2.3 Study design

The assessment employed the participatory performance improvement processes based on the Community Health Worker Assessment and Improvement Matrix (CHWAIM) toolkit. The CHWAIM was developed by the USAID Health Care Improvement Project (HCI) as a toolkit to help organizations assess CHW programs, improve CHW functionality and strengthen performance programs.

2.4 Data collection and Analysis

The capacity of VHTs to manage the community MNCH interventions was assessed using the adapted CHW-AIM tool which was administered in both English and Acholi (the local language). Since VHTs are a community health worker structure, this tool was adopted for their assessment. The AIM Tool assessed 15 core components defined as essential for effective programs. The AIM approach was based on a guided self-assessment that allows a diverse group of participants to rate their own program against fifteen programmatic components that contribute to successes or shortfalls, and four levels of functionality. For each of the 15 components, four levels of functionality are described, ranging from non-functional (Level 0) and highly functional (Level 3). Component definition Level of Functionality was as follows: score 0 = non-functional; score 1 = partly functional; 2 = functional and score 3 = very functional (best practice). Data collection process engaged district health teams, sub-county health officials and VHT leaders in VHT mapping, data collection and analysis, VHT functionality scoring, gap

analysis and action planning. During the exercise, the VHT assessment process included; 1) VHT Mapping where there was ahead count of the VHTs in the districts so as to plan the assessment, 2) Orientation of Assessment team to AIM tools which included health workers, VHT leaders, district health teams, 3) Data collection and analysis and lastly was Community Health worker functionality rating which was done by all stakeholders working with community health workers. Using the data sets obtained from the VHT AIM assessments; the data was pooled into the district database and analyzed using the Microsoft Excel 2007 for windows to assess the means and frequencies at district and sub-county level.

2.5 Ethical consideration

The study was approved and followed the Uganda National Council of Science and Technology guidelines on research. In addition, the study received consent from the Institutional Review Committee (IRC) of Makerere School of public health, IRC clearance. Permission to conduct the study in the district was obtained from the office of the District Health Officer (DHO) before actual data collection. The aim of the study was explained to all the participants.

3. RESULTS

3.1 Village health team functionality

According to the end of project evaluation for the World Vision Uganda Amuru -Lamogi maternal newborn and child health project (2016), Amuru district Village Health Team programme functionality greatly improved from 38.3% (2013) to 60.4% (2015) compared to national level VHT functionality of 46% (Babughirana Geoffrey *et al*, 2016). Generally, the World Vision ALMNCH project impacted greatly on the 15 VHT programmatic components that have been found to contribute to an effective community health worker program (See fig 1). Between 2013 and 2015 the project supported VHT functionality processes that generated sub-county specific matrices action plans that greatly realized VHT functionality improvement in the project operational sub-counties of Amuru from 33% to 84.4% and Lamogi from 42.2% to 60%. In contrast, there were only slight improvements in non-project sub-counties of Atiak from 37.8% to 48.9% and Pabbo from 40% to 42.2%, indicating greater performance in the project sites (See fig 2).

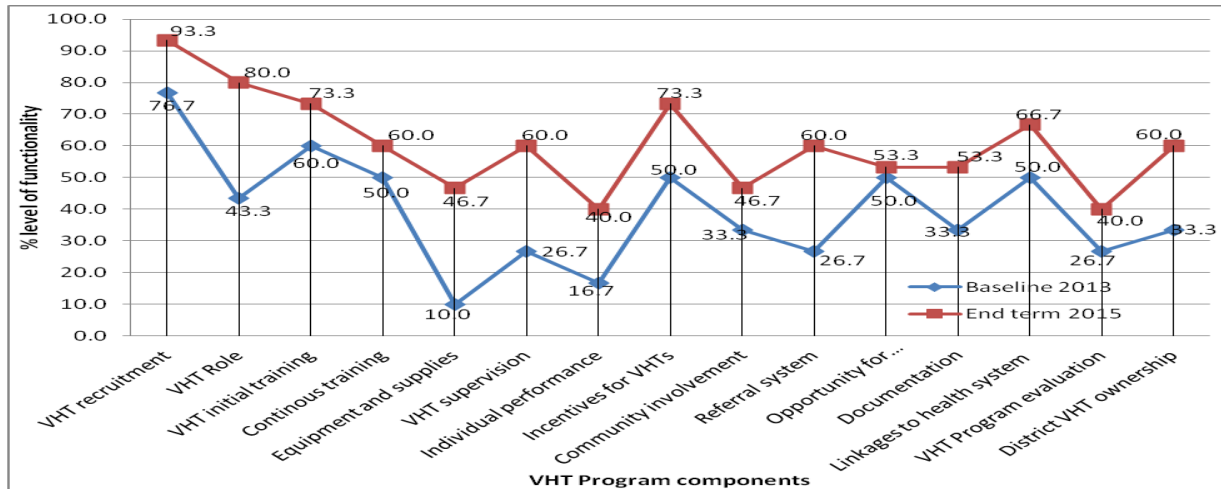
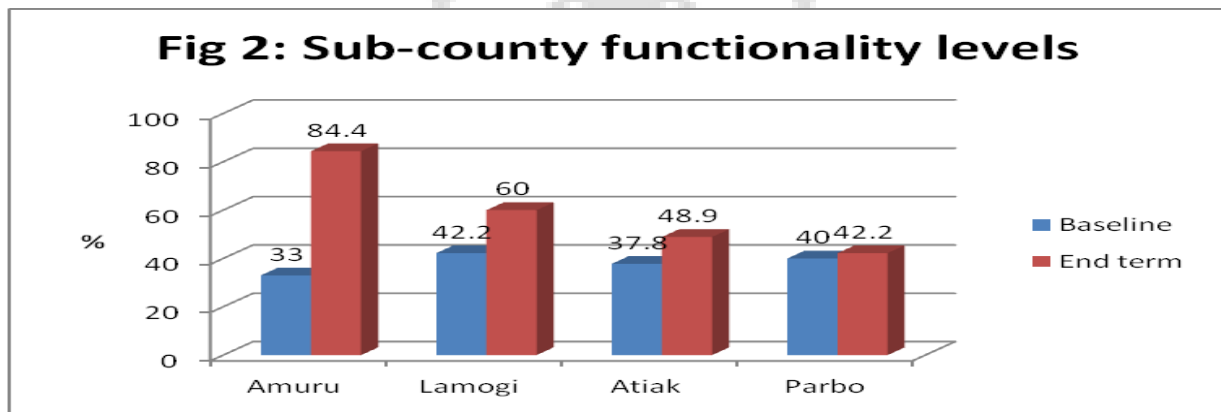


Figure 1: Performance of the 15 VHT functionality program components in Amuru District.



3.1.1: Recruitment: Overall in Amuru district, this improved from 76.7% at baseline (2013) to 93.3% at end of project evaluation (2015). The project area improvement was from 83.3% to 88.9% when compared to an improvement from 66.7% to 100% in the non-project sub-counties. The improvement in the project area is attributed to the recruitment support of 300 VHTs following ministry of health VHT selection guidelines. The initial project target was 280 VHTs but after a household mapping, exercise in Amuru and Lamogi sub-counties, the project team realized that they had to increase the number of VHTs to 300 if they are to realize the project goal. Only 21.4% of the VHTs selected and trained are female and this was because few women would be able to read and write in their local language due to the effects of the war. It was found that the recruitment criterion provided by MoH was followed and that is why the project area improved on this component.

3.1.2: Village Health Team roles: This improved from 43.3% at baseline (2013) to 80% at end of project evaluation (2015) for the district. The project area registered improvement from 33.3% to 77.8%, compared to the improvement from 50% to 83.3% in the comparison sub-counties. The alignment, design and clarity of VHT role were emphasized during the 2010 basic strategy training for all the VHTs and were further empathized in the project area during the blanket capacity building and airing of the RDL contributing to the high ratings above.

3.1.3: Initial training: At the district level, this improved from 60% at baseline (2013) to 73.3% at end of project evaluation (2015). The project area registered an improvement from 50% to 55.6% when compared to the non-projects sub counties that stagnated at 66.7%. This was because after the mapping exercise the project decided to roll out initial recognized MoH basic strategy of 2010 to all the VHTs. *“The project supported us to develop a team of VHT ToTs in the district who later trained and supervised the VHTs. The training content was relevant and consistent with the Ministry of Health guidelines”* DHT Charles Okwera.

3.1.4: On-going training: This is important because it updates VHTs on new knowledge and skills to reinforce the initial training and ensures that the VHTs are practicing skills learnt. At the district level, it improved from 50% at baseline (2013) to 60% at end of project evaluation (2015). Focusing on the project specific areas it improved from 33.3% to 55.6% in comparison to non-project sub-counties where it remained stagnant at 66.7%. The findings indicate that the project supported regular ongoing training for VHTs in the project area especially ttC, diarrhea management and nutrition. In addition, the project funded retooling of VHTs through the RDL.

3.1.5: Equipment and supplies (including Job Aids): At the district level, this improved from 10% at baseline (2013) to 46.7% at end of project evaluation (2015). The project area improved from 16.7% to 66.7% in comparison to non-project areas where it improved from 0% to 16.7%. The project management committee ranked this as very important for VHTs to deliver expected services right from baseline. Before training of ToTs and VHTs in the basic strategy, the project facilitated procurement of basic VHT tools including (household registers, counseling cards, referral forms, VHT bags). Government and partners also supported procurement and distribution of additional supplies including MUAC tapes, condoms and some ICCM medicines.

3.1.6: Supervision: At the district level the VHT supervision improved from 26.6% at baseline (2013) to 60% at end of project evaluation (2015). The project supported health assistants on a monthly basis to carry out administrative tasks and provide VHT individual performance support including feedback, coaching, and data-driven problem solving. This, therefore, led to the improvement from 16.7% to 77.8% in the project area in comparison to non-project sub counties that did not register improvement but remained stagnant at 33.3%.

3.1.7: Individual VHT performance evaluation: Individual VHT performance evaluation improved from 16.7% at baseline (2013) to 40% at end of project evaluation (2015) for the district. However the project area registered improvement from 16.7% to 66.7% compared to non-project sub-counties that registered a decline from 16.7% to 0%. While the project supported annual VHT programme evaluations for the last two years, stakeholders observed that no or limited individual VHT evaluations are conducted. In addition, the community is not asked to provide feedback on VHT's performance; no targets are set for VHTs during a specific time period and no rewards are given to good performing VHTs.

3.1.8: Incentives: Incentives for VHTs improved from 50% at baseline (2013) to 73.3% at end of project evaluation (2015) in the district. The project contribution to this in the operational sub counties stagnated at 66.7% compared to non-project sub-counties that registered an improvement from 33.3% to 83.3%.

3.1.9: Community involvement: Community involvement improved from 33.3% at baseline (2013) to 46.7% at end of project evaluation (2015). The project site registered an improvement from 50% to 66.7% compared non-project areas that registered improvements from 16.7% to 33.3%. In the project site the community support to VHTs was noted as important to the work of VHTs in the community. *“While the community is involved in the selection of VHTs, they do less in supporting VHTs in doing their work, however more community members and structures are increasingly recognizing VHTs as a resource”* LCIII Chairperson, Lamogi sub-county.

3.1.10: Referral system: The referral system improved from 26.7% at baseline (2013) to 60% at end of project evaluation (2015). The project registered an improvement from 16.7% to 66.7% compared to non-project sub-counties that registered improvement from 33.3% to 50%. The process for determining when referral is needed, logistics plan for transport and or payment to a

health facility when required and how referral is tracked and documented is an important factor in the function of a VHT. It was also noted that referral is not well tracked by the VHT, community or health facility. *“We were given referral books by World vision MNCH project but some health workers don't respect them, when we send patients to the health facilities they ignore our referral forms and don't give us feedback”* VHT in Lamogi sub-county.

3.1.11: Opportunity for VHT advancement: This improved from 50% at baseline (2013) to 53.3% at the end of project evaluation (2015) generally for Amuru District. In the project area this improved from 33.3% to 77.8% compared to non-project area that registered a remarkable decline from 66.7% to 16.7%. The possibility for VHT growth, advancement and retirement was advanced as an important factor for VHT functionality. It was mentioned that to a large extent VHTs are given opportunities as research assistants, vaccinators, trainers and advance as councilors whenever possible. However, it was noted that the process is not well planned and not clear to most VHTs. *“The project identified me as a district trainer for tC and diarrhea management, I feel good and inspired to continue serving my community”* said Lemoi Denis.

3.1.12: Documentation, information management: How VHTs document visits, how data flows to the general health system and back to the community and how it is used for service improvement is an important factor for VHT functionality. VHT documentation and information management improved from 33.3% at baseline (2013) to 53.3% at end of project evaluation (2015) at the district level. Focusing on the project site the improvement was from 33.3% to 77.7% compared to non-project area which stagnated at 33.3%. The success registered in the project is partly attributed to the fact that the project procured documentation and information management materials such as household registers, referral form books and manuscript books that are important in VHT community information management. In addition, through health assistants, capacity of VHTs was built on relevant health information management systems, reporting and interpretation especially during VHT monthly meetings at respective health facilities. The project also distributed VHT quarterly reporting forms (HMIS 097) to VHTs and this improved VHT reporting at health facilities. It was however noted that VHT data accuracy, utilization and timely reporting still needed further strengthening.

3.1.13: Linkage to health system: How VHTs and communities are linked to the larger health system is a strong factor in VHT service delivery. To a larger extent, the study communities had

a strong linkage with the health facilities through VHTs who meet at respective health facilities on a monthly basis. VHT linkage to the health system improved from 50% at baseline (2013) to 66.7% at end of project evaluation (2015) for the entire district. However the project rates increased from 50% to 77.8% compared to non-project sites that did not improve at all (50%). *“The relationship between health facilities and VHTs is very strong, right from the beginning the project closely involved health facilities in recruitment, training and supervision of VHTs.”* District MNCH focal person.

3.1.14: VHT program performance evaluation: The District performance registered an improvement from 26.7% at baseline to 40% at end line. The project area registered an improvement from 33.3% to 66.7% compared to non-project area that registered a decline from 16.7% to 0%. This factor was highlighted by partners as very important to make general evaluations of the performance against targets, overall VHT program objectives and indicators. *“It is important for VHTs and stakeholders to always reflect on performance of this program to inform programming.”* District Councilor.

3.1.15: Country and or district ownership of VHT strategy: This improved from 33% at baseline (2013) to 60% at end of project evaluation (2015). In the project area this improved from 33.3% to 55.6% compared to non-project area that registered improvement from 33.3% to 66.7%.

“Unless the district and sub-county authorities own up the VHT strategy beyond words, VHT functionality will only be realized in communities supported by partner NGOs” Dialogue participant. While VHTs have been fully integrated into the health system and policies in place, district and sub-county support in terms of local budgets and logistical support (e.g. supervision, supplies) to sustain VHT work in the sub-county was found to be very limited.

4.0: DISCUSSION

The results above provide important insights on how a MNCH project can significantly contribute to improved VHT functionality in a post-conflict district using a health systems strengthening approach. The Amuru-Lamogi MNCH project utilised VHTs as a community-based health system structure linking households and the entire community to the health system. At district level, findings indicate that VHT functionality improved from 38.3% to 60.4% and

greatly improved in the project area (37.6% to 72.2%). Although VHT functionality components were greatly impacted, equipment and supplies, individual VHT performance evaluation, community involvement, (55.6% & 66.7%) opportunity for VHT advancement and documentation are still low and therefore need to be prioritised for support. This is however not unique to Amuru district only, according to Babughirana Geoffrey *et al*, 2016, in Uganda, there are several external issues that affect VHT functionality including availability of equipment and supplies, community involvement, country ownership and health system performance. Initial training for VHTs in the MoH 2010 basic strategy improved greatly and this helped a lot to prepare VHTs for their role. Through on-going capacity building for VHTs to update them on new knowledge and skills and to reinforce the initial training, trainings were conducted on ttC, nutrition, diarrhea management. *“The MNCH project made a strategic choice to invest in improving the performance of VHTs especially to cause positive MNCH behaviours that were very low at the beginning of the project in 2013”* DHO Amuru district. Through ttC, VHTs closely monitored expectant and lactating mothers and their children throughout the 1000days. The project invested in ttC training, mentoring and coaching as part of continuing skilling and ttC data management. VHTs were then tasked to cause positive behaviours that were found lacking targeting the entire household. This is believed to have contributed to VHT functionality and consequently impacted on important MNCH indicators for which the project was designed. For example, while the national coverage for ANC 4th visit is at 47.6% (RMNCH, 2015), in the project area it improved from 66.5% in 2013 to 72.3% in 2015. The percentage of births attended by skilled birth attendants increased from 57.1% in 2013 to 74% in 2015 compared to the national level at 58% (UDHS, 2011). Mothers delivering from TBAs and their own homes greatly reduced from 42.9% at baseline to 27.1% respectively at end of project evaluation. This is slightly higher compared to national level at 18% according to UDHS 2011. Performance results for child immunization were outstanding with the proportion of 1-year-old immunized against measles at 95.3% compared to national coverage at 75.8% (UDHS, 2011).

The improved VHT functionality is believed to have increased the role of VHTs in community education, ttC, routine monitoring, follow-up and referral of children for immunization. The evaluation revealed that the project supported monthly integrated community outreaches to underserved communities, child health days that were done twice a year in which VHTs were actively engaged as mobilizers. The findings, in addition, indicate that while the projects

intervention were focused in two sub-counties of Amuru and Lamogi, it impacted on the general district especially by facilitating district trainers of trainers for VHTs and ttC and facilitating annual VHT assessment and improvement.

CONCLUSION

From the results above, it can be observed that the VHT functionality greatly improved around the 15 community health worker program components. It is evident that project focused on improving the functionality of VHT components in order to impact on MNCH behaviors and outcomes implemented through a VHT focusing on increasing the capacity of communities to advocate, demand and take responsibility for their own health. According to senior officers at the district Health office, the progress of implementation of the VHT strategy in the district is slow and VHTs are functional in only a few sub-counties where World Vision implemented the MNCH project due to a lack of resources.

A functional VHT system is a good mechanism for addressing supply side bottlenecks due to lack of human resource capacity to provide maternal newborn and child health services. One reason for low VHT motivation is irregular supervision and lack of incentives hence high attrition rates.

VHT work but most do not have the requisite skills, yet most of them lack opportunities for training.

The study also reveals that a well organized motivated VHT system in Amuru district partly helped in addressing demand side bottlenecks for MNCH by ensuring caregiver compliance for use of MNCH services.

RECOMMENDATIONS

More effort is required to consolidate and sustain the efforts registered by the MNCH project. Resources need to be allocated to identify and train VHTs in the sub-counties where the project did not operate to help deliver health benefits for maternal and neonatal health to the community. Caution should be exercised to avoid overloading individual VHTs with various tasks through increasing VHT capacity (numbers, skills mix and robust individual performance evaluation and feedback).

Further implementation research is needed to guide VHT engagements in rural districts.

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