



MANIFEST

PROGRESS BRIEF

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Village Health Teams (VHTs) are an Important Resource for Community Mobilization and Health Information

The Issue

In Uganda, maternal and newborn indicators have barely changed over the past decade, with maternal mortality ratio and newborn mortality rate currently at 438/100,000 and 27/1000 live births respectively (UDHS, 2011). Most of the causes are preventable. However, limited access to health services constrained by poverty, inadequate birth preparedness, transport and poor quality of care still persist in most of the rural areas. Consequently, over 40% of mothers still deliver outside the formal health system with unknown health outcomes. Some of the constraints that hinder facility delivery can be addressed through improved birth preparedness. The VHTs can support communities to plan their births better by offering critical information and encouragement through home visits. In addition, they can collect demographic and health information on critical health outcomes. Although Government introduced the VHT strategy in 2005, there are still challenges in the implementation of the strategy, with some parts of the country still not covered. This brief highlights implementation experiences from the Maternal and Neonatal Implementation for Equitable Systems (MANIFEST) study using VHTs to stimulate demand for maternal and newborn health services.



A VHT health educates a pregnant woman in Bugulumbya in Kamuli District

About MANIFEST

MANIFEST is a 4 year study (2012-2015) study involving the Makerere University School of Public Health and the districts of Kamuli, Pallisa and Kibuku.

We are using a participatory action research approach, in which the different stakeholders work as partners rather than study subjects. In 2012, we engaged various stakeholders in the design of a sustainable and scalable intervention aimed at improving maternal and newborn health outcomes. The resulting design has three major components, with district health teams leading on their implementation. The components include:

- Community mobilisation and sensitisation
- Savings and transport
- Health systems strengthening

Our Approach

In order to understand the best practices for VHT implementation and inform policy, the MANIFEST team adapted and implemented the VHT strategy in Kamuli, Kibuku and Pallisa Districts. A total of 1680 VHTs were trained by the district trainers following a training of trainers (TOT) for four days. Most (54%) of the VHTs were female, and 61% had reached secondary level of education, 31% reached primary level, 7% tertiary while 1% had no education at all. Almost all the VHTs (96%) had previously been involved in community based voluntary health work, mainly drug distribution, for more than five years.

The trainings were conducted at sub-county level with an average of 30 participants starting in the last quarter of 2013. VHTs received five days training about birth preparedness, health seeking practices, how to conduct home visits and give health education talks to people in the villages through community dialogues. The training also covered how to identify danger signs in pregnancy and newborns, and how to facilitate referral of pregnant women, mothers in postnatal period and sick newborns to the health facility.

The training course was skills-based, and focused on promoting key selected practices as obtained from formative research. The methods included: participatory discussions, demonstrations and role-playing, as well as a practical field session of a home visit under the supervision of a trainer to ensure knowledge translation. These being VHTs with variable literacy levels, the trainings were conducted mainly in respective local languages. We ensured that the training also covered a counseling skills based component to build the skills of the VHTs that would enable them to engage in dialogue with mothers and families. There was improvement in VHTs' knowledge, with an average post training score of 77% as compared to the pre-training average score of 41%. The health workers and health assistants from the respective sub-county (VHT supervisors) were in attendance to understand the scope of VHT training.

A total of 168 supervisors received a two day training on how to supervise VHT activities in the communities. The supervisors' trainings commenced at the beginning of 2014 and were conducted by the national VHT trainers together with the district trainers using adapted Ugandan VHT supervision guidelines. Each supervisor was assigned an average of 10 VHTs for technical assistance in use of counseling cards, VHT register and report writing, and how to conduct a home visit through directly observed supervision (DOS).

VHTs conduct two home visits during pregnancy (1st and 3rd trimesters), and two visits within the first week after delivery (first within the first 48 hours and second on the fifth day in first week of postnatal period) (Box 1.). They register household members and update the registers on a quarterly basis. This includes information on births and pregnancy outcomes, and deaths of any member in the household. This has been noted to be more comprehensive than the facility-based HMIS (Health Management Information Systems), since it covers all those births and deaths that have occurred from health facilities and at community level.

Box 1: Roles of VHTs

VHT roles under MANIFEST project

A. Two home visits during Pregnancy (Antenatal care)

Focus of pregnancy visit 1 (as early as possible or in first trimester)

- Counsel on and refer for ANC including TT, IPT and ITNs
- Counsel on family planning
- Counsel on Saving, birth preparedness and use of clean delivery practices
- Assess and counsel on danger signs of pregnancy and facilitate referral if present

Focus of pregnancy visit 2 (in third trimester)

- Counsel on Saving, Birth Preparedness
- Assess for maternal danger signs and facilitate referral if present
- Counsel on clean delivery practices
- Counsel on immediate maternal and newborn care practices
- Counsel on newborn danger signs
- Advise mother to deliver from health facility

B. Two home visits after delivery (Postnatal care)

Postnatal visit 1: day 1 of birth or day 2 for facility birth

- Screen for and counsel on maternal and newborn danger signs and facilitate referral if present
- Support temperature management (skin to skin for low birth weight, delayed bathing, and wrapping)
- Support immediate and exclusive breastfeeding
- Encourage cleanliness especially cord care
- Refer for immunization if necessary, facilitate referral of all home deliveries for postnatal care

Postnatal visit 2: 5th day after birth

- Assess for maternal and newborn danger signs and facilitate referral if necessary
- Counsel mother on breast-feeding, cord care and warmth maintenance
- Counsel on birth-spacing/Family Planning
- Reinforce need to seek care/call CHW/VHT for signs of local infection or danger signs
- Dealing with other problems in the home e.g. improving sanitation
- On-going care for the mother and the baby

C. If very Low Birth Weight is suspected

- Promote temperature management (skin to skin, wrapping and delayed bathing)
- Assist with feeding if possible
- Attention to hygiene and cord care
- Facilitate referral

Preliminary Findings

In a period of nine months (January to September 2014), there have been significant changes in the maternal and newborn care practices as a result of home visits and community dialogue meetings. According to the VHT reports, 27,522 pregnant women and 11,752 newly delivered women were registered and visited by the VHTs. This implies we have achieved 89% of our target for pregnant women (39,230/43848) and 19% of our target for newly delivered women (15,543/43,840). Activity reports indicated that a total of 40,553 people (of which 49% were male) attended community dialogues. Our target was to reach 37,997 people through dialogue meetings and so far we have reached 56,156. During the same period, there was an increase in facility delivery by 16%, from 66% to 82%. VHTs reported 145 low birth weight babies and 145 (12/1000 births) newborn deaths compared to 93 newborn deaths reported by facility-based HMIS.

With regard to danger signs knowledge, women who were visited by the VHTs during pregnancy in the intervention, were two times more likely to know three danger signs during pregnancy compared to those who were not visited by VHTs (RR=2, p=0.001), while in the control area, there was no association between VHTs visits and knowledge of at least three danger signs during pregnancy.

In relation to improving care practices for mothers and newborns, VHTs sensitize women and the community through home visits and community dialogue meetings. The preliminary results also indicate some improvement in cord care practices, prompt health seeking behaviour and exclusive breast-feeding, among other indicators. However, bathing newborns immediately after birth has not changed much. Comparing the baseline and the midterm evaluation, the percentage of women who delayed bathing newborns in the first 24 hours after birth increased by only 1% (14% to 15%) in the intervention area.

Challenges encountered during implementation

1. VHT drop-outs: Since the beginning of the study 61 (3.5%) VHTs have dropped out due to various reasons including migration, deaths and getting employed elsewhere. Although all the drop-outs were replaced and replacements trained, they take time to catch up with the rest since the training period is not enough to equip the VHTs with all the necessary competencies. The quarterly group supervision meetings and encounters with their respective supervisors are used to reinforce knowledge and skills.
2. Poor performance of some VHTs has been noted. This has been attributed to low levels of education which results in difficulties in reading relevant material and record keeping, lack of monetary compensation for time and lack of transport facilities e.g. bicycles.
3. Some supervisors were not committed to supervising VHTs. The reasons included return to school for further studies, transfers to other areas, poor attitudes towards VHTs, long distances to travel to the community/villages, limited amount of transport refund, work overload at the health facilities, etc.

Lessons learnt

1. Specific criteria should guide the selection of VHTs. The community should be informed about the criteria, after which they can select appropriate persons as VHTs, rather than selecting any person in the community who was previously involved in some health activities, e.g. Drug distributors.
2. Short training sessions of VHTs are good for orientation of the VHTs in the general issues of maternal and newborn care. However, these should be followed with regular support supervision sessions for reinforcement of knowledge and skills focusing on a few issues at a time particularly in their first year of work.
3. Conducting a training of district trainers (TOT) at the beginning of the intervention avails a wide pool of VHT trainers. However, before rolling out the training, the district trainers should work closely with national/experienced trainers.
4. VHTs require regular and continuous support supervision for motivation and improved performance.
5. Use of health workers to supervise VHTs from their catchment areas is important in building VHT skills as well as improving the community-facility linkages and relationships resulting into improved health service utilization.
6. Non monetary incentives like a T-shirt, certificates, status in the community can motivate VHTs to continue working. However, monetary incentives and transport means like bicycles are the major motivators.
7. Despite the VHT efforts in mobilization and creating awareness, some mothers continue to deliver from home or at TBAs due to transport challenges and supply side issues.
8. Reports from VHTs are an important resource for the HMIS that can complement the health facility based information system. District Health Teams should endeavor to integrate the two forms of reporting for a more comprehensive health information system.



Credits

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