

Establishing Village Health Clubs

[To improve community health worker motivation and performance]



About the learning paper series

Since starting operations in 2003, Malaria Consortium has gained a great deal of experience and knowledge through technical and operational programmes and activities relating to the control of malaria and other infectious diseases.

Organisationally, we are dedicated to ensuring our work remains grounded in the lessons we learn through implementation. We explore beyond current practice, to

try out innovative ways – through research, implementation and policy development – to achieve effective and sustainable disease management and control. Collaboration and cooperation with others through our work has been paramount and much of what we have learned has been achieved through our partnerships.

This series of learning papers aims to capture and collate some of the knowledge, learning and, where

possible, the evidence around the focus and effectiveness of our work. By sharing this learning, we hope to provide new knowledge on public health development that will help influence and advance both policy and practice.

www.malariaconsortium.org/learningpapers

A village health team member says that through the village health clubs, people are gaining a better understanding of prevention of childhood diseases.
Photo: Tine Frank



Contents

AUTHORS

[Tine Frank](#) Consultant
[Karin Källander](#) Malaria Consortium
[Sarah Marks](#) Malaria Consortium

CONTRIBUTORS

[Daniel Strachan](#) University College London
[Paula Valentine](#) Consultant

With thanks to inSCALE field workers and project staff, especially Edmond Kertho, Godfrey Ayebale, Benson Bagorogoza, Patrick Lumumba, Maureen Nakirunda and Agnes Nanyonjo

SERIES EDITOR

[Portia Reyes](#) Malaria Consortium

Copyediting by [Roo Griffiths](#)

DESIGN

[Transmission](#) Art direction & design
[Cajsa Holgersson](#) Cover illustration

CITATION

Frank, T., Källander, K., Marks S. (2015). Establishing Village Health Clubs to improve community health worker motivation and performance. Learning Paper series. London, Malaria Consortium.

COPYRIGHT

© Malaria Consortium. Published October 2015
Unless indicated otherwise, this publication may be reproduced in whole or in part for non-profit or educational purposes without permission from the copyright holder. Please clearly acknowledge the source and send a copy or link of the reprinted material to Malaria Consortium. No images from this publication may be used without prior permission from Malaria Consortium.

CONTACT

learningpapers@malariaconsortium.org

inSCALE PARTNERS



Implemented in partnership with Uganda
Ministry of Health

FUNDED BY

Bill & Melinda Gates Foundation
The Innovations at Scale for Community Access and Lasting Effects (inSCALE) project was a five-year multi-country study in Uganda and Mozambique funded by the Bill & Melinda Gates Foundation. The views expressed in this publication do not necessarily reflect the position and policies of the donors.

4. Introduction

6. Designing the inSCALE community intervention

12. Implementing Village Health Clubs in Uganda

18. Lessons learnt

22. Conclusions and recommendations

Executive summary

Malaria Consortium's inSCALE project has been working in Uganda to help scale up quality integrated community case management programmes to improve child health. This Learning Paper details the process of establishing Village Health Clubs with the aim of improving the motivation and performance of community health workers – known as village health team members (VHTs) in Uganda.

Formative research from inSCALE has shown that status and community standing are important to VHTs in Uganda, yet many feel the purpose of their work is not well understood in their communities. The Village Health Clubs were designed as a participatory community engagement approach to promote the VHTs as key village health assets.

The Village Health Clubs were implemented through a series of processes, which included stakeholder discussions, developing and pre-testing job aids and sensitisation plans and training 880 iCCM VHTs using a training-of-trainers approach.

VHTs received initial support and supervision in setting up and running the clubs. Ongoing progress reviews and process evaluations, have found that 59 percent of the clubs were still active nine months after training. A majority of VHTs reported a positive impact on their status and standing in the community; community support; a feeling of connectedness to the community; improved performance and motivation; and increased access to and use of appropriate treatment for children under five.

Some of the main challenges reported for Village Health Clubs were in relation to drug stock outs, which reduced club attendance as well as a lack of supervision of the Village Health Club facilitators. The key recommendations include linking the Village Health Clubs to income-generating activities for improved sustainability, as well as facilitating regular supervision by health facility supervisors. Due to the popularity of the Village Health Clubs, Malaria Consortium will continue to introduce this concept in and beyond Uganda, as well as incorporate the lessons learnt into the development and implementation of other social mobilisation activities.

The inSCALE Learning Papers

As part of the project's advocacy and communications components, inSCALE aims to promote 'coherent and coordinated policies' to advance best practices and innovations to improve CHW programmes delivering iCCM at country level. In support of this, inSCALE has been capturing knowledge and learning from the implementation of inSCALE interventions and sharing these through Learning Papers. Three complementing inSCALE papers have been published:

Developing intervention strategies (to improve community health worker motivation and performance) (2012), documents inSCALE's research and intervention design process.

Establishing Village Health Clubs (to improve community health worker motivation and performance) (2015) summarises knowledge and learning from the implementation of inSCALE's community intervention in Uganda.

Implementing mHealth solutions (to improve community health worker motivation and performance) (2015) documents implementation of the inSCALE technology intervention in Mozambique and Uganda.

To read the Learning Papers:
www.malariaconsortium.org/inscale



“ Overall the club has been successful. We have seen improved cleanliness in members’ homes. They’re now using drying racks and latrines and are clearing stagnant water and cutting bushes around their homes. There has been an improvement in their lives and in the health of community members.”

Kabagenyi Scovia and Kiiza Langton, village health club facilitators in Kigungu village
Photo: Tine Frank

Introduction

Integrated community case management

Integrated community case management (iCCM) is an approach where community health workers (CHWs) are trained to identify and treat pneumonia, diarrhoea and malaria in children under five years, as well as to refer severely ill cases to the nearest health facility. Evidence in African countries shows that CHWs, if properly trained and equipped, have the potential to reduce child deaths from malaria, pneumonia and diarrhoea by up to 60 percent through the delivery of iCCM¹.

However, iCCM programmes have faced challenges in scaling up. The Bill & Melinda Gates Foundation, through a series of consultations with country programme managers and development partners, identified three main implementation barriers, related to supportive supervision; CHW motivation – through remuneration or otherwise; and monitoring and evaluation data for programme planning.

The inSCALE project

The Innovations at Scale for Community Access and Lasting Effects (inSCALE) project was a five-year multi-country study in Uganda and Mozambique funded by the Bill & Melinda Gates Foundation. The project was conducted between 2009 and 2014 (extended to 2016 in Mozambique) by Malaria Consortium in partnership with the London School of Hygiene & Tropical Medicine and University College London.

The aim of the project was to demonstrate that government-led iCCM programmes in two African countries could be scaled up while maintaining quality of care by addressing the barriers to iCCM implementation – namely, lack of supportive supervision and CHW motivation. This would be achieved by:

1. Identifying best practices and innovations with the potential to increase CHW motivation and supportive supervision;
2. Assessing the feasibility and acceptability of these innovations among different user groups;
3. Evaluating the impact of the innovations through randomised controlled trials;
4. Costing iCCM implementation and the innovations;
5. Promoting the implementation and spread of iCCM by sharing findings and best practices with key national and international stakeholders.

Developing the intervention strategies

Step 1 Existing experience and theory

- Literature review
- History and context reviews
- Expert consultations

Step 2 Creating interventions informed by theory

- 'Best bets'
- Pile sorting
- Formative research

Step 3 Materials and monitoring tools

- Pre-testing of materials

Between January 2010 and August 2012, through a rigorous research, review and evaluation process*, a multi-disciplinary inSCALE technical team developed two intervention packages that were evaluated through randomised controlled trials. The two interventions were:

1.

The technology intervention

implemented in Mozambique and Uganda. Promoting CHW learning and support, this approach aims to use low-cost technology, through the development of tools and applications for mobile phones, to increase CHWs' feeling of connectedness to the wider health system. The mobile technology developed by inSCALE supports CHW motivation and performance through self-learning, provision of job aids, data submission and performance-related feedback.

2.

The community intervention

implemented in Uganda only. Promoting CHWs as key village health assets to improve motivation and performance, this community mobilisation approach is focused around the formation of Village Health Clubs as a platform for participatory and locally owned identification of health problems and solutions, followed by a learning and action cycle.

These two interventions were compared with control areas that received the standard Ministry of Health (MoH) iCCM package, implemented with support from Malaria Consortium².

Mozambique and Uganda were selected for implementation of the inSCALE project partly because they were among the four countries in which Malaria Consortium had been implementing an iCCM programme since 2009. Furthermore, the two countries have shown a willingness to make a firm commitment to community-based care as a way of reducing morbidity and mortality in children under five years; have very different models of community-based health delivery; and have demonstrated their ability to be regional leaders in this field. In Uganda, iCCM became a nationwide strategy for reducing child mortality in 2010, and the Mozambican CHW programme, locally known as *Agentes Polivalentes Elementares* (APEs), has been in existence for more than 30 years. However, in-country assessments and other literature identified an urgent need for strategies that improve performance and retention of CHWs if such iCCM programmes are to successfully provide high-quality care to sick children in both countries.

As the local APE strategy already incorporates substantial community components, the proposed inSCALE community intervention was not seen as sufficiently innovative for the Mozambique context. Therefore, and also because of time constraints, it was decided that Mozambique would implement only the technology intervention.

Under the iCCM programme in Uganda, where CHWs are known as village health team members (VHTs), each village should have an average of five VHTs, two of whom have been trained to distribute medicines under iCCM. There are no real literacy or education requirements – although ideal candidates are able to read and write the local language – and VHTs receive five days of basic health training, with six days of additional iCCM training for the iCCM VHTs. Notably, VHTs are volunteers, receiving only \$5 a month to cover travel costs, and have an average catchment population of 250 people. Treating only children aged two months up to the age of five years, a VHT typically sees 20 cases per month.

*This is described in detail in the Learning Paper 'Developing intervention strategies to improve community health worker motivation and performance', www.malariaconsortium.org/resources/publications/167/

Designing the inSCALE community intervention

The inSCALE formative research showed that, in Uganda, status and community standing are important to VHTs, yet many feel that their work and aims are not well understood in their communities.

The community intervention design process was circular, moving back and forth between findings and guiding principles from the theoretical review and formative research stages.

Existing literature showed several current village committees, such as the government's Village Health Committee, and groups had been unsuccessful owing to a lack of government involvement, infrequent meetings, groups being too exclusive and not representative of the whole community, a shortage of funding to take action and lack of a functional system in which the groups could operate, resulting in a lack of response to issues identified.

Formative research found purposeful and participatory community activities that are open to all, enjoyable and focused on positive local health outcomes were likely to be motivating and sustainable for VHTs and their communities.

After discussing and discarding different concepts and group structures that were found not to be sustainable, the inSCALE community intervention eventually evolved into a participatory community engagement approach called Village Health Clubs.

The Village Health Clubs seek to further engage those individuals who do not normally participate in community initiatives in order to maximise support around the VHTs and their work. The design of these clubs is based on recorded successes from existing structures in Uganda and Africa Applied Health Education and Development's (AHEAD's) community health club approach, which has proven effective in terms of hygiene behaviour change but has not been evaluated in relation to increasing CHW motivation or appropriate treatment³.

inSCALE Village Health Clubs

Promoting VHTs as key village health assets to improve VHT performance, motivation and retention.

The Village Health Club approach aims to enhance the perceived value of the VHTs, both for themselves and for the communities they serve. This should lead to greater status for VHTs, as well as increasing demand for their services, contributing to the sustainability of their role and increased utilisation of health services for sick children.

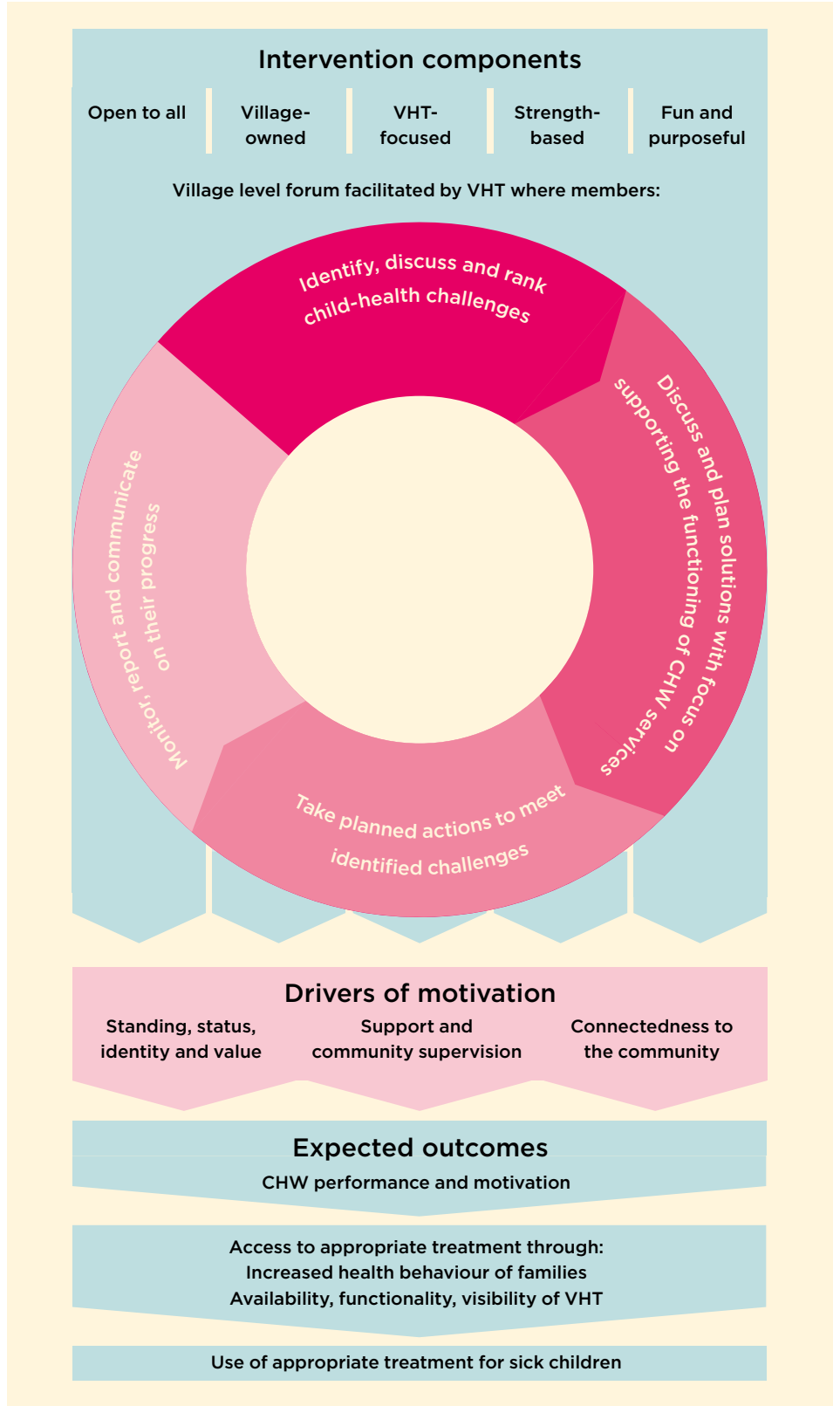


“ I know many mothers who have suffered because they did not have money for transport to the health facility. Now we have an emergency fund for club members, I know the money is there, and I feel happy and relieved.”

Twaise Josephine, member of Tufeeyo Village Health Club, Hoima district
Photo: Tine Frank

What are Village Health Clubs?

Village Health Clubs are community-led forums that aim to improve child health with the VHT as the main focal point and facilitator. The clubs are based on five key pillars, and use a four-step participatory learning and action cycle designed to engage community members in taking action to solve child health problems.





“ I got the idea to build a latrine from the VHTs and the health club, to improve hygiene and avoid flies. Before, the younger children would get sick from diarrhoea a lot – maybe three times per month one of them would get sick. Now there is very little diarrhoea.”

Aramanazani Grace, member of Kagamba-Kamu Village Health Club, Buliisa district
Photo: Tine Frank

By being locally relevant, focusing on VHT challenges and working to identify and action practical local solutions, Village Health Clubs help improve community members' understanding of what VHTs can and cannot do, and their potential to improve child health in the village. In doing so, Village Health Clubs:

- Improve the status and standing of VHTs as key village health assets;
- Increase VHT motivation and quality of service provision;
- Potentially increase demand for VHT services and the number of children accessing them; and
- Communicate to VHTs and other village members that VHT work is important, of value and appreciated.

Through the implementation of a participatory learning and action cycle, members define child health problems and decide on actions and solutions together. Over a period of three to four weeks, actions are implemented at household and community level to effect individual and collective behaviour change. Club meetings actively review activities and results.

The key innovations in the inSCALE community intervention are that Village Health Clubs are focused around VHTs, contrary to existing community groups and health committees, and are designed to be locally owned, with the VHTs accountable to the communities in which they operate. These innovations are meant to strengthen the intervention's sustainability beyond the life of the inSCALE project.

In the theoretical review and formative research stages, key guiding principles were identified that informed the design of both the community and the technology intervention packages. Theory determined that the interventions should promote CHWs as members of a collective by highlighting a sense of shared experience; focusing on alignment between CHWs and overall programme goals; and emphasising the actions that lead to good performance. The Social Identity Approach, a combination of social identity theory and self-categorisation theory, was selected as the theory most likely to lead to the development of effective, scalable and sustainable interventions⁴. The formative research and pre-testing provided the information to finalise intervention design and elements, as illustrated here.

The 5 pillars

Open to all

VHT-focused

A strength-based approach

Village-owned

Fun and purposeful

The inSCALE Village Health Club intervention design

Formative research	The 4-step action cycle	Testimonials
<p>Participatory activities in the community that are open to all, enjoyable, purposeful and focused on positive local health outcomes delivered through the VHTs are likely to sustain community interest and engagement and be motivating for VHTs. Formative research revealed lack of this element as a key factor in why the government's Village Health Committee initiative was less successful.</p>	<p>Step 1 Club formation The VHTs sensitise and mobilise local leaders and organise the first meeting to establish the club, inviting anyone in the community to join, encouraging members who do not usually participate in community activities. The community is informed of the purpose of the Village Health Club and new members are given membership cards.</p>	<p>“When we started the Village Health Club, we used religious leaders to pass on information. People in communities have belief in the religious leaders and this has helped increase the membership of our Village Health Club.” VHT, Kyegegwa district</p>
<p>VHTs value technical feedback and supportive encouragement from both supervisors and community members. Often, the role of the VHT is misunderstood and community members do not know what the VHTs can and cannot do.</p>	<p>Step 2 Prioritising child health problems; finding out causes and solutions; taking action at home The VHTs facilitate this step. In contrast with existing initiatives, this innovation is meant to promote the VHTs as key community health assets. Through collective problem-solving, communities will come to understand the full extent of the VHTs' role and responsibilities, facilitating solutions to VHT problems and enabling them to carry out their work more effectively.</p>	<p>“Club members now contribute transport money [for the VHT] to collect drugs from the health centre. These days they know our importance in the community. Some members, when they harvest their crops, they bring us some food in appreciation of our work.” VHT, Hoima district</p>
<p>By tapping into existing strengths in the community, such as village networks and structures, the VHTs and community members can employ personal experience and knowledge, creativity and other communal assets to help solve identified child health problems. Changing the mind-set towards sustainability, clubs should harness support from non-governmental organisations to become self-sufficient, rather than relying on continued support.</p>	<p>Step 3 Finding solutions and taking actions together Facilitated by the VHTs, health club members understand and focus on the community's strengths, such as local resources, people, skills and networks, focusing on the positives in the community rather than the needs and challenges. Applying these strengths, VHTs and members work together to solve identified child health problems.</p>	<p>“Community members now understand the importance of collective responsibility regarding health issues in the community, and this has prevented diseases and also improved on people's relationships in the community. They now work together for a common cause, especially when it comes to issues related to health.” VHT, Masindi district</p>
<p>VHTs are motivated by their status and standing in the community and a sense of the value they add. If community members themselves chose the organising committee from people who choose to join up, rather than being selected by a local leader, club members are likely to feel a stronger sense of ownership, which in turn positively affects sustainability.</p>	<p>Step 4 Reviewing our actions – how did we get on? What more do we need to do? This innovation, where communities are responsible for taking charge of their own health, improves the sustainability of the Village Health Clubs. As the community sees improvement in their general health, they are likely to attribute the change to the clubs and the facilitating VHTs – a great motivating factor for the VHTs.</p>	<p>“In the club, they identify a health problem in the community, discuss it and come up with solutions that will help get rid of the problem. So, everyone keeps reminding each other what to do. They have realised solutions have to come from them to improve their livelihood.” VHT, Masindi district</p>
<p>Formative research showed the popularity of meeting attendance is dependent on the interest and relevance of the issues under discussion. 'Fun and purposeful' describes the spirit of actively making change happen through quick and tangible results, rather than waiting for outside help. Meetings were also seen as an effective forum for getting to know fellow community members and receiving information.</p>	<p>The fun and purposeful element of the Village Health Club design is a cross-cutting feature the VHTs apply across all pillars and action steps, often incorporating drama or performances to educate and demonstrate solutions to identified health problems in a relaxed and entertaining manner. Providing a safe, fun, supportive place to learn, and making the clubs locally relevant and interesting, this element can be key to improving the sustainability of club activities.</p>	<p>“People used to dislike sleeping under bed nets because it is so hot here. So we developed a drama showing how the mosquitoes bite mostly at night and how that leads to malaria, and people started sleeping under nets. People started attending the meetings. They would cheer and enjoy and join up as members.” VHT, Buliisa district</p>

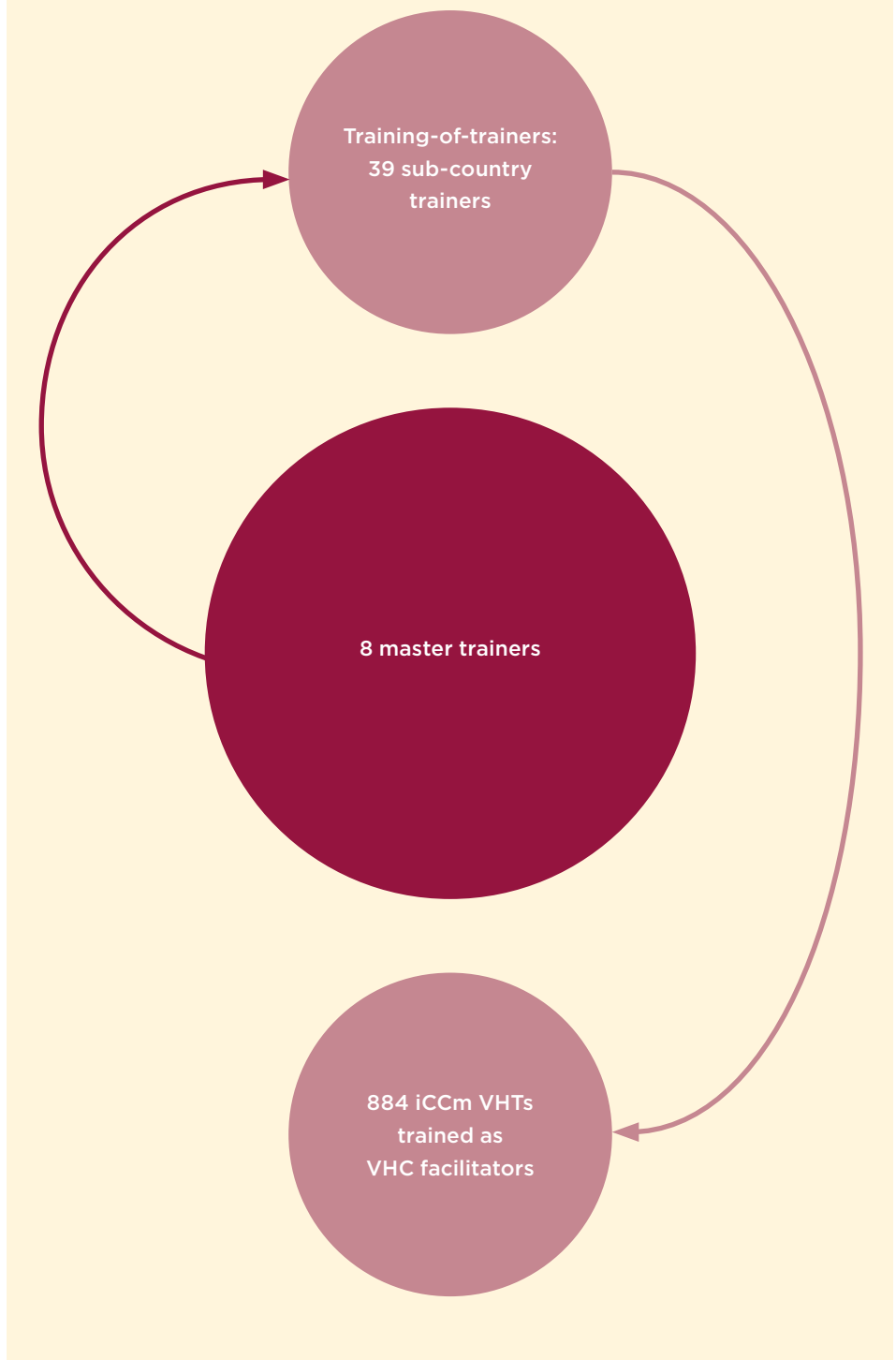
Implementing Village Health Clubs in Uganda

Processes

Key processes involved in implementing the Village Health Clubs included:

- Discussions with relevant MoH stakeholders to produce operation and implementation guidelines for the approach;
- Pre-testing of the Village Health Club concept with VHTs and community members to introduce the intervention and gather feedback on acceptability and feasibility, as well as testing images and messages on picture cards included in the flipbook;
- Development, design, pre-testing and revision of content for facilitators' guides and job aids, in particular the VHT flipbook, a multi-purpose job aid designed to ensure VHTs use participatory and interactive techniques; guide them through the four-step cycle; help pass on motivating behaviour change communication messages; and act as a reference for accurate child health information;
- Designing, pre-testing and producing reporting formats and membership cards for the Village Health Clubs, followed by pilot testing and revision based on pilot results;
- Developing, pre-testing and piloting a community-level sensitisation plan to explain and promote the Village Health Club concept to local leaders;
- Training through a supervised training cascade using a training-of-trainers approach.

Training-of-trainers approach



Training

The inSCALE community-based intervention involved 884 iCCM-trained VHTs from the five selected project districts, who were prepared through a training-of-trainers approach.

First, eight master trainers (five district, one MoH and two Malaria Consortium staff) went through a three-day training course, after which they conducted a pilot training with 17 VHTs. Lessons learnt from the pilot were incorporated into the training approach and materials.

Following this, two three-day training-of-trainers sessions took place, training 39 sub-county development officers, health facility in-charges and health assistants as trainers in adult learning, the participatory empowerment methodology and the Village Health Club approach and flipbook.

This step saw the development of a training-of-trainers guide, an individual progress chart, a peer observation form, a VHT workshop evaluation form and a VHT training report. Master trainers supported trainers in order to ensure the quality of the training and support their continuous learning in participatory approaches.

Additionally, 'supervising-the-supervisor' trainings took place, training VHT supervisors in the specifically developed competency-based checklist for VHTs on setting up and running Village Health Clubs.

The sub-county trainers trained two VHTs in each of the 440 project villages as Village Health Club facilitators. The VHT training sessions each had 20 VHT participants and were run by two or three sub-county trainers, with initial practical guidance and support from the master trainers. To strengthen their position as facilitators and key village health assets, the VHTs were equipped with:

- A flipbook and a set of child illness picture cards to facilitate Q&A sessions;
- A facilitator's starter kit of membership cards, stationery, certificates and t-shirts;
- Evaluation forms and attendance registers.



“ I have learnt you take the child straight to the VHT if it has signs of diarrhoea. There’s a picture in his book [inSCALE flipbook] of a woman carrying a sick child.”

Rosemary Kaserenye, member and chair of Kitaleesa Village Health Club, Kyegegwa district

Photo: Tine Frank

Establishing Village Health Clubs

Following the training and the development of materials, the VHTs work with their peers and local leaders to establish Village Health Clubs in their communities, receiving supportive supervision from sub-county trainers to ensure the smooth set-up and running of the clubs. After an initial meeting with local leaders, a 'core group' meeting, including VHTs, supervisors and local chairpersons, takes place to come up with a sensitisation plan to publicise the first Village Health Club meeting.

This first meeting is meant to introduce the Village Health Club concept to community members, with the VHT leading discussions on the village's overall health situation, and to promote the benefits of working as a group to improve the community's health.

Once established, VHTs facilitate club meetings using a participatory learning and action (PLA) cycle. Identified child health challenges are ranked using picture cards, causes pinpointed, solutions discussed and actions decided on. Over a period of three to four weeks, actions are reviewed and discussed and further actions decided on if necessary.

As Village Health Clubs are designed to be fun and purposeful, the majority of the clubs employ some form of dance and drama entertainment in order to attract and retain members and to educate on childhood disease prevention and treatment in an enjoyable and interactive manner.

The intended supervision structure was designed to strengthen the intervention's sustainability by tapping into existing supervision layers in the health care system, and not to depend on continued donor support after the end of inSCALE. Defined supervision roles included:

- **Health facility supervisors and health assistants.** Already supervising VHTs for iCCM-related activities, and trained as trainers in the Village Health Club approach, these frontline health workers are perfectly placed for supervisory roles, including clarification of club activities and dealing with specific health-related questions raised in meetings.

- **Parish coordinators.** Chosen from the group of VHTs, the parish coordinators serve as a focal point and link between the clubs themselves and between the VHTs and health facilities.

- **Community development officers (CDOs).** Utilising existing layers in the health care supervision structure, the idea was that CDOs would have a vested interest in supervising the Village Health Clubs as they complement their existing activities and objectives.

- **Community leaders.** Often referred to as 'club patrons', these key community members can provide supportive supervision in the form of signing off and monitoring collective action plans, mobilising for and attending meetings and lending moral support/problem-solving.

- **Community members.** One Village Health Club innovation is the community itself as a form of supportive supervision mechanism, through VHT collaboration with and accountability to community members.

Progress review

Between January and March 2013, about two to five months after club rollout, a number of ‘unpacking’ exercises – one for each district – took place to understand why some VHTs and communities succeeded in launching Village Health Clubs while others did not. Across the project districts, individual experiences were compiled in detail – what had made VHTs succeed and how they had overcome challenges. Specific suggestions were then provided on how VHTs could improve the running and sustainability of Village Health Clubs.

District review meetings followed in September 2013 that introduced peer-to-peer learning for VHTs, pairing up those who are slow adopters to fast adopters, to channel advice and experience on how to overcome challenges in forming Village Health Clubs. Although not an intentional activity in the intervention design, this peer-led sharing of individual successes proved very useful for VHTs who had struggled to launch their Village Health Clubs, as they felt encouraged and/or challenged by their colleagues’ successes.

“ The most significant change I have seen as a result of the Village Health Club is a reduction in the number of cases treated in the village for malaria and diarrhoea. People have been equipped with knowledge to prevent themselves against diseases. When I move around in the village, I see homesteads have improved in cleanliness. They have put up latrines and drying racks and are boiling drinking water. Even when their children fall sick they know what to do. My workload is becoming less and I can manage to do my other work.”

VHT, Masindi district

Community uptake of Village Health Clubs

Between September 2013 and February 2014, extensive data were collected from VHTs and their supervisors in order to evaluate the process of implementing the Village Health Clubs and communities' uptake of the intervention. Data were collected through questionnaires filled in by VHTs attending progress review meetings, representing 415 Village Health Clubs.

In addition, research assistants who had undergone a two-day training in the study's objectives, concepts and tools conducted qualitative key informant interviews with 24 VHTs and eight VHT supervisors. The qualitative data were analysed using a thematic content data analysis approach.

The research assistants collected a total of 63 field stories from VHTs – across both inSCALE interventions in Uganda – to be used in the Most Significant Change evaluation methodology. This is a form of participatory evaluation that involves many levels of stakeholders, who rank the changes they consider most important for the programme, along with justifications for the ranking.

For inSCALE, three rounds of reviews of the stories took place, in which the organisational, district and national stakeholders went through systematic selection of the most significant stories, providing qualitative data on impact and outcomes to use to assess programme performance as a whole.

Following VHT training, 96 percent of the villages had established Village Health Clubs; 59 percent of the clubs were still active nine months later. The process evaluation showed the majority of clubs had between 21 and 50 members, predominantly female, with monthly or bi-monthly meetings dealing mostly with the prevention and treatment of malaria, diarrhoea and pneumonia.

After the clubs had been rolled out for 18 months, an endline survey was conducted, which visited over a thousand households. Of these, about every third household had participated in the club activities.

Lessons learnt

Successes

Data collected from the progress review questionnaires and 32 key informant interviews conducted in the community intervention revealed predominantly positive feedback, especially regarding VHT motivation and performances. Key responses are presented on page 19.

In addition to the indicators directly addressing the desired outcomes of the inSCALE community intervention, VHTs and their supervisors reported a number of other key successes:

- Village Health Clubs have greatly reduced VHT supervisors' workload, both at health facility level, owing to reduced patient load, and at community level, as the clubs are performing health education and sensitisation. Additionally, the clubs have eased the information flow to communities for meetings and outreach activities.
- Village Health Clubs have contributed to communities' economic empowerment through the evolution of the clubs into community-based organisations and establishing saving and credit cooperatives (SACCOs) and income-generating activity groups.

“ The VHC members are doing most of the work by following what they agree on in their meetings. As a supervisor, I used to be alone in this work, but now we are many and work as a team, and my work is reducing tremendously because of this team work.

VHT supervisor, Kyegegwa district

“ I supervise 12 VHTs who have all formed active clubs. These VHTs have formed a SACCO with the aim of benefiting from the government National Agricultural Advisory Service programme.”

VHT supervisor, Masindi district

Outcome	Indicator	Testimonials
Improved VHT status and standing	Village Health Clubs have improved sanitation and hygiene in the communities, which has reduced rates of disease, especially diarrhoea and malaria, through preventative behaviour. Where attributed to the efforts of the VHT, this greatly impacts his/her standing in the community.	<p>“The Village Health Club has made VHTs more popular in the communities they serve because there is direct interaction between them and the community, and the action plans that are agreed on greatly impact the community if properly implemented. So, after the community members get the desired result, they appreciate the work of VHTs and look at them like real doctors. This has elevated their status in the community and people look at them with a lot of respect and admiration.”</p> <p>VHT supervisor, Masindi district</p>
Improved VHT support and supervision from the community	The majority of VHTs and supervisors felt the Village Health Clubs had increased appreciation and respect for, and recognition of, VHTs in the communities. VHTs are more widely known, and there is an increased awareness and understanding of their role and responsibilities. In addition, the clubs have resulted in improved relations with village government and religious leaders, and strengthened relationships with community members.	<p>“In some villages, community members have appreciated VHTs and contribute some money to help VHTs access some basic needs at home, since they spend most of their time doing voluntary work. This is a sign communities have recognised the efforts of VHTs in trying to improve the health of their communities and have in turn appreciated their work.”</p> <p>VHT supervisor, Masindi district</p>
Increased VHT feeling of connectedness to the community	The majority of VHTs and supervisors felt the Village Health Clubs had increased appreciation and respect for, and recognition of, VHTs in the communities. VHTs are more widely known, and there is an increased awareness and understanding of their role and responsibilities. In addition, the clubs have resulted in improved relations with village government and religious leaders, and strengthened relationships with community members.	<p>“The Village Health Clubs have tried to change community expectations towards the VHTs. Some community members now understand VHTs are volunteers, who need to be respected for the good work they are doing for the community.”</p> <p>VHT supervisor, Hoima district</p>
Increased VHT performance and motivation	The Village Health Club flipbook (facilitator’s guide) has increased VHT knowledge and skills on disease management and prevention, positively impacting the quality of service provision. The clubs and facilitator training have improved VHT public engagement skills, helping them to manage large crowds and people of different backgrounds. When giving health education to one attentive group as opposed to individual household visits, VHTs are using their time more efficiently. The reduced workload in turn frees up time for the VHTs, which the formative research identified as a great motivator.	<p>“I have learnt a lot from using the flipbook. The pictures in the flipbook are very direct and the steps we follow during club meetings have also enlightened me about the prevention of diseases.”</p> <p>VHT, Masindi district</p> <p>“In the past, I would spend a lot of time moving around the village at the expense of my work that pays me, but now people come together and I facilitate at once. The work I would do in a month is done in one day when all people come to the meeting.”</p> <p>VHT, Kyegegwa district</p>
Increased access to and use of appropriate treatment	Village Health Clubs have led to greater understanding of and appreciation for the VHTs’ roles and responsibilities as well as limitations. This has, in many cases, increased demand for and uptake in VHT services, better adherence to referrals and improved early treatment-seeking behaviour.	<p>“In the past, people believed in witchcraft. A caregiver would have a child suffering from diarrhoea and claim it was witchcraft. But, with sensitisation from the Village Health Clubs, members now bring their children to the VHT for treatment, and when we refer them to the health centre they go and seek treatment, unlike in the past, when they would go to buy drugs from the clinic instead.”</p> <p>VHT, Buliisa district</p>

Challenges

Where Village Health Clubs were not successful, the main challenges defined by the VHTs in starting and running the clubs include:

- A lack of interest from the community – in particular from youth and men – in attending the Village Health Clubs, despite repeated mobilisation efforts by the VHTs.
- Inadequate stationery supplies to run Village Health Club meetings affected attendance and membership – in particular membership cards running out.
- Community members expecting allowances, lunch and/or free items such as t-shirts and mosquito nets would be demotivated from attending meetings.
- There was a lack of support from local leaders in mobilising for and attending meetings and signing membership cards.
- In periods of drug shortages, club meeting attendance drops significantly.
- With no facilitation for supervisors, VHTs largely run the clubs with minimal supervision. The designed supervision structure did not work as intended, largely because of a lack of facilitation. Although the VHT-community supportive supervision mechanism exists in the clubs, VHTs felt the need for more formal and traditional support supervision from district supervisors.
- Drop in attendance and activities during festive periods and planting/harvest seasons, as well as other community events like burials and weddings, affected attendance.
- Income-generating activities and the need to care for relatives can take priority over club activities, especially in villages with only one active VHT, running the club alone.
- Larger villages and migratory populations pose challenges for VHTs in carrying out continuous mobilisation, given the time-consuming nature of recruiting new members and following up on club-agreed activities in this setting.
- Some Village Health Clubs stopped organising meetings when they ran out of topics suggested and illustrated in the inSCALE flipchart and picture cards.



“ In the past, you would find me on my bicycle, carrying three children at a time to the health centre. Things were not good in my home. I have eight children, and there was a lot of vomiting and diarrhoea. Through the club I was inspired to build a drying rack and a latrine. Now there is no more diarrhoea.”

Bahoire Oliver, member and chairperson of Kisongi Village Health Club, Buliisa district

Photo: Tine Frank

Conclusions and recommendations

1.

The Village Health Club intervention, when the key elements are in place, can be an effective approach to achieving behaviour change, while strengthening and supporting the role of the VHT. Furthermore, the clubs can be used as platforms for other community education and empowerment initiatives – either by the community themselves or for non-governmental and government initiatives. By linking the clubs to income-generating activities, the clubs are more likely to become self-sufficient.

2.

Although the community-to-VHT supervision structure offers some support to the VHT, it is recommended that Village Health Club support and supervision be integrated into district and sub-county development plans and budgets to further strengthen the VHTs as key health assets and the Village Health Clubs as community solutions to child health challenges. It is, however, important to note that the Village Health Clubs were formed and remain active even where VHTs received little or no sub-county-level supervision, speaking to the potential sustainability of the intervention.

3.

Incorporating peer-to-peer learning sessions for VHTs during district review meetings significantly boosted club formations, membership and activities, and fostered a sense of connectedness and community among the VHTs. They were particularly useful for VHTs struggling to form or maintain clubs, as they would learn good practices from colleagues running active and successful Village Health Clubs.

4.

Planning for tools and elements to be in place is essential for the successful rollout of the Village Health Club intervention. Simple things such as an adequate stationery supply are vital in retaining and recruiting club members; club membership cards proved key in recruiting new members and many Village Health Clubs, despite efforts to guide the VHTs in making new copies facilitated by the club itself, experienced difficulties in attracting new members when they ran out of cards.

5.

To keep the Village Health Clubs active in the longer term, linkages should be made to future projects, tackling other health issues such as maternal health and neglected tropical diseases to continue community education on other health topics. To support this, additions could be made to the existing flipbook.

6.

When scaling up the intervention, it is important to consider workload. With more VHTs per village trained as Village Health Club facilitators, the workload – especially mobilisation and follow-up – will lessen for the individual VHT, which will furthermore make club activities less reliant on VHT availability. With a workload more manageable for the VHTs, the intervention is more likely to sustain.

7.

Peri-urban areas did not respond well to the Village Health Club concept, whereas rural communities tended to embrace the concept more willingly. The suggestion is that the need for VHTs in peri-urban areas is likely to be different to that in rural areas. Further research would determine whether the Village Health Clubs can still provide a mechanism through which VHTs can sustain their motivation if these needs are identified and solutions to them are led by community members.

Moving forward

Beyond the project life of inSCALE in Uganda, Malaria Consortium is continuing to share lessons and findings from the Village Health Clubs with interested and relevant partners and stakeholders.

1.

Malaria Consortium is providing support to iCCM and technical assistance to the MoH, and participates in appropriate technical working groups. As the MoH is revising its iCCM strategy, Malaria Consortium is sharing lessons from the inSCALE community intervention and encouraging the uptake of the Village Health Clubs.

2.

Malaria Consortium will continue to introduce Village Health Clubs in other parts of Uganda, with additional learning materials included on neglected tropical diseases and maternal health.

3.

In and beyond the Uganda context, lessons learnt from the Village Health Club intervention are being incorporated into Malaria Consortium's social mobilisation activities in other countries, with plans to strengthen Community Health Committees in Mozambique by adding social identity and social group theories to how they work with CHWs and communities.

Malaria Consortium continues its efforts to share learning more broadly, for example by making available the Village Health Club implementation package, training-of-trainers manuals, etc. to other organisations interested in replicating the intervention model, as well as facilitating exchange visits for other implementers of this or similar interventions.

As final findings are being analysed, Malaria Consortium will publish a final endline paper to establish the actual impact of the Village Health Club intervention in Uganda, including costing the intervention and its various components.

References

1. Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS. 'How Many Child Deaths Can We Prevent This Year?' *Lancet*, 362, (9377) 65-71.
2. Källander K, Strachan D, Soremekun S, Hill Z, Lingam R, Tibenderana J, Kasteng F, Vassall A, Meek S, Kirkwood B 'Evaluating the Effect of Innovative Motivation and Supervision Approaches on Community Health Worker Performance and Retention in Uganda and Mozambique: Study Protocol for a Randomised Controlled Trial'. *Trials*, 2015, (16) 157.
3. Waterkeyn J, Cairncross S 'Creating a Demand for Sanitation through Community Health Clubs: A Cost Effective Intervention in Two Districts of Zimbabwe'. *Social Science & Medicine*, 2005, (61) 1958-1970.
4. Strachan DL, Källander K, Nakirunda M, Ndimba S, Muiambo A, Hill Z, the inSCALE Study Group. 'Using Theory and Formative Research to Design Interventions to Improve Community Health Worker Motivation, Retention and Performance in Mozambique and Uganda'. *Human Resources for Health*, 2015, (13) 25.

Malaria Consortium

Malaria Consortium is one of the world's leading specialist non-profit organisations. Our mission is to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted diseases and promote child and maternal health.

We work across Africa and Asia with communities, government and non-government agencies, academic institutions, local and international organisations, to ensure good evidence is used to improve delivery of effective services.

Our uniqueness is in our ability to consistently design and apply tailored, technically excellent, evidence-based solutions, fit for effective implementation, with impact on the wider health system and economy.

Malaria Consortium works with partners, including all levels of government, to improve the lives of all, especially the poorest and marginalised, in Africa and Asia. We target key health burdens, including malaria, pneumonia, diarrhoea, dengue and neglected tropical diseases (NTDs), along with other factors that affect child and maternal health. We achieve our goals by:

- Designing and conducting cutting edge implementation research, surveillance and monitoring and evaluation.
- Selectively scaling up and delivering sustainable, evidence-based health programmes.
- Providing technical assistance and consulting services that shape and strengthen national and international health policies, strategies and systems and build local capacity.
- Seeking to ensure our experience, thought leadership, practical findings and research results are effectively communicated and contribute to the coordinated improvement of access to and quality of healthcare.

www.malariaconsortium.org

Village health team members show community members the importance of sleeping under mosquito nets through drama.
Photo: Tine Frank





Malaria Consortium
Development House
56-64 Leonard Street
London EC2A 4LT
United Kingdom

Tel: +44 (0)20 7549 0210
Email: info@malariaconsortium.org
www.malariaconsortium.org



UK Registered Charity No: 1099776
US EIN: 98-0627052
