AMREF’s Experience Working with VHT and CMDs

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AMREF

- AMREF is the largest African health development organisation
- HQ in Nairobi, Kenya
- Integrated health programmes and offices in Ethiopia, Kenya, Somalia, South Africa, Sudan, Tanzania and Uganda
- 97% of AMREF’s staff are African
- 12 offices in Europe and North America support these programmes in Africa through funding, advocacy, and technical support
AMREF Uganda Program sites

- AMREF has projects operating in about 9 districts.
- It has 2 programmes (LSSP and PHCT) operating country wide.
- AMREF has worked with CHW for 25 yrs in Uganda (including, counselor aides, community medicine distributors, trained TBAs, community vaccinators).

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AMREF’s Values

AMREF operates under three overarching Pillars:

1. Community partnerships

2. Building capacity (training, equipping, infrastructure, partnerships, etc.)

3. Evidence-based practice and advocacy
Partnership with Communities for Better Health

• Almost all current AMREF Uganda projects involve working in partnership with communities to improve their health status.

• Partners include community health workers (VHTS, CMDs, TBAs) and community members (religious and other leaders, women, pump mechanics, masons, youth in and out of school), local governance structures (Parish Development Committees, Parish AIDS Committees) and CBOs.
Under this pillar AMREF seeks to ensure that:

- Health systems effectively include community structures and institutions in health improvement processes and respond to the health problems and needs of their communities

- It creates empowered communities that are able to better communicate their strengths and needs to the formal sector, specifically health services;
<table>
<thead>
<tr>
<th>Project</th>
<th>Activities</th>
<th>Outcomes</th>
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| Integrated Malaria, HIV/AIDS and TB project Luweero. | ➢ Community Based Health management Information System (CBHMIS) used by Village Health Teams  
➢ Sensitization on malaria control and prevention  
➢ strengthen referral  
➢ Case management HBMF | ➢ Scaled up the training of VHTs.  
947 members have now been trained and are active in 139 villages (representing 12% coverage of both districts).  
➢ A data collection tool for the VHT has been developed and will hopefully inform the formal HMIS. |
| EU Integrated Malaria and HIV project Soroti. | ➢ Community Based Health management Information System (CBHMIS) used by Village Health Teams  
➢ Trained 2200 VHT and facilitated them with IEC Materials bicycles | ➢ Better sanitation practices increased about 260 model homes in place  
➢ Documentation of common childhood illness managed at housed level  
➢ Increased referrals for HCT and malaria treatment at Health Units |
## AMREF Projects Working with VHTs and CMDs

<table>
<thead>
<tr>
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<th>Activities</th>
<th>Outcomes</th>
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<tr>
<td><strong>Nakasongola Malaria project</strong></td>
<td>➢ Train CMDs on the new drug policy using ACTs</td>
<td>➢ Btn July-Dec 2008 1804 children under 5 years treated for malaria by CMDs within 24 hrs compared to 985 treated after 24hrs.</td>
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<td>➢ Roll out of CBHMIS developed for CMDs for the Home Based management of Fever using ACTs.</td>
<td>➢ Over 90% of CMDs reporting monthly &amp; Data utilization has started at local governments (resolution made from supervision visits)</td>
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<td>➢ Sensitization of communities on malaria control and prevention</td>
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<td>➢ CMDs are part of distribution network for ITNs</td>
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<tr>
<td><strong>Home Based Care Project Northern Uganda</strong></td>
<td>➢ Train VHT on Home Based Care and immunization.</td>
<td>➢ VHT/CMDs trained in all 12 sub counties in Kitgum and 6 in Pader</td>
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<td>➢ Train CMDs on new drug policy using Coartem and are involved in ITN Distribution</td>
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<tr>
<td><strong>Northern Uganda Water and Sanitation Umbrella (WASUP) project.</strong></td>
<td>➢ CBHMI S framework developed for VHT, water source committees and School health committees.</td>
<td>➢ An assortment of data collection tools generated and pre-tested</td>
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<td>➢ A data base created to analyze and store data at district level</td>
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<td></td>
<td>➢ No. of h/steads with latrines at various levels determined (completed, pit dug, superstructure</td>
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Success stories in Uganda

- AMREF has increased immunization coverage in 4 districts in post-conflict districts of Northern Uganda by 50% to 90+ in 4 years.
- Decreased attrition rate of community medicine distributors by 30% in UMPP Project through provision of non monetary incentives.
- Improved immunization coverage by 10% in Butuntumula sub-county in Luwero district using TBAs as child health promoters.
- Improved sanitation coverage from 4 - 60 % in Madi Opei sub-county in Kitgum District through community-based health promotion.
## Constraints and remedies

<table>
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<th>Remedies</th>
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</table>
| Consistent Motivation             | - Community Recognition  
- Acquisition of new skill through refresher training  
- Facilitation (bicycles, drug kits, registers)  
- Identification (badges, T-shirts)  
- Peer support (through peer supervisors)  
- Support Supervision  
- Preferential treatment  
- Involved in decision making level at parish and sub county level. |
| Inadequate govt. support/funding (lack of drugs and materials) | - Provide health workers with skills on drug management  
- Facilitate CHWs to monitor drug levels and estimate needs based on their catchment areas |
## Constraints and remedies cont’d

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<tr>
<td>Lack of Community awareness/involvement</td>
<td>- Community Involvement in CHW Selection</td>
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<td>- Community Organizations (CBOs) that support CHW work.</td>
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<tr>
<td></td>
<td>- Community Involvement in CHW training</td>
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<td>- Communities involved in supervising CHWs</td>
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<td></td>
<td>- Community Information systems</td>
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<td>- Involving CHWs during sensitization campaigns</td>
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<tr>
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<td>- Involving CHWs during National campaigns and programmes.</td>
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<tr>
<td>Lack of Harmonized Guidelines</td>
<td>- AMREF is working with the MoH and partners like MACIS to develop an integrated guideline for CHWs.</td>
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<td>- AMREF is learning from experiences and best practices.</td>
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Lessons learnt

AMREF has learnt that to be successful, CHW programs are highly dependent on:

- Recruitment and selection
- Training and continuing education
- Supervision and logistical support
- Incentives
- Quality assurance/supervision
- Political stewardship and adequate resources
Recommendations

• Need for harmonization of training and incentives.
• Adoption of multi-disciplinary approaches to support supervision of CHW.
• Need to recognize CHW as an integral part of the formal health system.
• Support to CHW should be in-built in government work plans for sustainability.
VHTs at an immunization post in Northern Uganda
Incentives to CMDs
THE CASHE MODEL: VHT NETWORKING WITH OTHER COMMUNITY STRUCTURES

- District W&S Committee
- Sub County Health Committee
- Parish Health Committee
- Departmental Heads

- Water Source Committee
  - 1. Men and Women
  - 2. School Health Committee

- Village Health Team
  - 1. HH Heads
  - 2. School Health Committee

- School Health Committee
  - 1. Mothers/Caretakers
  - 2. School Health Club

- Beneficiaries communities

- O&M Management
- Sanitation Promotion
- Hygiene Promotion

CBMIS

O&M Management
Sanitation Promotion
Hygiene Promotion

Water Source Committee
Village Health Team
School Health Committee

1. Men and Women
2. School Health Committee
1. HH Heads
2. School Health Committee
1. Mothers/Caretakers
2. School Health Club

Beneficiaries communities
## VHT Sanitation Data Collection tool

### SANITATION MONITORING FORM

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>Drying</th>
<th>Refuse</th>
<th>Improved Latrine by type</th>
<th>Hand washing facility</th>
<th>Compound</th>
<th>Animal house</th>
<th>Bird house</th>
<th>Main house</th>
<th>Kitchen</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH No.</td>
<td>Name of Household Head</td>
<td>No. of Users</td>
<td>Ordinary</td>
<td>VIP</td>
<td>Ecosan</td>
<td>Communal</td>
<td>Bath shelter</td>
<td>Clean</td>
<td>Dirty</td>
</tr>
</tbody>
</table>

- **Available**
- **Missing**
- **Desired**

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THANK YOU

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