

THE PERFORMANCE OF THE VILLAGE HEALTH  
TEAMS IN MANAGEMENT OF CHILDHOOD ILLNESS  
IN KARAMOJA PASTORAL COMMUNITIES: A CASE  
STUDY OF MOROTO DISTRICT.

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# DECLARATION

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I Nandawula Juliet Lubega, I hereby declare that all the work in this dissertation is original and has not been submitted for another degree in this or any other university or institution of higher learning.

**Signature**

**Date**

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**NANDAWULA JULIET LUBEGA**

# APPROVAL

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This dissertation is submitted for further examination with my approval as university supervisor

**DR. WOODING NICK**

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**SIGNATURE**

# DEDICATION

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This book is dedicated to my grand mother, Mrs. Nswa Namugabo Margaret, now 100 years old, for believing in girl child education. To my beloved husband for the love, encouragement and support he has offered and to my mother for believing in me.

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# LIST OF ACRONYM

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<b>ABEK</b>	Alternative Basic Education for Karamoja
<b>ARI</b>	Acute Respiratory Infections
<b>CHA</b>	Community Health Agents
<b>CHWs</b>	Community Health Workers
<b>CUAMM</b>	Doctors of Africa
<b>EPI</b>	Expanded Programme for Immunisation
<b>FGDs</b>	Focus Group Discussions
<b>GAM</b>	Global Acute Malnutrition
<b>HC</b>	Health Centre
<b>HMIS</b>	Health Management information System
<b>Ibid</b>	As mentioned above
<b>ICCM</b>	Integrated Community Case Management
<b>MDG</b>	Millennium Development Goals
<b>MMR</b>	Maternal Mortality Rate
<b>MoH</b>	Ministry of Health, Uganda.
<b>NGOs</b>	Non Governmental Organisations
<b>UBOS</b>	Uganda Bureau of Statistics
<b>UDHS</b>	Uganda Demography and Health Survey
<b>UNICEF</b>	United Nations Children Fund
<b>UNOCHA</b>	United Nations Office for Humanitarian Assistance
<b>VHT</b>	Village Health Team
<b>VHTs</b>	Village Health Team Members
<b>VHW</b>	Village Health Workers
<b>WHO</b>	World Health Organisation

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# ABSTRACT

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The study was about establishing factors that influence the performance of Village Health Teams in Moroto in the management of childhood illness in the current project of Integrate Community Case Management (ICCM). The main objective was to assess Village Health Teams' performance in the management of childhood illness in Karamoja, and suggest recommendation for gaps identified.

**Specific Objectives** of the study were to assess the influence of training of VHTs in management of childhood illness; to analyse the effect of supervision of VHTs in management of childhood illness; and to assess the influence of facilitation / motivation of VHTs in the management of childhood illness in Moroto district.

**Methodology:** A cross sectional study was conducted in the current Moroto and Napak districts. Ten Sub-Counties were sampled and a total of 121 respondents were sampled. These included the 54 respondents for the questionnaires, 12 key informants 15 caretakers and 40 persons in four focus group discussions. Data was analysed using the SPSS computer data analysis application.

**Key findings:** The study revealed that communities appreciated the services of the VHTs; however, poor motivation, inadequate supervision from health workers and low literacy levels among the VHTs influence their performance in the management of childhood illness.

**Conclusion:** The study concluded that the VHT's services in the villages are very important and appreciated by the community. VHT performance can be boosted if the incentive / transport allowance is increased; adequate supervision and coaching is provided and constant drug supply is ensured.

**Recommendation:** The study recommended for continuous coaching and mentoring, a sustainable motivation mechanism, improved drug chain management and provide financial empowerment for the VHTs.

# CHAPTER ONE

---

## 1.0 INTRODUCTION

### 1.1 Background

The study highlights VHTs' performance in the management of the childhood illnesses in Moroto. It has been observed that at household level, the health service delivery was low and children were the most affected, thus increasing child mortality in Uganda (MoH, 2010).

Thus, with the advent of the VHTs that were trained in management of childhood illness, it should offer the patients easy access to early treatment. This would empower communities to take decisions that affect their health.

Karamoja is a pastoral community, poor and under developed in Uganda. Like most pastoral communities, Karamojongs frequently migrate in search of water and pasture when faced with drought, food insecurity, disease, ethnic violence and extreme poverty. The child mortality rates of under five are 153/1000 live births compared to the national rates of 90/1000 live births (UBOS, 2012). The literacy levels are very low at 11% compared to 67% nationally, and poverty is 82% compared to 32% respectively. Karamoja is still faced with a high Global Acute Malnutrition (GAM rate) of 11% compared to 6% nationally (UNOCHA, 2008). According to MOH, more than 76% of the mortality in Uganda is due to preventable or treatable infections like malaria, pneumonia and diarrhoea (MoH, 2010). With long-standing criticism about meaningful community participation in health, the Village Health Team (VHT) is one of the latest approaches adapted to ensure that communities are involved

and concerned about the improvement of their own health (Komakech I., 2007). The study used the terms Community Health Worker(s) (CHWs) and Village Health Teams (VHT) inter-changeably.

According to MOH, access to health care is limited, provision of information on home based care for patients is very poor and this is coupled with the challenge of failure to promote preventive health interventions. For example, less than half of the sick children are assessed for immunization status, weight, and feeding habits. Visual aids to educate caretakers are available in only four of 10 facilities that offer sick child services, and are rarely used during consultations (MoH, 2007). In an effort to manage childhood illnesses in rural areas, the government of Uganda has introduced a program called Integrated Community Case Management (ICCM) of diarrhoea, pneumonia and malaria. ICCM engages communities in mobilizing and identifying volunteers to provide basic village health services and thus, improve utilization of life saving curative interventions (MoH, Uganda, 2010).

Before the VHT training, the MoH and the district health office together with partners developed a number of sensitization campaigns. The district health teams were sensitised about the program and their roles were discussed. The health centre staff including the in charges were sensitized and trained on case management and supervision skills. The communities were sensitized about the VHTs and their roles in the management of malaria, pneumonia and diarrhoea. When VHT training was conducted the training focused on giving skills and knowledge on case management of diarrhoea, malaria and pneumonia, record keeping, referral of severe cases and drug supply management.

This strategy uses VHTs to treat cases with pre - packaged drugs, mobilise communities to demand for health services, referral of the newborn with danger signs, collect data, and do

timely reporting. Experiences in ICCM have shown that communities valued and used the services provided in the community; and that motivation of VHT members is very critical and caregivers are able to comply with treatment especially if pre-packaged drugs are used. It is important to promote early care seeking for illness, community managements of malaria, pneumonia and diarrhoea and timely referral of severe cases to health centre facilities (Pagnoni F, 2010). The Ministry of Health in Uganda notes that bringing services closer to the people in the community is a key component of the strategies to reduce inconsistencies to health services, among others (MoH, 2010) and thus reducing child mortality rates.

There are many studies that have been conducted on Community Health Workers and some have covered service delivery and justification of a community based approach to childhood illnesses. Other studies have explored the role of CHW in child health, perception of the community on services of the CHWs, the ability of CHWs to treat malaria cases, performance of CHWs in terms of number of the children treated and dosage administered. However, no study has been conducted on the performance of the VHTs in the management of childhood illness in the pastoral communities in Uganda. The study focused on the individual members of the VHT; and assessed his or her ability to manage childhood illness in these underserved and hard to reach communities. It explored their ability to understand and use the job aid, (cards used by VHTs with summarised information of how to treat children), fill in referral forms for complicated cases, maintain regular records, the ability to identify danger or illness signs in children and ability to provide right dosage to children.

## 1.2 **Statement of the Problem**

Karamoja sub region has one of the highest child mortality rates in Uganda in spite of the fact that the region has many selective health programs including immunisation and nutrition.

Karamoja is a unique area faced with challenges of accessing healthcare; this is due to the

nomadic life style and the under developed health facilities that are usually inaccessible and with severe shortage of drugs, poor data management, weak referral systems and high turnover of health workers (CUAMM 2009). To manage the above problem, the district is divided into health sub-districts and each of these consists of a set of HC IIs, HC IIIs and a referral facility such as an HC IV or a hospital. At the community level, each village is serviced by VHTs, and this is what constitute an HC I. Two of the VHTs per village have been trained to manage three major childhood illnesses, malaria, diarrhoea and pneumonia for children under five years of age. However the level of performance of the VHTs in the management of childhood illnesses in Karamoja is not understood, leading to high infant and child mortality rates in this particular sub region.

In order for Moroto district to reduce the child mortality rates the VHTs must be effective in management of childhood illness. Our study therefore explored the level of performance of the VHTs in the reduction of child mortality in Moroto district, and elicited recommendations on improving their performance.

### **1.3.1 General objective of the study**

To assess Village Health Teams' Performance in the management of childhood illness in Karamoja: A case study of Moroto district.

### **1.3.2 Specific objectives**

1. To assess the influence of training of VHTs in the management of childhood illness in Moroto district.
2. To analyse the effect of supervision of VHTs in management of childhood illness in Moroto district.
3. To assess the influence of facilitation / motivation of VHTs in management of childhood illness in Moroto district.

### **1.3.3 Research Questions:**

1. How has the training of VHTs influenced the management of childhood illness in Moroto district?
2. How has the supervision of VHTs influenced the management of childhood illness in Moroto district?
3. What is the relationship between facilitation of VHTs and the management of childhood illness in Moroto district?

### **1.3.4 Scope of the Study**

The study focused on the training of VHTs, supervision of VHTs and facilitation of VHTs and their influence on job performance. The study was particularly limited to Moroto District and was guided by the Maslow's hierarchy needs theory. In using this theory, the researcher explored the possibility that for someone to reach self actualisation i.e. in their performance, their basic needs must be met (they must be able to have food, clothes and shelter). Likewise, is it feasible to have volunteers working without pay yet they cannot meet their basic needs? Are the VHTs motivated by the hope of getting employed or receiving an incentive in future a motivation for VHTs to work? Or is it just purely the need to help their communities to have a better life.

### **1.3.5 Significance of the study**

The study will assist the district in planning and identification of feasible ways that would make VHTs more effective and functional thus improving health care delivery in the pastoral communities.

The study will also generate questions that would be used as a basis of policy revision or implementation thus improving the VHTs performance at village level,

The study will help readers understand the factors influencing the performance of VHTs in the management of childhood illness.



The study will provide a description of how VHTs and health systems work to combat child mortality rates

The recommendations in the study will also be useful in guiding the MoH officials, district staff and development partners in the review of VHT / ICCM guidelines.

### 1.3.6 Conceptual Framework

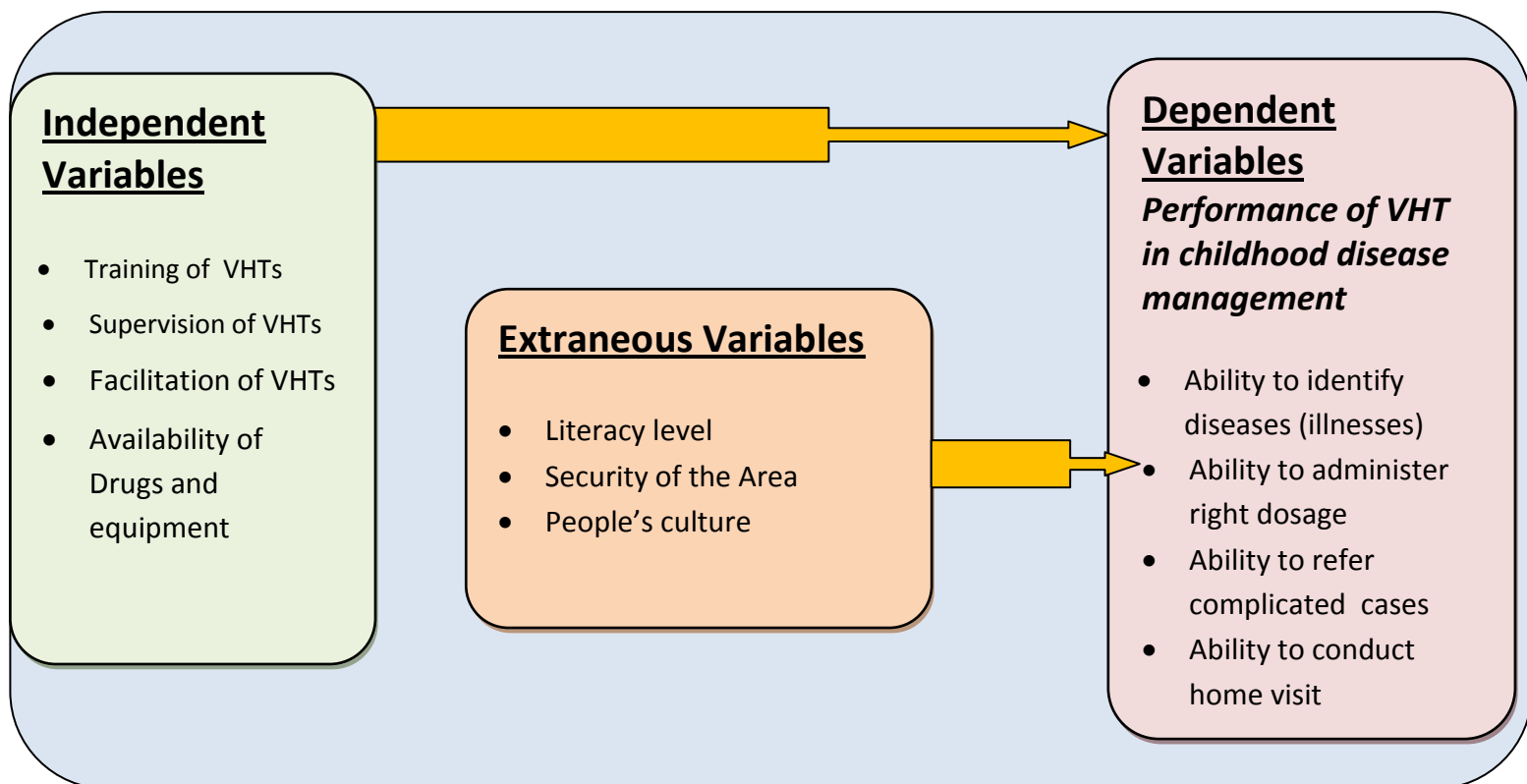


Figure 1 Conceptual Framework for VHT Performance

In figure 1 the independent variables include training, supervision and facilitation of VHTs.

The dependent variable is VHT's performance that will be measured in terms of ability to identify symptoms of the illness, administer the right dosages, refer complicated cases and conduct home visits. This study therefore investigated the relationship between the

independent variables on the dependent one. The extraneous variables include security of the area, the literacy level and traditions/ culture. Their effects on the study variables have been assessed.

# CHAPTER TWO

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## LITERATURE REVIEW

### 2.1 Introduction

In 1978, the Alma Ata declaration redefined health when it emphasized community participation in the health arena. According to the declaration, ‘health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination’ (WHO, 1978). Oakley observed that community involvement had introduced mechanisms for community participation in health through social policy, legislation and other public means (Oakley, 1989). Therefore primary health care was broadened to integrate economic and social aspects of individuals and communities and not just provision of health care at the health unit (Wooding N, et al 2012). The focus included accessibility, cost effectiveness, ability to address local needs, ensuring service delivery and not just individual ill health. Alma Ata looked at full participation of the community because it formed an integral part of a country’s health system thus bringing at comprehensive approach to health care.

#### *VHT involvement in Child Survival:*

In Uganda the national health policy has included Village Health Teams (VHT) because they are fundamental in all villages and play major roles in health promotion, disease control and prevention (MoH, 2010), which cannot be ignored. With the comprehensive approach to healthcare, emphasis was put on community participation, health promotion (to be done by VHTs), use of appropriate technology, and universal accessibility based on equity (Toshabya and Ogwal 2004, Wooding et al 2012). In 2001 the Ministry of Health Uganda adopted the

use of community health workers properly known as VHTs in the health care delivery. The main purpose was to empower communities to participate in decisions that affect their health. The Ministry of Health believed that provision of health services and mobilizing people would increase utilization and thus save the fragile lives of infant and children. It is based on these arguments that the VHT was introduced and incorporated into the Health Strategic Sector Plan to reduce the gap in health care delivery. Bhattacharyya points out that that the decentralisation and health care reforms have given local government greater autonomy (Bhattacharyya, 2001) and thus influenced involvement at all levels including villages. The VHTs complete the comprehensive health delivery model and a link to the community and may be regarded as a health centre I.

#### ***Government's efforts to improve child survival to meet MDG 4.***

Uganda has been battling with child and infant mortality rates since precolonial period. In an effort to improve child survival various selective programs were implemented. These included the Expanded Programme of Immunisation (EPI) that saw immunisation coverage of 90% of children in 2010, compared to 5% in 1974. Then in 1997, came the safe motherhood program, that focused on both maternal and child health in Sub-Saharan Africa. By 2006, child mortality rates in Sub-Saharan Africa reduced from 185/1000 live birth in 1990 to 148 / 1000 live births in 2007 (Wooding N, et al., 2012). Whereas, there has been great improvement in child mortality, attributed to the use both comprehensive and selective strategies, the situation of Karamoja is still bad.

In 2010 the MDG report on Uganda observed that in spite of the reduction in the mortality, Uganda was behind and would not achieve the MDG target of 56/1000 by 2015. Child survival in Uganda remained a challenge and this was due to failure to reduce neonatal deaths (Ntale 2007). The accessibility to the health facility was cited as a major contributor to the treatment gap in Karamoja. In rural places only 7.1% live within a five Km radius of the

health centre. The other factor in the treatment gap was the shortage of health workers because it is hard to reach the places (Annual Health Sector Performance Report F/Y 08 / 09).

Based on the above needs, the use of VHTs to implement ICCM was the most feasible strategy that would guarantee accessibility and utilisation of health care in the remote places like Moroto. To ensure meaningful community participation and ownership, communities selected their own volunteers, the Ministry of Health designed the training, the district identified trainers, and the health workers at the health centre then tasked the supervision and drug distribution to the VHTs. (Webster C W., 2009, Nakigudde F., 2011). It was observed that in western Uganda the VHT implementing the Integrated Management of Childhood illness programme had decreased child mortality by 25% and that in spite of working without payment the retainment was 85% (Nakigudde F, 2011)

In 2009, in an effort to meet MDG 4, to reduce child mortality and increase child survival, Integrated Community Case Management (ICCM) was introduced and implemented by VHTs at village level. ICCM was a selective program funded by UNICEF; it was integrated into Uganda's comprehensive approach to health care and it used VHTs to increase accessibility, community participation and health care. The VHTs were tasked with a duty to manage these case of malaria, diarrhea and pneumonia among the under-fives at village level, (MoH, ICCM) thus reducing the treatment gap. According to the MoH findings;

*“A total of 33 million cases of malaria, diarrhea and malaria go untreated every year in Uganda. It is therefore important that this large treatment gap is addressed with a combination of a high impact cost effective intervention such as ICCM working alongside the health system. This will reduce the high levels of avoidable death”. (ICCM Guidelines)*

According to those ICCM guidelines, the MOH urges that communities valued and used the services provided in the community (ICCM hand book). Thus to promote early treatment of childhood illnesses, the community management of disease becomes the best strategy.

As Uganda struggles to combat the current child mortality rates, managing childhood illness must happen at both health centre and community level. In 2000, Uganda's approach to the reduction in the child mortality rate was to target the treatment of malaria in children under 5 years of age; this was under the Homapak project. Unfortunately this did not yield a lot of success because it targeted only malaria whereas most caretakers presented children with multiple illnesses. It was based on the above observation that Uganda changed to an integrated approach to childhood illness (Nsabagasani X, 2007). This led to the birth of Integrated Community Case Management (MoH 2010) using the Village Health Teams.

Bryce emphasized the role community health workers can have in reducing morbidity and mortality in certain settings (Bryce et al, 2005). Children in areas with community health workers are more likely to be treated for illnesses (Kelly, J et al, 2001). This allows the community health workers to monitor response to drugs and ensure that care givers comply with the treatment. Tiona notes that community health workers play the role of 'triage staff' for the health facilities by treating cases and referring complicated ones to health facilities (Tiona 2008). The use of community health workers to combat child mortality is currently promoted in Uganda, because it ensures that health care is accessed at village level, classified as the health centre I. Studies show that providing health care through community health workers could improve the dosing of anti – malarials if administered at home, an approach that is consistent with WHO (Kelly, J 2001). There is evidence of a reduction in child illness and mortality in areas where community health workers are involved in case management.

Results in the community demonstrate success of the case management of pneumonia in infant death, showing an overall reduction in mortality of 24%. (Sazawal S, Black RE, 2003). In Gambia, child mortality and morbidity reduced in areas where community health workers were involved in the management of childhood illness. (Lewin SA, et al, 2005).

***Performance:***

Determining performance is based on the ability of the VHTs to achieve set targets based on the ICCM manual. Tim Hannagan, believes that performance measures can only happen in an environment where predetermined standards are set against the objects / aims of the task (Hannagan T, 2008). When the roles and responsibilities are set up for the team, they act as a yardstick to measure their performance. This may be associated with identifying ways to conquer performance barrier (Griffin & Moore 2007). However, there are arguments that performance tagged on output without looking at the process usually illustrates short term goals; this is very common with selective programs (Rosta, et al 2008, Wooding et al 2012). However, in a situation of the VHTs managing childhood illness, performance is not going to measure the number of children treated, but how the treatment of ill children is conducted. It will look at the VHTs ability to offer services, and identify training needs.

**2.2 Influence of Training on VHT performance:**

The use of CHWs in health care delivery comes with challenges that need to be addressed if countries are to make progress in reducing the child mortality rates. Studies show that many caretakers do not seek health care for children at health facilities, (Perez 2009). This is mainly due to the remoteness of homes and long distances to health facilities. Therefore the improvement of health facilities may not address the child mortality rate holistically. It is important to look at other factors that may influence access to health care. In rural settings, the low literacy levels of caretakers influence health seeking behaviour. Simple

communication tools may improve community knowledge of child health and thus improve compliance (Ibid). Also noted is that increasing access to treatment for children through caretakers is a performance measure, because then, mortality rates greatly improve.

According to the study conducted in Siaya in Kenya, it was observed that CHWs had difficulties managing cases because of complicated and ambiguous guidelines that were used during the treatment. Biswas, urged training in child health which can influence and rejuvenate skills (Biswas et al, 2011), thus improving performance and effectiveness of the services offered by CHWs. Use of effective job aids with picture cards (cards used by VHTs with summarised information of how to treat children), flip charts and role play are important (Perez F, 2009) to help CHWs remember and perfect the skills of identifying the danger signs and providing the right dosages to children. It was noted that educational background and status of the training in child health may influence and rejuvenate skills (Ibid). In Kenya, Kelly, discovered that CHWs failed to refer some severe cases for fear of criticisms from the community or health centre staff, in case the person referred turned out not be very ill (Kelly, J 2001). Training and retraining is very crucial for CHWs to retain clinical competency, manage childhood illness and build their confidence while performing their duties.

### **2.3 Influence of Supervision on VHT performance:**

Whereas, training and knowledge transfer are fundamental in providing treatment in the community, it was noted that the barefoot doctors in China, needed constant supervision and refresher training from health workers at a regular basis depending on the prevailing need (Sidel V.W, 1972). Failure of professional health workers to conduct regular supervision was another gap identified that affected the quality of service offered by CHWs (Biswas, 2011) and affected performance. Supervision of CHWs is very important and must be undertaken by both the professional health workers and community. In Uganda, studies showed that

supervision of CHWs at village level improved child mortality. Other studies showed that CHW volunteers did not feel well supervised, adequately facilitated or recognised by the local government (Nsabagasani X., 2007) and this affected their ability to perform the duties effectively. All in all, one may say that supervision ensures effective, equitable and efficient health care. To have a reliable and regular supervision, supervision tools like a checklist are important and may be shared with the supervisee who may be motivated because he / she is aware of what is expected of him / her.

Drug stock out is another area that has made case management of childhood illness challenging and may affect performance. Whereas CHWs are trained to manage childhood illness at community level, it is impossible for them to fulfil this obligation if they have no drugs to provide to their clients. Building community confidence and ensuring that CHWs provide a quality service to the child is paramount; however, when the CHWs constantly run out of stock, the rural communities easily abandon the service and opt for ‘over the counter drugs’ (Perez F, 2009).

#### **2.4 Influence of Motivation on VHT performance:**

The selection criterion of the CHWs is key to performance, ownership and sustainability of the community childhood illness management. Various authors have pointed out the importance of community participation in selection and monitoring of CHWs (Perez F, 2009). In the Ugandan context, Nsabagasani observed that ownership and sustainability of a community based approach to health care could not be guaranteed if communities were not consulted and their roles defined (Nsabagasani X, 2007). The other challenge of high labour turnover or lack of interest in work by CHWs is when they learn that their service cannot be remunerated in monetary terms by the government. In the Uganda context, due to high unemployment, most volunteers hope to get remunerated; however, the sector cannot afford



cash incentives (Ibid). In Nigeria, Village Health workers (VHWs) did not work for more than two years citing small salary as the reason (Gray and Ciroma 1987, in Bhattacharyya K., et al., 2001). In Ethiopia, each house contributed a small fee once a year, which was used to cover 85% of the incentive of Community Health Agents (CHAs) (Bhattacharyya K., 2001). However, providing incentives to CHWs may not improve their performance or retention, especially if they did not consider their incentive adequate. Even when non monetary incentives were provided to CHWs, they were not sufficient to maintain and retain CHWs' motivation. Bhattacharyya suggested exploring different types of motivation that would be critical to job fulfilment. For instance building relationships with the communities, encouraging personal growth and development opportunities through training (Ibid) can motivate health workers. However, in future, it would be very difficult to get community volunteers who would accept to work without payment or incentive of any kind.

The ability to read and write was a requirement by the Ministry of Health when selecting VHTs; however, in Karamoja, this was not observed. This is because of the low literacy level of 11% (UBOS, 2006), which made it almost impossible to get VHTs, and of the few who had been identified, the majority were male. To ensure a representative group, it needed to include women but they could not read or write, but were committed and agreed to get trained. The success of VHTs depended mostly on their enthusiasm and interest and not on their innate abilities. Thus, focus must be invested how best they can be facilitated to enable them to perform the tasks at hand.

Although literacy requirement has always been emphasized when it comes to handling medicine, in Guatemala however, studies have shown that illiterate volunteers performed as well as the literate in providing treatment for malaria and recording patient data (Ruebush II, T.K et al 1990). Apart from ensuring that the right tools are used during the training, the

illiterate volunteers did not require more time to train and supervise and yet treated more or less the same number of patients at the end of the year as their literate counterparts. It is evident that illiterate volunteers have been trained and have been successful in various countries in South Asia and Africa (Arole and Arole 1975; Fourier and Djermakoye, 1975; Cross, 1981; in Ruebush II, T.K et al 1990). It has been observed that the choice to use illiterate volunteers is because these communities are remote and isolated, with low literacy levels, and the few that can read and write may not be willing to accept the responsibility or offer free service. Therefore, illiterate volunteers or community health workers, as in the case of Karamoja, according to studies elsewhere can perform and learn successfully in primary health care.

The Integrated Community Case Management was started in 2009 and is funded by UNICEF; the agency is working with MoH and development partners. ICCM is currently piloted in Karamoja Sub – Region, and selected districts in Northern, Central and Western Uganda.

***How ICCM is implemented using the community based approach;***

- All the VHTs are selected by the community members
- VHTs are then trained, and given a treatment kit
- Pre-packaged medicines, including diagnostic tools are provided
- Communities are sensitized and mobilized to demand for ICCM services with the help from VHTs.
- Only children under five with fever, cough and diarrhea would receive treatment and mothers counseled on home care and care seeking
- Newborns with danger signs and severely illness will be referred to health centre
- VHTS would have peer supervision

- And health workers in the catchment areas manage referred cases and supervise the VHTs

By improving access and availing health workers with treatment for children shows that health care delivery is moving towards equity, thus catering for both the rich and poor. Therefore providing relevant training to VHTs guarantees an empowered human resource and shows that MoH has the capacity to integrate health based interventions with a diagonal approach. The diagonal approach marries the comprehensive approach of involving communities, improving infrastructure, training human resource with the selective approach to support child survival strategy.

VHTs were tasked to counsel mothers and treat children of target households. The severe cases were expected to be referred to health unit and record keeping is done for all patients including reporting medicine reactions. VHTs were also expected to conduct follow up and home visits for purpose of health promotion. One may say that the fact that VHTs are treating children is a move towards community involvement in reduction of child mortality rates. When communities are empowered to demand for accountability, usually service delivery greatly improves. Therefore, if health services are organised and well managed and emphasis put on the incentives influencing users and providers, the access of quality health is not difficult (WHO report, 2010.)

# CHAPTER THREE

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## **RESEARCH METHODOLOGY**

### **3.0 Introduction**

This chapter covers the design, data collection tools and techniques. It also includes the study population, research instruments, data analysis, procedure, quality control, plan for dissemination, ethical considerations and limitations of the study.

### **3.1 Study Design**

A cross sectional study design was used in the collection of quantitative and qualitative data. The design describes the important variables that are responsible for the performance of VHTs.

### **3.2 Sources of data**

In order to obtain information about the research variables, primary and secondary data sources were used. Acquisition of primary data involved interacting with respondents during field visits in Moroto, through face to face interviews with key informants, filling of the questionnaires by VHT members, FGDs conducted and observations. Secondary data involved collecting records and reports from the district offices and development partners. It included analysing and recording information relevant to the study from published and unpublished books, government and international reports, journals, newspapers, the internet and magazines.

### **3.3 Study Population**

The target population for this study were the VHTs working on the Integrated Community Case Management Program. The research also included the health workers at the health centres, the district health team, the local authority and partners /NGOs.

### **3.4 Sampling Technique**

A simple random sample technique was used to determine the Sub Counties that would participate in the study. Choosing of the respondents was also done by simple random sampling. The health centre in charge or representative provided the researcher with the list of VHTs in the catchment area. The researcher then used a lottery method to select the respondents, giving VHTs an equal opportunity to be selected. When the researcher arrived in the Sub County, the name of each of each VHT was written on a piece of paper. The pieces of paper were then folded and put in the container and shaken then the researcher selected the number required based on the calculation previously made. Then the names of those that appeared on the selected pieces of paper were read out and interviewed. A simple random sampling is usually free of bias and easy to use. `

#### *3.4.1 Selection of 54 respondents for structured questionnaires*

The respondents were sampled from greater Moroto<sup>1</sup>, which comprised the current Moroto district and New Napak district. Cluster sampling for Napak and Moroto was applied for this study. In the Napak and Moroto clusters, five out of seven sub counties were selected using a simple random sampling technic. From the ten sub counties, eight VHT members were selected using the simple random sampling technique. It involved listing all the names of the VHT members in that sub county that were present for the review meetings and randomly picking one at a time till all the respondents were identified. The sample size of each Sub County was based on the number of villages; the Sub-Counties with more villages had bigger sample sizes than those with fewer villages. The selected villages were based on the Uganda Bureau of Statistic (UBOS) records<sup>2</sup>.

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<sup>1</sup> Greater Moroto will refer to both Napak and Moroto districts, originally one district.

<sup>2</sup> Due to the nomadic life of Karamajongs villages move depending on the season. However, UBOS has a confirmed list of villages used for planning.

For the focus group discussion, 10 to 15 respondents were purposively selected from each of the participating sub counties. The selected respondents included active members and peer supervisors of the VHT activities, and some FGDs included local leaders, opinion leaders, women leaders and religious leaders and health assistants. In total four focus group discussions were conducted. The respondents in FGDs were different from those who had answered the questionnaires.

### 3.4.2 Selection of 12 Key Informants.

The Key informants were purposively selected and these included the Health Centre In charge, the VHTs focal person at the health sub district, development partners, care givers, trainers / facilitators and the district health educator. All these respondents played a major role in selection, training and supervision of the VHT / ICCM activities in the district.

### 3.5 Sample Size Determination

The sample size for the VHTs' selection was based on Yamane formula 1967.

Yamane formula 1967

$n = \frac{N}{1 + N(e)^2}$ <p>n = required sample size</p> <p>e= Level of precision 0.1</p> <p>N = Population Size (Number of VHTs conducting ICCM)</p>	$n = \frac{340}{1 + 340(0.1)^2}$ $= \frac{340}{1 + 340(0.01)}$ $= \frac{340}{1 + 3.4}$ $= \frac{340}{4.4}$ $n = 77.3$
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Using the Yamane formula of sample size with an error of 10% and confidence interval of 90% (Yamane, 1967) the calculation of a population of 340 VHTs in all the ten Sub Counties had a sample size of 77.4 respondents to be interviewed. For key informants, it was mainly purposive sampling. (Yamane T; 1967)

### **3.6 Data collection techniques**

The researcher used both qualitative and quantitative data collection tools while in the field.

#### *3.6.1 Quantitative methods*

The method involved the use of questionnaires. The questionnaires were designed in English and the research assistants used the local language to ask questions. The VHT interviews were administered by the research assistants in the local language. Questions included supervision visits, drug stock-outs, relevance of the training challenges faced in implementation and motivation. The questionnaires also assessed VHT's ability to identify and treat pneumonia, diarrhoea and malaria among children. The questionnaire provided for assessment of the skills of using a respiratory timer. Unfortunately due to failure to get a health worker to conduct the assessment, this question was not asked. Because of the limited time and resources it was impossible for the researcher to back translate the questionnaires.

To ensure that the questionnaire was proof read and relevant, the researcher pre tested it on a group of 15 respondents and the suggested changes were made. The researcher also conducted one day training for the research assistants; this was to ensure that they understood the questions, how to build rapport and the dangers of unethical conducts like filling questionnaires without meeting respondents.

### ***3.6.2 Qualitative methods***

Focus Group Discussion (FGDs), Key informants and review of information.

#### ***3.6.2.1 Focus Group Discussion (FGDs)***

FGDs were used to collect the experience, opinions and views of the respondents implementing ICCM. With the help of the researcher, 10 – 12 participants were selected. Questions asked included, their role in selection and training, participation in supervision, community support provided, drug management, challenges and motivation. Focus group discussions for various categories were conducted. These included peer supervisors, development partners, local leaders and mothers with children below five (caretakers); this enabled their views to be elicited. When conducting a focus group discussion for the care givers, men were separated from women; the purpose was to allow the two groups to discuss comfortably. Usually the women in rural setting do not voice their opinions in the presence of men.

#### ***3.6.2.2 Key Informants Interviews***

These included health centre in charges, peer supervisors, VHT focal persons, implementing partners and district officials. The focus of the interviews was on the strategy and implementation of ICCM, their role and involvement in supervision and ownership and sustainability of the program.

### ***3.6.3 Using available information***

The researcher had access to Health Medical Information Systems (HMIS) statistics, which provided the number of outpatients and inpatients diagnosed with diarrhoea, malaria and pneumonia. The data also included the number of deaths in the health centre due to the above



infections. Monthly reports, drug stock cards, training manuals, job cards, minutes for meetings and attendance list were also shared with researcher. This provided information on the numbers trained, VHT record books, availability of drugs / stock-outs, number of referrals of severe cases and even the number of children.

#### ***3.6.4 Data management quality control***

The tools used in the study were discussed and agreed on with the supervisor before data collection. They were edited and questionnaires piloted to check errors and ensure accuracy and relevancy. The research assistants were conversant with the local languages and were trained on data collection tools. The researcher supervised the research assistants and provided guidance whenever required and also ensured none filled the questionnaires without meeting the respondents. In the field the supervisor cross checked questionnaires and validated the information collected.

### **3.7 Data analysis**

The questionnaires were coded and entered in the computer using the SPSS computer data analysis application. Later frequency tables, charts and graphs were generated; these formed the foundation of analysis. Qualitative data from key informants and FGDs guides was analysed by summarising outcomes in categories.

Data collection in research involves analysis, interpretation and presentation of findings. Data analysis involved editing the qualitative and quantitative findings. The data filled in the interview guides was coded in frequency tables which were calculated in terms of percentages and presented in terms of graphs or pie charts.

### **3.8 Ethical Consideration.**

All data was treated with confidentiality and would only be used for academic purposes. The respondents were asked not to fill their names in and were assured that none of the questionnaires could be traced back to them. The researcher sought permission from IHSU

and consent of the respondents before conducting the research and administering the questionnaire. The questionnaires were stored in a safe place and a padlock was used to secure them. The researcher supervised the research assistants and ensured that all data was collected from only the sampled respondents.

### *3.9 Limitations of the Study:*

The major limitation of the study is that the findings may not apply in areas outside the Karamoja sub region; this is because the life style of Karamoja and other socio – economic situations make the area unique.

The sample size was smaller than what was planned; for instance the researcher got 54 for quantitative questionnaires instead of the 77 respondents. This is because the rainy season made it impossible for some respondents to come to the health unit for interviews.

### *3.10 Challenges and how they were over come:*

Moroto was originally one district when the ICCM / VHT programme was rolled out. When the researcher conducted the study, the district had been divided into Napak and Moroto.

Therefore the researcher decided to sample five sub counties with each district.

The research was conducted during the rainy season and thus it was impossible to access the homes of the VHTs for interviews. The rainy season washed away roads and accessing health units was also very difficult. However, the researcher planned to meet the VHTs at the health units when they came for the review meeting and drug stocking. With the help of the development partner, the researcher was offered transport to the health units.

The majority of the VHTs could not speak English, so the researcher hired research assistants that were able to speak the local language.

The other challenge was that the researcher failed to get research assistants who speak the local language and also had a medical background. Therefore, when it came to using the

respiratory timer, they failed to administer the question. However, the researcher tried to elicit the help of the health worker; this too was not successful, as the health workers were either very busy with patients or not did not have time to spare for the research.

Meeting with district focal persons was almost impossible, but, the researcher was able to interview their representatives, of which most of them had very little knowledge on the ICCM programme.

# CHAPTER FOUR

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## DATA PRESENTATION AND ANALYSIS

### 4.1 Introduction:

The study was carried out in July in the Districts of Moroto and Napak, originally Moroto district. Ten sub counties were sampled and 54 VHTs of those areas were interviewed. This chapter presents results of the investigation of the various variables. It specifically looked at characteristics of the respondents, working conditions and general factors that influenced their performance and ability to manage childhood illness.

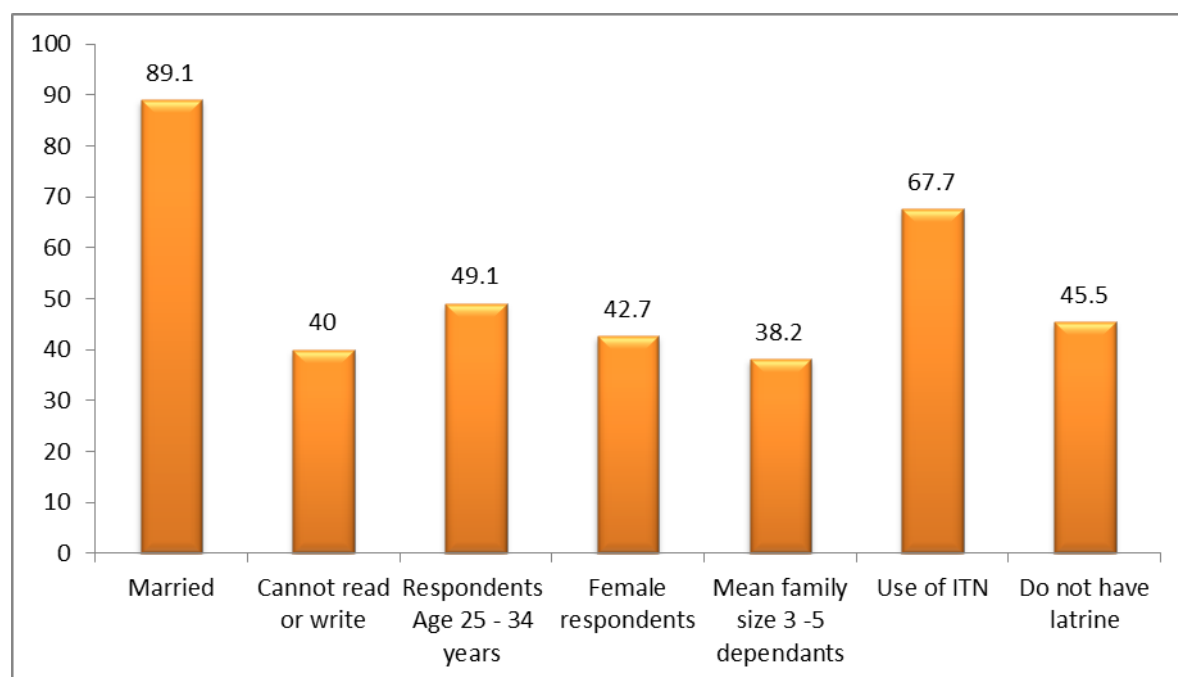
### 4.2 Characteristics of the Respondents

The 54 VHT members interviewed were less than the targeted 77 respondents. 89.1% of the respondents were married and 40% could not read or write. The investigation revealed that 49.1% of the respondents were between 25 – 34 years of age (figure 1). The women comprised 42.7% of the respondents and average family size was 3 – 5 dependants. The majority asserted that they did not engage in any income generating activities, though there were those that were farmers, casual labourers and in retail business. Because VHTs are also supposed to promote hygiene and sanitation, they were asked whether they had latrines and used ITNs in their home, 45.5% did not have a latrine, while only 67.7% used treated mosquitoes nets. However, the researcher failed to verify the presence of facilities because the interviews were conducted outside the homestead (locally referred to as Manyatta).

*“I find it difficult to tell people in the village to construct latrines in their manyatta when I do not have one myself. However, I have dug the pit and will be soon putting a shelter around it. Maybe then I will be a happy VHT”*

*(VHT in Lopei)*

**Figure 2: Socio Demographic Characteristics of Respondents**



Source: Primary data

### 4.3 Influence of training of the VHTs

#### 4.3.1 Training and Knowledge

Asked to mention the treatment given to a one year old with malaria, 88.2% correctly gave the drug (coartem yellow). When asked about the dose they would give to a one year old with cough, fast breathing and fever, 83.6% correctly mentioned Amoxicillin and Coartem.

**Table 1: Testing for Knowledge and Practices**

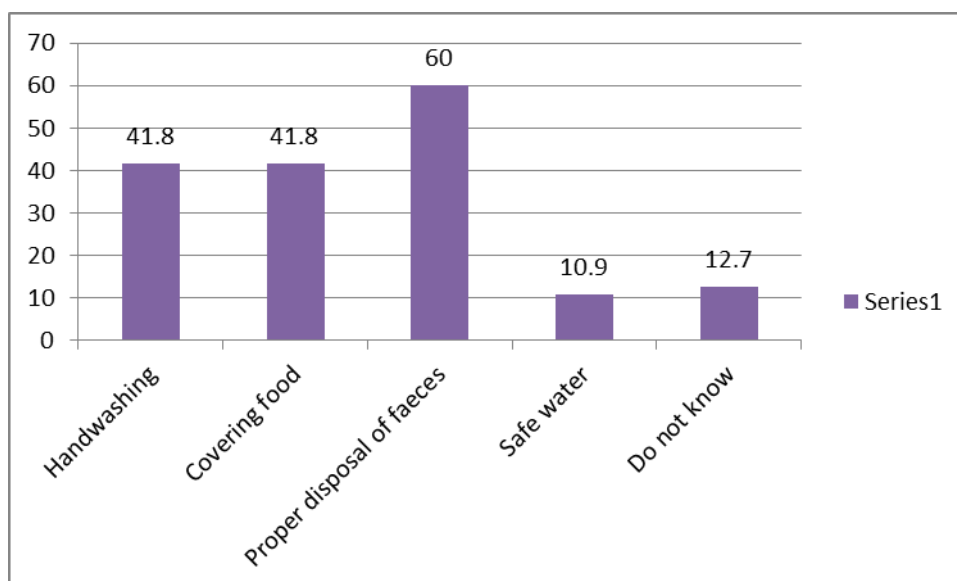
Knowledge	Frequency (n=54)	Percentage (%)
Refresher training attended	51	94.4
Explain job aids	44	81.5
Referral of severe cases	50	94.3
Follow up of severe cases	52	96.3
Signs of a severely sick child -	36	65.5

How malaria is spread	36	65.5
Malaria prevention - sleeping under ITN	46	83.6
Coartem pack is given to 1 year child	45	83.3
Amoxicillin and Coartem given to patients with fever, cough	46	85.2
How to assess rapid breathing of the child	51	96.2
Ability to read and write	33	60.0

*Source: Primary data*

The findings of the investigation show that all had sufficient skills and knowledge during the training and 94% had had refresher training. Each VHT was asked to explain the job card and scores were given out of 10 and the percentage average score was 81.3%. The job card was give to each respondents, they were then asked to explain the relevancy to all the pictures on the card (Appendix 1). The investigation found that 65% of the VHTs interviewed mentioned at least three danger signs in patients that required referral. 83.6% recommended the use of the ITN as a preventive measure for malaria; however, only 65% could mention that malaria was transmitted by mosquitoes. With questions on pneumonia, 96.3% (Table 4) could mention the use of a respiratory timer as the best way to assess fast breathing; 64% could mention all the three symptoms of pneumonia that included chest in drawing, fast breathing and nasal flaring .

**Figure 3: Knowledge on how to prevent diarrhoeal diseases**



*Source: Primary data*

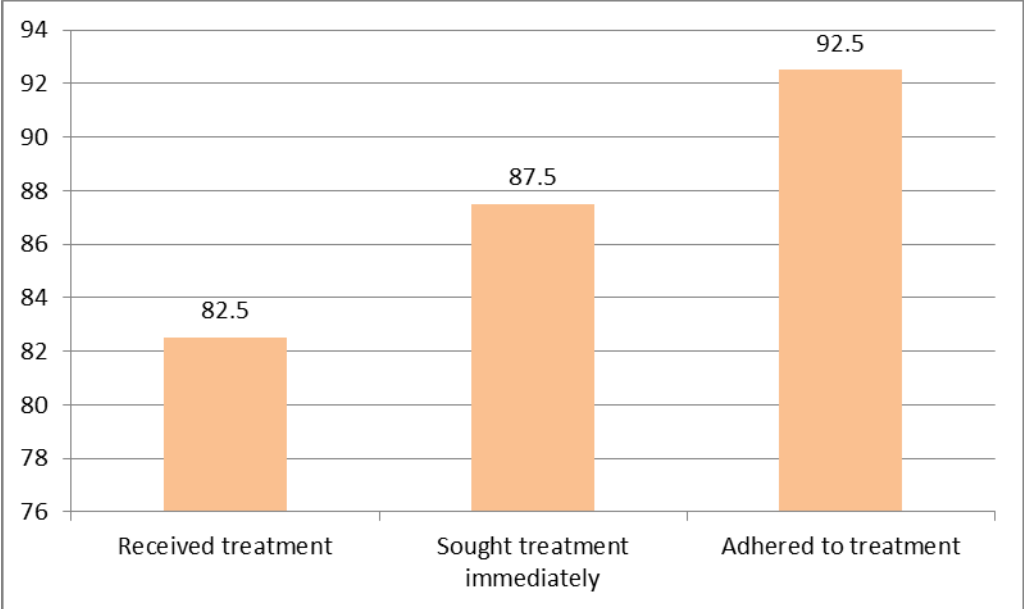
On questions relating to diarrhoea, 85.5% mentioned bloody and watery diarrhoea, 60% of the VHT members recommended safe disposal of faeces, and unfortunately 12.7% (figure 4) did not know how to prevent diarrhoea.

#### *4.3.2 Caretakers and Adherence to treatment:*

The FGD caretakers stated that they had confidence in the VHTs because they had been trained and used a chart while treating patients. A total of 15 caretakers were interviewed, who had visited the VHTs for treatment of their children. 81.4% of caretakers mentioned that they had obtained treatment on their first day when they went to the home of the VHT's; however, some were unable to get treatment for reasons like the VHT was not at home, or drug stock out. When asked if they took their children for treatment on the onset of the illness, 85% stated yes; however, those that said no, gave reasons like they were not at home when the child got ill, others went to the health unit and were later sent to the VHT; in some places the VHT member was living very far away; insecurity especially in the nights; and others felt

that the child was not very sick. When asked if the caretakers adhered to the treatment, the majority said yes; however; those that said no gave reasons like they forgot.

**Figure 4: Caretakers and Adherence to treatment**



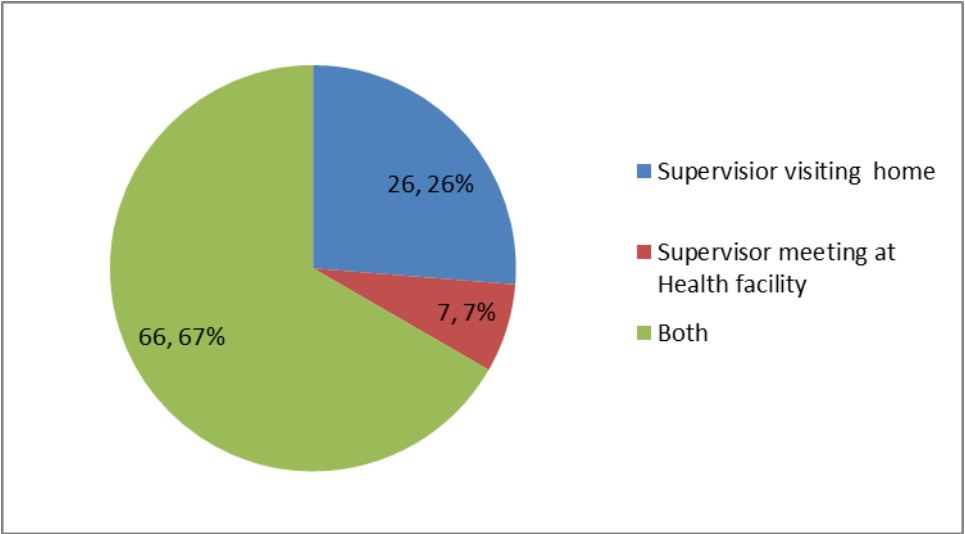
Source: Primary data

**4.4 Effects of supervision of VHTs**

*4.4.1 Analysing the effect of supervision of VHTs on their job performance*

When asked how often they were supervised, 100% responded that it was at least once a month and 66% preferred to be supervised both at home and in the health facility.

**Figure 5: VHT Members and Supervision Places**





*Source: Primary data*

The findings in table 3 reveal that 85.1 % were supervised at home. Asked who supervised them, 100% stated they received supervision from the health centre unit during monthly review meetings. When asked how often they were supervised, 100% responded that it was at least once a month and 66% preferred to be supervised both at home and in the health facility.

**Table 2: Supervision**

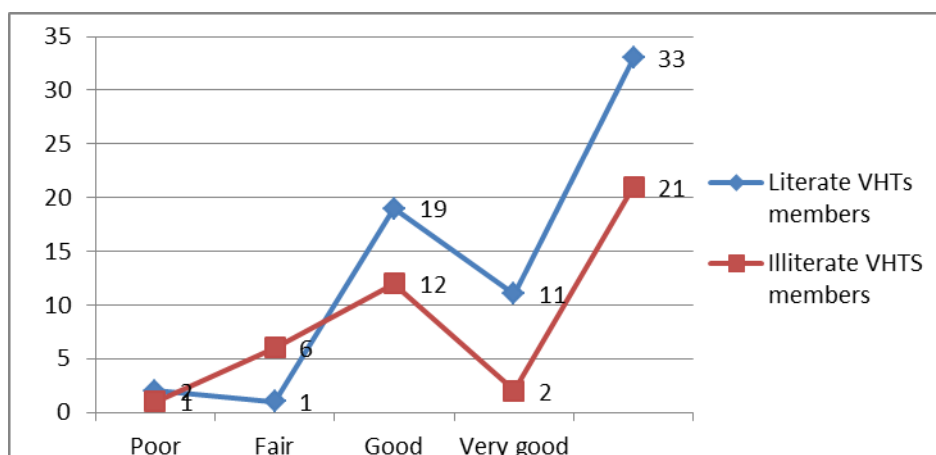
Supervision	Frequency (n=54)	Percentage (%)
Preferred supervisor visiting the home and meeting at the health unit.	35	66
Received home supervision from peer supervisor	44	85.1
VHT members that received monthly supervision	54	100
Submitted more than 10 reports during supervision	35	66

*Source: Primary data*

#### 4.4.2 Reporting and record management

During supervision, supervisors were expected to check the records and support the VHTs to update their records, registers and stock cards. To assess for recording, the researcher examined the records to check for updates of drugs / stock, if patients records were up date and referral forms were filled. These were marked out of three. That is to say if one had filled only the patient register then they would get 1/3. However, the referral and record keeping scores were very low at 64.6% and this is because of low literacy levels among the VHTs. According to the graph it is evident that the VHT members who were literate had better record keeping skills than the illiterate. However, it is important to note that the VHTs that had difficulty in updating records sought the help of the supervisor and were helped on a regular basis or immediately by people in the village that could read and write.

**Figure 6: Record keeping for both literate and illiterate VHTs**

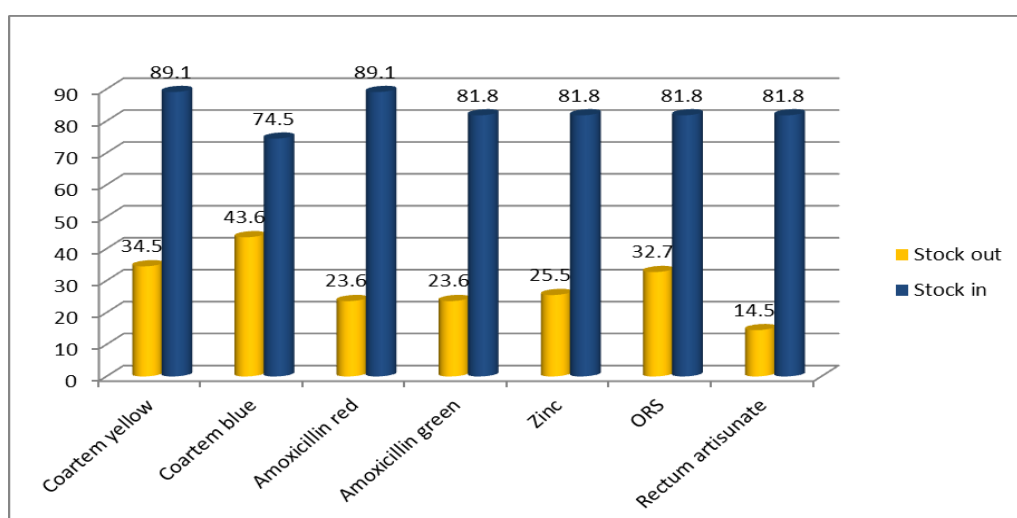


Source: Primary data

#### 4.4.3 Medicine supply and Drug management

The supply of the medicines and drug management was done partners together with the health centre in charge. And it is through quarterly supervision and reports, that updates of stocks were monitored. Monthly supervision also offered VHTs opportunities to restock drugs. The findings of the investigation discovered that 43.6% of the respondents had experienced a stock out of Coartem Blue, 34.5% Coartem yellow and Rectal Artisunate had the lowest rate of stock out, at 14.5% (Figure 6)

**Figure 7: Medicine Availability and stock out**



Source: Primary data

When asked about the current drugs present, an average of 82.8% had all the drugs and 17.2% experienced drug stockout.

#### 4.5 Influence of facilitation on VHT

##### 4.5.1 Facilitation and Motivation

98.2% of the respondents received 5000/- per month every time they attended a monthly review meeting and this was offered by government as a facilitation or incentive. However 94.3% stated that 5000 /- per month was too little to motivate them.

*“The government needs to review the 5000/- given as transport allowance, because, it is too little to even cover the cost and time we spent taking care of the children and attending the review meeting”*

*(VHT Peer Supervisor)*

**Table 3: VHT's Motivation**

Motivation	Frequency (n=54)	Percentage (%)
Not satisfied with money received	50	94.3
Are you motivated every time you attend a meeting	53	98.2
Motivated by VHT facilitation materials	45	83.3
Demotivated by others (insecurity, long distance to health facilities and drug stock out)	23	42.6

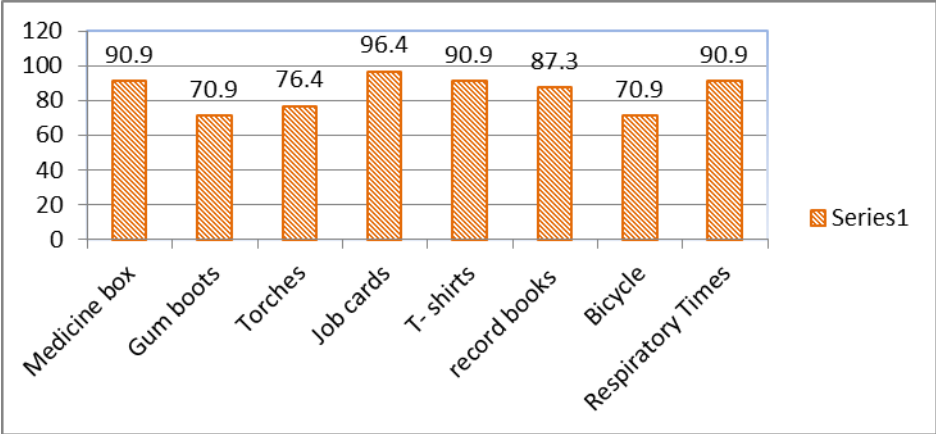
*Source: Primary data*

After training, all the VHTs were offered materials to facilitate and motivate the VHT members and these included a medicine box, T- shirts, Acute Respiratory Infections (ARI ) timers, job aids, torches and a record book. 70.9% were provided with a bicycle (figure 2).

Apart from money, findings show that VHT members were motivated by the respect from communities and involvement in health campaigns.

The respondents mentioned stock out of drugs, insecurity due to cattle raiding and difficulties in accessing health units especially during the rainy season, as some of the factors that affected their morale to work.

**Figure 8: Percentages of VHT Members that Received Facilitation**



Source: Primary data

4.5.2 Working conditions and managing childhood illness

When asked about the number of households each VHT was supposed to cover, 57% target more than 44 Households. Asked about the workload, 51.9% claimed that work was too much as opposed to 48.1% who thought the workload was reasonable. 63% of the VHT members spent an average of 15 min or less on the patients and 98% answered that the patients went to their homes for treatment. A considerable percentage of the respondents walked more than 5km to the HC for drugs and review meeting (37%).

*“Following up the patients and their caretakers and attending reveiw meetings take a lot of our time. Sometimes, one has to choose between weeding the garden and visiting a patient or attending a reveiw meeting”*

*(VHT in Matanyi)*

**Table 4: Working Conditions for Respondents**

<b>Working conditions</b>	<b>Frequency (n=54)</b>	<b>Percentage (%)</b>
VHTs that targeted more than 44 households	31	57.4
VHTs that spent an average of 15 Minutes per patient	34	67
VHTs who cited to much work load	28	51.9
VHTs that walked more than 5km to health centre for review meetings / restock drugs	20	37

*Source: Primary data*

Working conditions do not only affect motivation but they influence the performance of the VHTs. For example the 37% of the VHTs that work more than 5km to attend review meetings or restock drugs are likely to miss review meetings or have more drug stockout.

# CHAPTER FIVE

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## DISCUSSION OF THE FINDINGS

### 5.1 Introduction:

The study described the factors influencing the performance of VHTs in the management of childhood illnesses like malaria. The findings are discussed under the following titles to answer the objectives.

### 5.2 Socio – economic characteristics of VHTs:

VHTs are volunteers that have been selected by the communities. According to the findings 89.1% of the VHTs interviewed were married. This presented a degree of stability, because usually communities prefer to select members that are reliable and willing to stay with them for a considerable time. In line with the Ministry of Health, the selected volunteers were members of those communities and comprised of both men and women (42.7% women).

The investigation revealed that 49.1% of the respondents were between 25 – 34 years of age and the average family size was 3 – 5 dependants. Karamoja has one of the lowest literacy rates at 11% compared to 67% nationally (UNOCHA, 2008), and this explains why 40% of the VHTs could not read or write. However, in spite of the challenge of literacy, the use of pictorial job cards and regular supervision made it easy for VHTs to improve their performance. The majority of the respondents asserted that they did not engage in any income generating activities. However, those that did were farmers, casual labourers and market vendors. This meant that the majority of the VHTs regarded their volunteer work or assignment as a source of employment. Unfortunately, the job of VHT only attracted 5000/- per month given as transport refund. Therefore because of the high expectations, this affected their motivation to work and perform effectively.

VHTs were expected to participate in various health campaigns including hygiene and sanitation promotion, and when they were asked whether they had latrines and used ITNs in their home, 45.5% did not have a latrine while only 67.7% used treated mosquitoes nets. However, the researcher failed to verify the presence to facilities because the interviews were conducted outside the homestead (Manyatta). Nevertheless, the lack of sanitation facilities was a setback to the programme because, according to the Ministry of Health. VHTs were tasked to promote the increased use of hand-washing to reduce diarrhoea, (MoH, ICCM guidelines). According to the household health survey, Karamoja has less than 11% latrine coverage compared to 67% nationwide (UBOS, UHDS 2007). Therefore the VHT's were expected to be role models to influence communities to participate in preventive interventions that included the use of ITNs, hand washing and immunization. Therefore, lack of latrines and failure to use ITN by the VHTs was a setback which limited their ability to influence the community and thus affected performance negatively.

*“When the VHTs were trained, latrine construction and use was emphasized. However, it is disappointing that more than a year after the training, considerable numbers of VHTs do not have latrines,. How can we expect them to spearhead and promote latrine use when they do not live by example. ”*  
*(Health worker, Napak)*

### **5.3 Linking knowledge and training to performance;**

It is important to note when the researcher discussed with the health centre in charges about the performance of the VHTs; they all commented that their services in the village had reduced the work load at the health unit (the district offices were not willing to give copies of the records)

*“Before the program, the unit used to receive a big number of children under five coming for treatment and many of them were severe case; however with*

*the presence of the VHTs in the village, fewer caretakers bring children at the health unit..... This we greatly attribute it to the early treatment patients receive when they are in the village” (Key informant in Katekitile Sub County)*

In the study VHTs were assessed on symptoms of malaria, pneumonia and danger signs for severe patients. They were asked about knowledge regarding to the prevention of diarrhoea, malaria and pneumonia. Assessment was done to determine their knowledge of providing treatment, giving the right dosage, use of the job aid and their ability to refer severe cases. This was based on the content in the initial and refresher training that they had offered to the VHTs.

According to the findings 100% of the respondents were trained for six days and 94.4% had a three day refresher training. The training was conducted in the local language, very interactive, with lots of group discussions, role plays and brainstorming to allow the group that could not write and read to memorise as much as possible. When the researcher assessed their ability to explain the job aid, it was discovered that among those that scored Good (the rating was based on poor, fair, good and verygood) 38.7% were from the illiterate group and 61.3% literate VHTs. However, it is important to note that they had knowledge on disease and were able to identify the right drugs and dosages to give to the patients. Asked how that was possible, the focus group discussion noted that use of job cards was a very helpful tool to assist remembering how to administer treatment to the patients. This is because the pictures and local language used on the job card made it easy for all VHTs to follow. The instructions were very clear, short and with pictures, and most of all the drugs are pre-packed and marked according to colour. Because of this, 63% of VHTs were able to spend less than 15 minutes in administering treatment. Knowledge helps teams to perform effectively and may influence and increase workers problem solving skills, improve efficiency and thus led to better performance (Gardner H K, et al 2012).



In the focus group discussion, the VHTs commented that the training provided all the knowledge and skill they needed; however, the job aid was the most important.

Training empowered the VHTs and built their confidence, thus improving their ability to administer the right drugs in the right dosage, ability to diagnose disease, refer severe cases and conduct home visits. When assessing performance, it should not only focus on the knowledge but look at supervision, security, cultures and how they influence the practices of the VHT. The training status and education background may greatly influence the skills of the community health worker. However, training alone cannot guarantee great performance; it needs to be coupled with strengthening health systems, regular supervision, availability of drugs and equipment (Biswas, 2011). All in all community health workers must have their skills sharpened on a regular basis with a help of re-orientation trainings. This is because training and knowledge are very instrumental in influencing the performance of the VHTs.

#### **5.4 Supervision:**

Supervision is to ensure quality health care. For a functioning system, supervision should be accompanied with a checklist and guideline and also ensure instant feed back is provided (Schellenberg JA, et al 2004). The ICCM program was designed in a way that the health workers at the health unit would be responsible for the supervision and they were trained and given checklists. Although 91.5% of the respondents claimed that were supervised every month, this happened mainly at the health units during the review meeting. Interviews with health workers indicated that they failed to conduct home visit supervision due to challenges of getting transport, insecurity, bad roads that make it impossible to access VHTs homes, and heavy work load at the health facility. However, at least once a month, every VHT received home visit supervision from the peer supervisor in their area. The peer supervisor was facilitated with a bicycle and lived in the same catchment area with the VHTs. The VHT

supervision was designed to assess abilities, knowledge and skill against the objective or purpose of the project with an aim to strengthen the performance of the volunteers.

The FGDs listed the activities involved in the supervision, among them was to cross check for drug inventory, restock drugs and review the VHT register and records. It is during these monthly review meetings that supervisors provided extra coaching in areas where VHTs had difficulties, for example information on how to identify danger signs, provide feed back on case management and record keeping. Usually the review meetings provided information on up coming community health campaigns like distribution of ITNs and immunisations.

*“..... The VHTs will be responsible for mobilising, the communities bring their children for immunisation and also recieve deworming and vitmin tablets. -----”*

*(Minutes taken when for planning for child day plus)*

The District Health Team together with partners conducted quarterly technical supervision of health facilities Ideally they were supposed to conduct at least one VHT home visit, though this was very difficult. The FGD confirmed that supervision and review meetings helped in the identification of challenges and finding solutions.

Regular supervision is very significant because the performance of community health workers greatly improved when conducted especially by the health facility staff. To ensure effective supervision, guidelines and checklists need to be used (Kelly, et al 2001). It was noted that in order to sustain a program, an inbuilt support supervision system and strong support logistics must be developed (Biswa 2011). Performance monitoring and supervision must involve districts and other sectors could be involved for instance in publicity and sharing of the findings (Wooding N, et al., 2012). A study conducted in the Philippines with regards to

supervision and performance concluded that supervision and instant feedback among health workers greatly improved their performance (Loevinsohn BP, et al 1995). Supervision with good systems yields high quality care, however, good supervision within a weak system has very little impact and yields low performance (Schellenberg JA, et al 2004).

Conclusively one can say, that whereas, the health workers were unable to conduct home visit supervision on VHTs, it was observed that the peer supervision and monthly review meeting play a big role in influencing and increasing performance of the VHTs. The regular supervision offered facilitated the VHT's ability of record keeping and accountability of drugs and treatment of patients. It also provided an avenue to improve on case identification, giving the right drugs and knowledge of how fill referral forms. The FGDs also noted that supervision helped them improve skills of using the respiratory timer and administering the rectum artusumate tab.

*“..... After the training, I was unable to use the timer, however, with the regular supervision and reveiw meetings, the health workers have been helpful and provided guidance on how to use it. Sometimes counting is a problem because some VHTs can count only up to ten, however, this too the supervisor has helped us to maneuver ..... ” (FGD in Lopei)*

## **5.5 Motivation and facilitation**

Motivation mainly examined the incentives and rewards offered to the VHTs as an appreciation for work done. These included transport refund or provision of bicycles, gum boots, T – shirts, and posters. The study found that VHTs were offered a monthly incentive of 5000/- per month as transport refund for attending the review; however 94.3% stated it was too little to motivate them. As expressed in the FGD:

*“5000/- is too small to even cover transport; the Ministry should know that we VHTs put a lot of time and make sacrifices to ensure the children in our villages are healthy. We implore the MoH to reconsider and revise the 5000/- to at least 20,000/- .....”*

*(FGDs, one member in Apietolim)*

Fredrick Herzberg's theories of motivation show that money or salaries cannot be the only motivator for staff; recognition of their efforts by seniors is very important. According to Abraham Maslow's hierarchy of needs model of motivation, allowances bring in an aspect of security (Slocum JW and Hellriegel D, 2007). This is true when VHTs mentioned that they were also motivated by appreciation and respect received from the community, recognition of their services by the health workers at the health unit, saving life when children recovered from illness and facilitation kits of drugs, working timers, boots and a bicycle, besides money.

*“Being a village doctor earns you respect from the community. You are regularly consulted and your opinions are taken very seriously. Sometimes, people can come and weed your garden. But the most important of all is that health workers recognise our efforts and when we refer patients they are attended to immediately. This gives the caretaker confidence and hope that VHTs are real” (meaning, very effective) (VHT in Apeitolime)*

In a study conducted by the Uganda National Association of Occupational Health, it was observed that if VHT's recognition and motivation were addressed, this could enhance their performance (Sekimpi DK, 2007). During the discussions in the FGDs, insecurity especially during the periods of cattle raiding, the long journey they take to the health unit to attend meetings and stockout of drugs affected their morale negatively. Rosenbluth observed

that poorly motivated workers usually lacked commitment and this affected the quality of work offered and led to poor performance in terms of efficiency and effectiveness. Inconsistence, absenteeism and indifference to patients were usually signs of low motivation (Rosenblunh, H and Peter, D , 1992). Increasing motivation for the VHT can be done through continuous recognition of their efforts by the health worker supervisor (Schellenberg JA, et al 2004). In Vietnam, studies on the performance of the Village Health Volunteers observed that recognition from health professionals, local leaders and families were motivation to the volunteers and enhanced their performance. (Nguyen TH, 2001). Therefore, it is irrefutable that motivation plays a role in performance, the lower the motivation the lower the performance and the reverse is true.

#### **5.6 Availability of Drugs and Equipment**

In the iCCM program the Ministry of Health was responsible for packaging, quantifying, and timely delivery to ensure that there was not a stock out of the medicine. In turn the health units were responsible for supervising VHTs and ensuring that there was no over prescription and proper accountability of drugs by the VHTs. However, due to the weak systems, UNICEF still provided the drugs to partners who delivered them to the health unit for distribution to the VHTs. When there were delays in the UNICEF system, then automatically the VHTs would experience stock outs.

The VHTs had most of the drugs at the time of interviews, but when asked about the stock out in the last three months, they indicated that they had experienced stock outs especially of Coartem Blue, which was mentioned by 43% of the respondents. Interviews with health workers, partners and store keepers confirmed that the drugs were not supplied through the National Medical Store systems, though there were plans to integrate it into the existing system.

The presence of drugs played a big role in increasing the level of performance, because the VHT's motivation was usually high when they had drugs and were able to treat (Schellenberg JA, et al 2004). The FGD asserted that the community were more appreciative of the VHTs effort because they had constant supply of drugs, unlike the health centres. When drugs were available they were able to handle cases instantly before they became severe and complicated. However, in a situation where there were no drugs for a while, they received lots of complaints from caretakers, and referred more severe cases to the health unit.

Categorically, one can say that lack of drugs can be the main reason to refer patients to the health unit. Absence of the drugs affects the performance of the VHTs and brings discontentment from the care takers and community.

## **5.7 Challenges:**

Throughout the interviews, key informant and FGDs, motivation and incentives were the main issues mentioned by the all the respondent.

Though the VHTs loved their work and were treating children, it was mentioned that the low motivation offered by the government would affect sustainability and continuity of the program because in the future more VHTs will drop out. The lack of time, poor working conditions and the lack of morale to work because of other pressing needs and duties to care for the family affected their ability to deliver effectively. And like high turnover of health workers in hard to reach places like Karamoja, it is speculated that in future there will be high turnover of VHTs.

The VHTs mentioned insecurity as a challenge especially during the dry seasons when cattle raiding is very rampant. They cited long journeys to the health unit some VHTs lived more than 5km from the health unit. Bad weather during the rainy seasons made access to the health unit almost impossible.

The other challenges they met is when they experienced drug stock outs. This is because the caretakers would not take this lightly when they needed their little children treated immediately. Therefore, this shows why VHTs needed drugsto have drugs all the time.

The key informants highlighted the difficulties of supervising VHTs at their home. They stated that access to some places was almost impossible, transport to the field was not readily available and the high workload at the facility due to few staff and with a big number of patients to attend to. However, they noted that efforts are made during the review meetings where VHTs are mentored and coached every month.

Poor record keeping was challenge and this too makes it difficult to get accurate reports and account for drugs used. However, this is due to the low literacy level among VHTs.

Stock outs, though not very common, are a challenge, because when they happen the VHTs have to take long journeys back to the health facility another day / time to pick up the missing drugs. When the care takers and local leaders were interviewed, they appreciated the VHT's services and the fact that their children were treated from the village. However, they observed that sometimes the drugs were missing, the VHTs were not at home and most of all, some of them were less enthusiastic than when they started work. All this was attributed to lack of payment or motivation for the VHTs.

The development partners working with VHTs expressed their appreciation and participation of the communities in ensuring that children under five years get treatment. However, for sustainability of the program, the district health office and health facility staffs need to provide continuous supervision.

45.5% of VHTs do not have latrines. It is difficult for them to improve community sanitation and latrine use when they are not exemplary themselves.

Discussing with officials at the district and partners, the researcher learnt that the ICCM program was experiencing funding problems and budget cuts. This would affect implementation of the program and ability to reach out to more children.



# CHAPTER SIX

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## **CONCLUSION AND RECOMMENDATIONS**

### **6.1 Introduction**

The conclusions drawn from the study are a combination of both qualitative and quantitative findings. The recommendations to improve the VHT performance and general delivery of the services in the community will be discussed in this chapter. Whereas the research was conducted with the greater Moroto, the findings and recommendation of the study may be applied in Kotido, Nakapiripirit and Amudat, because they have a similar setting.

### **6.2 Conclusion:**

From the broad analysis of the qualitative and quantitative findings, in spite of the various challenges that come from training volunteers to provide health care for children, one can conclude that the VHT performance in the management of the childhood illness in greater Moroto is commendable. Their ability to diagnose, provide treatment, refer cases, and conduct home visits was great influenced by the knowledge from the training, monthly supervision that included home visits from the supervisors and mentoring and coaching by health workers. However, there are areas that need improvement.

Motivation of VHTs is not about money, but it is also about creating an environment that can facilitate their work and make them feel appreciated. If there is no motivation in any form, then morale of the VHTs would definitely go down and later many would abandon the work.

Therefore, ensuring regular feedback, appreciation, provision of training opportunities, ensuring the presence of drugs and recognizing VHTs are priceless sources of motivation.

One can say that a motivated team will diagnose the disease, provide the right drugs, refer severe cases and follow up on the patients through home visits.

Supervision at all levels greatly improves performance and is very crucial in systems strengthening. Whereas there were challenges in supervision especially where there are weak

or no systems, it is apparent that without supervision, the performance of the VHTs would be poor.

Community involvement in health care creates demand for accountability and quality care. Because the VHTs selected were all from the communities it was easy for the caretakers to demand for better services from one of their own. And most of all, the community selected only those volunteers that were reliable and available for service. It did not matter whether they could read or not.

The fact that the district health office and health facility staff participated in the selection, training, supervision and reporting, is a guarantee of sustainability and continuity of the program. It is important that all ICCM activities be integrated in the main health system of the country.

In Karamoja, illiterate VHTs proved that they could treat children. This was possible because the training was conducted in the local language; the job cards were in the local language and had drawings that could be understood by even the illiterate VHTs. The regular monthly review meetings conducted with emphasis on mentoring and coaching were very instrumental in knowledge transfer. Therefore, to ensure effective knowledge transfer, one must use appropriate tools that cater for the category of participants. Coaching and mentoring of the VHTs must be continuous to achieve good performance.

### **6.3 Recommendations**

1. UNICEF and the donor community are currently scaling down the funding of the program; it would be important for the government of Uganda to fully integrate the budget of the ICCM program into the main health budget so that resources are provided by the government. This will ensure continuity and sustainability and guarantee that children will receive timely treatment of malaria, diarrhoea and pneumonia while in the villages

2. Whereas monthly meetings, supervision and quarterly review meetings are conducted regularly, the researcher recommends that health workers spare time and conduct home visits to VHTs. This will give provide health workers with an opportunity to meet the caregivers, provide instant feedback and increase motivation of the VHTs. The supervision period would also provide an opportunity to check if the timers are in good working conditions and the job cards are effective.
3. To improve household sanitation, the presence of a latrine should be put as a condition for one to be recruited as a VHT.
4. Improvement drug chain management will reduce stock outs and ensure a constant supply of medicines. This can be done by providing information to the VHTs on the available stock.
5. The procurement system needs strengthening and should be integrated into the current NMS system.
6. To improve performance with regards to provision of treatment of childhood illness, more refresher courses should be conducted, and continuous coaching of the use of the job cards and timers should be given.
7. Motivation may be improved by increasing the 5000/- incentive and providing greater recognition. This recognition would be done by providing uniforms, non food materials like soap and regular appreciation for their efforts.
8. Provision of bicycles to all VHTs to reduce on the time spent traveling to health centre for review meetings and restocking drugs.
9. Having VHTs in the villages would be very cost effective for partners that recruit volunteers for their programs. Thus, integrating VHTs in various programs like community mobilisation, health campaigns and nutritional surveillance would not only increase their motivation to work but would provide VHTs with wider knowledge and bigger opportunities.

10. At the community level, the partners and district officials should conduct regular sensitization on the role of VHTs. This can be done on radios and other media channels.
11. To ensure economic and financial empowerment the VHT's with help from partners can form village saving and loan associations or join available schemes in the villages. These can be instrumental in improving savings and household incomes.
12. To improve on the recording of patient data and filling of referral forms, the record books should be more pictorial and would only require ticking or shading.
13. Illiterate VHTs should enrol for literacy classes commonly known as ABEK (Alternative Basic Education for Karamoja).
14. And for the job cards, apart from the picture shown, the pre packed drugs to be given should be shown in colour. For example, instead of writing 'give coartem in yellow packet', how about, having a full colour packet drawn of yellow coartem?

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Sample of Questionnaire for Assessment:

# Questionnaire for VHTs

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Sub County (Name) .....

Parish.....

Village.....

Introduction: Thanks you for accepting to answer the questions below. The purpose of to assess the performance of VHTs in managements of child illness.  
Please tick inside the box

**Bio Info**

1. Sex
  1. Female
  2. Male
2. Age
  - 15 – 18
  - 19 – 25
  - 25 – 35
  - 36 – 50
  - 51 above
3. Marital Status
  - Single
  - Married
  - Widower
  - Widow
4. Family Size
  - Zero
  - 1 – 2 dependents
  - 3 – 5 dependents
  - 6 – 10 dependents
  - More than 10 dependents
5. Religion
  - Christian
  - Muslim
  - None
6. Can you read and write
  - Yes
  - No
7. Education Level
  - Primary Level
  - Secondary level
  - Tertiary / technical level
  - University level

- None
8. How many VHTs are in your village..... (state number of male and female)
- Females.....
  - Males.....
9. Are in any leadership position in your village you have a position of leadership in the community?
- No
  - Yes
10. If yes, which position? .....
11. Do you have any activity that brings in money?
- No
  - Yes
12. If yes, from what is it? .....
13. How many households are you targeting?
- 10 – 24
  - 25 – 34
  - 35 - 44
  - More than 45

***(Working conditions and managing child illness)***

14. What is the number of children under 5 in households that you are serving?
- 10 – 20
  - 21 – 30
  - 31 - 40
  - More than 40
15. How long have you been treating children in your community?
- Less than 6 month
  - 6 - 12 months
  - 12 - 24 months
  - More than 2 years
16. On average how long does it take you to treat a child much time do you spend on?
- Less than 15 minutes
  - 15-30 minutes
  - More than 30 minutes
17. Where do you usually offer treatment to the children?
- From the patients home
  - From VHT home
18. How do you view your workload?
- OK
  - Too much
  - Too little

19. How many days was your training that you received?
- Less than 6
  - Six days
  - More than six
20. Did you gain sufficient skills from the training?
- Yes
  - No
21. Have you had any refresher training?
- Yes
  - No
22. Do you understand the Job Aid that was given after the training?
- Yes
  - No
23. Can you explain the Job Aid you use for giving treatment (Rating)
- Poor (fail to explain / 1/4)
  - Fair (1/2)
  - Good (3/4)
  - Very good (all right)
24. Do you refer complicated patients to your nearest health unit?
- Yes
  - No
25. Do you follow-up children you referred?
- Yes
  - No
26. If no, why not? .....
27. Do you always get feed back from the health unit about children you have referred?
- Yes
  - No
28. Do you always think the caretakers comply with your treatment instructions?
- Yes
  - No
29. If no, why not? .....

**Testing for knowledge on child illness**

30. What are the four signs of a severely sick child that must be referred to the health facility?
- .....
  - .....
  - .....
  - .....
31. What is the most common sign of malaria in children?
- .....
  - .....
  - .....
  - .....
32. Describe three other signs of malaria in children?

- .....
- .....
- .....

33. How is malaria passed from person to person?

- .....
- .....
- .....

34. Give three parents should do to prevent their children from contracting malaria

- .....
- .....
- .....

35. Which Coartem pack should you give a 1-year old child? (circle the answer)

- Yellow
- Blue

36. How would you do you assess rapid breathing in a child?

- Counting the respiratory rate using timer
- Just by observing the breathing
- Other:.....

37. Do you have a working respiratory rate timer?

- Yes
- No

38. Give three signs of a child that has pneumonia?

- .....
- .....
- .....

39. Name the drugs that should be given a 2-year old child with fast breathing, fever and cough?

- .....
- .....
- .....

40. Give three things that parents should do to prevent pneumonia in their children

- .....
- .....
- .....

41. Give at two kinds of diarrhoea that affects children

- .....
- .....

42. Describe how ORS for children with diarrhea is prepared

.....  
 .....

43. Give at least three things you will tell a parent to do to avoid diarrhoea in children

- .....
- .....
- .....

44. Count the respiratory rate in 2 children

	Child 1 ( months / years old)	num ber	Child 2 ( months/ years old)	num ber
VHT rate Estimated				
Observer rate Estimated				

***Analysing the effect of supervision of VHTs on their job performance***

45. How many times often to you get supervision or meetings?

- Once a Month
- One in two Months
- Once in six Months
- Never

46. Do supervisors visit your home?

- Yes
- No

47. Which type of supervision do you prefer? (Read all options)

- Supervisor visiting your home
- Supervisor meeting you at the health facility periodically
- Both

48. Have you had any drug stock out (no drugs) in the last three months?

- Yes
- No

49. Have you had drug stock outs in the last three months for the following below (Tick yes or no)

	Yes	No
Coartem green		
Coartem Pink		
Amoxyclyne		
Zinc		
ORS		
Rectum tab		

50. What drugs do you have in stock today?

	Yes	No
Coartem green		
Coartem Pink		
Amoxyclyne		
Zinc		
ORS		
Rectum tab		

51. What support have you received for improvement of the health situation in your Village from the following: (List all the responses?)

District

Community  
 Health Sub District  
 Sub County

**Reporting and Record keeping**

52. How many VHT reports have you submitted in you started service?

- None
- 1 – 2
- 3 – 5
- 6 – 10
- More than ten

53. Looking at record books to check if they are updated

Patient record book		Referral form		Stock cards	
Yes	No	Yes	No	Yes	No

***Facilitation and motivation of VHTs***

54. What are the biggest challenges you face when serving your community?

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55. What kind of assistance and support do you need to perform your work better?

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56. Have you been supplied with the following materials since you qualified as VHT member? (Tick Yes or No)

	Yes	No
Medicine box		
Gum boots		
Torches and batteries.		
T-shirt		
Job Aides		
Soap		
Rain coats		
Bicycles		
Record books		

Respiratory rate Timers		
Posters		

57. Are you offered motivation every time you attend meetings?

Yes

No

58. Do you know of any VHT members that have dropped out?

Yes

No

59. If yes, what were the reasons for the drop out?

.....

Thanks for participating

## Key Informants – Health Unit in charge and NGOs

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Interviewer's name .....

Sex

- Male  
 Female

Sub County .....

Health Facility Name .....

Health Facility Level .....

Health worker title .....

Duration on job .....

1. How long have VHTs implementing iCCM been operating under support of your health unit?
  - Less than 3 Month
  - 4 – 6 Months
  - 7months – 1 year
  - More than a year
2. Were you involved in any VHT activities below ( tick all that apply)
  - VHT selection
  - VHT training
  - VHT supervision
  - Other: .....
3. Do you supervise any VHT?
  - Yes
  - No
4. If yes, how many VHT members do you supervise? .....
  - 1 – 5
  - 6 – 15
  - More than 15
5. What are the main challenges faced during the implementation of iCCM?
6. In the last six months have you received any feedback information on VHT supervision from following below (tick Yes or No;

	Yes	No
District		
NGO / Partners		
MOH		
Health Sub district		
Others		

7. State the number of supervision you have given to a VHT member in the last six months.
  - None
  - 1 – 2
  - 3 – 5



6 and More

8. State the number of supervision **home visit** that you have given to a VHT member in the last six months.

- None
- Once
- 2 – 3 times
- More than 3

9. Explain the kind of supervision do you normally give to the ? .....

10. Do you always get transport available to conduct supervision visit?

- Yes
- No

11. Do you get referrals from VHTs at your health unit?

- Yes
- No (skip to 14)

12. If yes, approximately how many referrals do you receive per month?

- 1 – 10
- 11 – 20
- More than 20
- None

13. Do you give feed back of the referred cases to the VHT?

- Yes
- No

14. If No, why not?.....

**Drug management**

15. What is your role in drug management for the VHTs?

16. Have you had any medicine stock out for the last 3 months? (Tick yes or no)

	Yes	No
Coartem green		
Coartem Pink		
Amoxyclyline		
Zinc		
ORS		
Rectum tab		

17. Do you make monthly reports on the VHT for make monthly reports on the VHT for the district?

- Yes
- No

18. What do you think are the main challenges and problems of implementing the VHT ICCM program?

19. What do you think are the good things about the VHT iCCM program?

# Focus Group Discussion: ( VHT peer supervisors)

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1. Explain how the training was undertaken? Do you think the training was adequate given the tasks? Why?
2. Were you satisfied with the content of training, the length methods used and facilitators, etc
3. What are your general perceptions in relation to the VHT program?
4. What motivates you to work? And how has working as VHT affected your lifestyle and status in community?
5. When the community and care takers support your work, how do you feel?
6. Describe the relationship you have with the health workers? And how do the health workers contribute to your work?
7. What do you consider to be the issues affecting your performance positively or negatively when you are working in your village?
8. What do you consider was not done well and what was done well in the implementation of the VHT program?
9. What would you consider the main problems in your work? And suggest how to overcome the challenges?

# FDG for Care takers

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1. What is the community awareness of the presence of the VHTs -----  
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2. How do you tell your child is very ill and needs to see a VHT -----  
-----  
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3. When did you take your child get ill? -----
4. When did you obtain treatment? -----
5. Are you aware of danger signs in children -----
6. Do think it is easy to get access to VHT when children are sick? Why? -----  
-----  
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7. How do feel about VHT members in management of pneumonia, diarrhoea and malaria at community level (probe for confidence, competence, interpretation of the symptoms, providing treatment and trust) -----  
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8. How can VHTs be helped to successfully accomplish their work in the community? ---  
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9. What can be done to improve the performance of VHTs in your community? (probe for motivation) -----  
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# ICCM JOB CARD

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