Formative research Uganda:
Community Arm

DRAFT REPORT – DO NOT CITE

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inSCALE – Innovations at Scale for Community Access and Lasting Effects

The inSCALE programme, a collaboration between Malaria Consortium, London School of Hygiene and Tropical Medicine (LSHTM) and University College of London (UCL), aims to increase coverage of integrated community case management (ICCM) of children with diarrhoea, pneumonia and malaria in Uganda and Mozambique. inSCALE is funded by Bill & Melinda Gates Foundation and sets out to better understand community based agent (CBA) motivation and attrition, and to find feasible and acceptable solutions to CBA retention and performance which are vital for successful implementation of ICCM at scale.

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Respondents for the study (VHTs, VHT supervisors, caregivers, male heads of households and Local Council 1 Chairpersons) set aside time to participate in for the Study travelling to designated places to meet the research team.

Mobilisation of VHTs, supervisors and district health officials was done by the Malaria focal persons in Kiboga District (Sister Catherine Nassiwa) in collaboration with the in-charge of health facilities.

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Executive summary

Section 1: perceptions of VHTs. Source - community interviews and group work

Awareness and use of VHTs
- Despite some initial resistance to the use of VHTs due to their perceived lack of training, VHTs are well known in the community and commonly used. This use is influenced by whether they have drugs in stock.

Problems VHTs face and how their work could be improved
- The bulk of VHT problems were identified as relating to drug stock outs, transport issues, having the right equipment for the job and having and maintaining community respect for their work.
- Solutions were suggested relating to providing VHTs with the tools they require for their work (usually from government or NGOs), increasing technical capacity of VHTs to engender respect, providing financial incentives as well as accountability incentives in the form of impromptu supervision visits and also increasing community understanding of VHT work through sensitisation.

What the community currently does and what could they do?
- The community occasionally lends bikes but they are required back by their owners and therefore loans are short term. They provide thanks to VHTs and the occasional soda or other food or drink if their child has been successfully treated.
- The community provide patients which allows VHTs to perform their role – viewed as support by some community respondents.
- Many community members say no support is provided and that they do not consider it necessary as VHTs volunteered understanding the terms of their work or at least they should have.
- ‘Support’ across respondent groups was commonly interpreted as a financial contribution. There were several reasons for resisting this. Such payments were:
  o thought of as penalising the poorest as those with greater means could pay for care elsewhere
  o considered to be corrupt in that they would invite treatment favouritism
  o considered likely to make people stay away from VHT services.
- Some felt the provision of support was beyond the means of the community. Others felt that if the need for support was well explained, then the potential (as well as the precedent) was there for community support of VHTs.

The need for community sensitisation
- Given the strong views articulated relating to community support for VHT activities it is recommended that inSCALE focuses on developing a clear rationale. In addition it is clear that community sensitisation as to the role of the VHT and both the need and nature of various types of support – including non-financial - is required.

Section 2: community meetings that currently take place: community, supervisor and VHT perceptions

Types of meetings that take place
- Range of local meetings.
- Most common are local council (LC) meetings which are regular but also agricultural meetings, local clean up meetings and food and security meetings. Health campaign meetings such as for mosquito net distributions also mentioned.

Who leads and participates
- The LC chairman plays a key role in mobilising and running community meetings. When not chairing the meeting himself / herself it is run by either the chair of a specific interest group or an external party such as the police in the case of a security meeting.
- While community members typically suggested it was the LC1 who organised, LC1 respondents also credited their committee for their mobilisation role.
- Women were reportedly more commonly in attendance than men.

Effectiveness and popularity
- Popularity dependent on interest and relevance of issues under discussion but most critically, whether there were any free items on offer. The least popular meetings were where there was nothing being given but there were requests for ‘support’ (interpreted as payments).
- Many community respondents noted that positive change had come from community meetings but slowly. Examples given were of greater community awareness and knowledge leading to higher school enrolments and better water sanitation and hygiene behaviours.
- Supervisors suggested that community meetings had led to a greater level of engagement with issues at the community level e.g. VHT selection and resolving conflicts. Meetings also an effective forum for getting to know ones fellow community members and receiving information.

Challenges
- The main challenges to community meetings were mobilisation due to spread out communities (for supervisors people may not be aware of meetings) and people being too busy to make the time, frustration at the slow pace of change, low levels of perceived relevance of the topics being discussed and poor time keeping of participants. All were suggested as contributing to increasingly poor attendance over time. Community respondents suggested that meeting attendance was low while supervisors said it was around 80% of community members.
- Supervisors noted that meeting attendance was influenced by seasons – especially the rains – where people are commonly preoccupied with agriculture.

Section 3: village committees that currently convene: community, supervisor and VHT perceptions

Types of village committees that convene
- Respondents identified a range of committees operation at community level. The main ones were the local council, agricultural groups such as NAADs, small loan groups and World Vision committees commonly focused on child welfare and school attendance.
- Committees addressed issues of local relevance depending on their special interest.

Who leads, selects and participates?
- Committees typically elect a chairperson and committee. They often charge membership fees – especially those with a loan function.
- Committees are usually selected by the community (e.g. local council) through nominations and show of hands at a community meeting.
Committee members participate in meetings.

**Effectiveness and popularity**

- Popularity of groups linked by respondents to relevance of information they provide, their ability to produce prompt and positive local change and the likelihood of material benefit – e.g. NAADs providing livestock
- Community respondents indicated a strong dislike for requests to contribute to committees. They also indicated a lack of trust in committees handling any raised funds appropriately.
- The perception of lack of representativeness of committees can impact on their ability to inspire change in the community regardless of the level of consensus within the committee.
- Attendance of committee meetings linked to perceived effectiveness and the likelihood of benefiting personally.
- Some committees criticised for excluding poorest members of the community by charging membership and ongoing fees and thereby excluding those whose need is greatest.
- World Vision committee that sought to implement a matched funding scheme in the creation of a school found community contributions were challenging to secure.

**Section 4: inSCALE community innovations: community, supervisor and VHT perceptions**

**Potential of village committees for positive impact**

- Respondents recognised the potential for the VC to effectively generate community support for the VHT in the form of small financial contributions and goods and services. It will be necessary for the approach to be designed with sensitivity the resistance to financial contributions that is evident.
- Greater community understanding of the VHT role and responsibilities and VHT understanding of community issues and expectations was thought likely to increase respect and support for VHTs resulting in greater VHT motivation.
- It was felt that the VC could assist the VHT by:
  - sharing sensitisation and mobilisation duties.
  - taking on responsibility for drug collection and storage and as a result share some of the burden of community expectation and disappointment around drug supply.
  - acting as a sounding board for VHTs between supervision visits and also advocate for VHT needs – especially the need for drugs – to the health facility
  - acting as a monitoring mechanism to which VHTs would feel a level of accountability.

**inSCALE components**

- **Component 1 – raising awareness in the community of VHT work**
  - Had spontaneously emerged as an approach from community respondents.
  - Challenges anticipated with lack of VHT credibility due to drug stock outs and the community becoming jaded over time with repetition of messaging
  - Suggested using radio and appropriate training in mobilisation for VHTs

- **Component 2 – working with VHTs to review their records and understand their challenges**
Was not suggested by participants but upon reflection was considered of value. By reviewing records it was suggested that the VC could help identify and solve challenges, monitor the VHT and to check data before submission.

Supervisors felt it could assist VHTs between supervision visits

The risk of the activity being viewed as a performance assessment was raised by respondents from all groups who advised that this perception could lead to a lack of cooperation from VHTs

Concerns were raised as to the VC's ability to navigate the VHT records. Training was suggested with some expressing concerns about the feasibility of VC members acquiring the necessary skills. Some respondents felt review of records should remain a technical task for the supervisor.

**Component 3 – solving VHT problems at the community level and communicating with supervisors about broader problems**

Problem solving was spontaneously mentioned by community members and supervisors as a means of reducing VHT workload and improving communications between the community and the health facility. A clear role definition for both supervisor and VC was advised

Several key challenges were raised:

- It was not considered feasible for the VC to lobby for support (commonly assumed to be financial) when they don’t themselves receive any according to community respondents. The community was considered likely to be unwilling to contribute anyway and be of the view that ‘volunteers’ should receive support from their programs (i.e. government or NGOs)
- Across respondent groups it was considered unlikely the VC would be able to help solve problems – especially those related to community adherence. A more worthwhile function was considered to be lobbying for change to higher authorities. Such an approach was considered to potentially have more traction than a lone VHT voice
- Community respondents often assumed that prompt reporting of problems would lead to prompt resolutions. If solutions are not forthcoming VHTs and community members are likely to become demoralised.

**Component 4 – arranging village meetings to discuss VHT work and develop plans to solve VHT problems**

While community meetings were considered a valuable and worthwhile forum for xx doubts were raised as to both the will and ability of community members to solve VHT problems. Some VHTs insisted that supervisors should continue to provide technical support

There was little confidence around the sustainability of community meetings despite initial curiosity and enthusiasm driving attendance. This was due to:

- Meetings being time consuming, expensive and impractical – due to distance and geography – to organise
- Needs to be a varied agenda and tangible and prompt benefits to participants to sustain interest of busy community members
At present content focuses on problems rather than benefits to community members.

**Village committee participation – making them work**

- A formal structure to the VC was recommended across respondent groups with a chairperson, vice chairperson, secretary and treasurer.
- Involvement of the LC1 was considered critical to success of the VC either by assisting with mobilisation or as a full member. Some supervisors warned that LC1s were already stretched so should not be called on for VC membership.
- Other suggestions were that:
  - the existing LC structure should be utilised instead of establishing a new mechanism (community respondents)
  - two members of the VC should participate in every other community group to raise awareness of the VHT program (community respondents)
  - VC members be incentivised with transport allowances and/or lunch and sodas (all respondent groups)
  - VC meetings should be quarterly and brief as VC members would be volunteers and have other responsibilities (all respondent groups)
  - VC members should receive training (supervisor respondents)
  - VC members should be elected by the community and understand their responsibilities before taking on the role. They should represent different sections of the community (e.g. youth, elderly, disabled) and be literate, well respected and responsible (all respondent groups)
  - Female representation on the VC be at least equal if not greater than male due to their greater insight into children’s needs (all respondent groups)

**Interacting with supervisors**

- Supervisors suggested that the VC should interact with supervisors face to face by coming to VC meetings, VC members visiting the HF or creating a special meeting. Creating a report for supervisors to use for advocacy was a popular suggestion.
- VHTs stressed the importance of being kept informed of ongoing communications between the VC and supervisors.
- Supervisors advised that when presented with problems by the VC such as drug stock outs they would forward the concern to Malaria Consortium or the district malaria focal person and explain to the committee the cause of the drug stock out.
- Supervisors also suggested they could mentor VC members and provide them with technical assistance. They suggested they should be involved in VC and community meetings to raise awareness and build confidence but that they would need advance warning.
- Supervisors envisaged the key risks to be:
  - Rising community expectations that supervisors will solve all VHT problems including drug stock outs
  - Committee members expecting sitting allowance and transport refund for attending committee meetings from the supervisor
  - The community raising complaints about the health facility.

**Village meetings – making them work**
It was universally agreed that it should be the VC chairperson and their vice chair person who organise meetings and that they should be open to all.

Key features of successful meetings were seen to be:
- A strong chairperson who has rules and procedures for who talks
- Extensive advance mobilisation – for some it was critical to involve the LC1 while others suggested supervisors – with a meeting agenda made available ahead of time
- Providing refreshments for attendees as an incentive to attend – seen as critical by many respondents
- Keeping meetings brief and locally relevant
- Ensure that actions from meetings are followed and people see the impact.

Section 5: current data use practices and preferences. Source – supervisor interviews.

Presentation and use of data - VHTs
- VHTs suggested data to be presented to the community related to their work should focus on the number of children who fall sick and have been treated to highlight both the need for preventive behaviours and the good work VHTs do.
- Some VHTs suggested verbal summaries would be better for community members while some suggested graphical aids – pasted on the wall – could be beneficial. The need to work in the local language was highlighted.
- VHTs mostly felt it should be them to create and present data summaries to the community and suggested if someone else were to do it they would feel undermined.
- Some VHTs felt supervisors should be involved in presenting data to the community as it would assist in establishing credibility.
- VHTs felt the data to be presented

Most useful information to present to village committees and the community - supervisors
- Supervisors felt that the most useful information for the village committee to be presented with related to the concept of iCCM, the basic facts about malaria, how the committee members should relate with the VHT, causes of illnesses among children – for the Committee to pass on to the community and the community in turn to act to reduce these illnesses, disease prevention of in the community, the number of children seeking treatment from the VHT, the number of cases followed up by VHTs of those treated and the quantity of drugs received, stored and dispensed by the VHTs.
- Supervisors felt that the most useful information for the community to be presented with related to diseases treated by VHTs, for instance, showing the number of diseases (malaria cases, measles, cholera) handled in a week, names of treated children by VHT per week to build community confidence in VHTs the age bracket of children treated by VHTs, signs of different illnesses among children, disease prevention in the community especially among children, the number of children treated by VHT (per month) to help the community to know the treatment patterns of a VHT, information on amount of medicines used, medicines available, the number of children referred by VHT, the number of children seeking treatment from VHT, the number of cases followed up VHTs of those treated, the quantity of drugs the VHT has remaining and information related to the role of the VHT.

Who should develop and present the data - supervisors
Supervisors had conflicting views on who was best placed to produce and present the data to VCs and the community – the supervisors themselves or the VHT. Those who argued for the supervisors suggested that:
- they could provide more technical information than VHTs if required, they have experience in collecting and presenting data and summarise all the data received from VHTs anyway. The identified risk with VHTs was that they may exaggerate the figures relating to the number of children treated. It was also suggested there would be no cross check on VHT data should the supervisors not be involved.

Those who argued for the VHTs suggested that:

- they are the source of the data; they in the best position to talk about any successes or challenges as they live in the community they serve and they would be able to provide a firsthand account. They also suggested that the supervisors were too busy.

3/6 supervisors suggested that a member or members of the VC should present data when the supervisor was not available to do so. They argued this would assist with community exposure and understanding of both their role and that of the VHT.

**How to best present data - supervisors**

- 4/6 supervisors interviewed argued that data should be presented verbally due to the low levels of literacy in the community. They added that the risk with visual aids was they may intimidate community members if pitched at an inappropriate educational level.

2/6 supervisors suggested the use of flip charts to present simple graphs could be meaningful for the community if accompanied by an adequate verbal explanation. If adopted as an approach, training for the in the development of charts and their presentation was considered essential.
Introduction

The inSCALE project goal is to develop and implement innovative activities, grounded in theoretical and empirical evidence, designed to promote VHT motivation, performance and retention and thereby demonstrate that government led iCCM programs in 2 African countries can be rapidly driven to scale with quality, leading to a sustained increase in the proportion of sick children receiving appropriate treatment.

Through extensive review of the literature and in-country program experience multiple innovations in two ‘arms’ are proposed in Uganda:

1. Technology supported approach: promoting VHT learning and support using ICT
   Aim: To achieve the principles of good supervision without frequent face to face contact we aim to utilise available technology and develop tools and applications for mobile phones and low-cost laptops which can be used for self learning; as job aides; for data submission and feedback; and for problem solving and peer-support.

2. Community supported motivation approach: promoting collective identity and accountability to improve VHT performance and retention
   Aim: To increase retention and performance of VHTs by improving the perceived value of the VHT to the VHT themselves and the community they serve. It will make VHTs more visible and will contribute to sustainability of the VHT role.

The current report concerns formative research into the feasibility and acceptability of innovations proposed under the community supported approach. This is the third stage of a three stage formative research process in Uganda with the first being a pile sorting activity with Ministry of Health representatives and the second being formative research into innovations proposed under the technology supported approach.

The innovations being explored in the current round of formative research are:

1. Village committees
2. Community meetings

Aim

The inSCALE formative research into innovations from the community supported supervision approach in Uganda aims to gauge the views of VHTs, their supervisors and key program implementers on:

1. The potential for the proposed innovations to meet genuine needs and have an impact in terms of the project aims.

2. The feasibility (i.e. whether they are possible) of implementation and scale up of the proposed activities.

3. The acceptability of the proposed activities to VHTs themselves, supervisors, communities, districts and the Ministry.
Using this information, the inSCALE team aims to develop the proposed innovations in the most effective way to fulfil the aims of the project.

**Method**

**Recruitment and training of fieldworkers and piloting of topic guides**

Four fieldworkers were recruited and trained for two days on the topic guides. Three of the four fieldworkers participated in the technology arm formative research in January and February 2011; so they were already informed background to the research. The ‘fair notes’ data collection method was used and the principle of informed consent and the participant consent process was followed in accordance with the ethics board requirements.

Fieldworkers, under supervision, conducted a one-day pilot of the community members and supervisor’s interview guide and the focus group discussion (FGD) guide with caregivers in Bukomero Sub-County (a large community in terms of total population) in Kiboga District. Fieldworkers wrote up the interview and FGD field notes and with the supervisors amended the guides accordingly.

**Data Collection**

Data collection was conducted in Kiboga District in: Kibiga Sub-County representing a large sized community (high population, dense settlement patterns and large geographical area); and, Dwaniro Sub-County representing a medium sized community (moderate population and sparse settlement pattern). The selection of respondents ensured a range of geographies (urban/rural), and type of supervising facility were accessed to produce the richest data set possible.

Thirty (30) in-depth interviews were conducted with VHT supervisors (6), VHTs (6), Local Council 1 Chairpersons (6), caregivers (6), male household heads (6); and 3 focus group discussions with caregivers, Local Council 1 Chairpersons, and male household heads. Key information relating to the respondents recruited as in-depth interview and FGD participants is in Appendix 1.

Key informant interviews targeted:

1. Community knowledge of the VHT work and challenges
2. Current situation with regard to community meetings
3. Existing village committee type structures
4. Beliefs on the inSCALE innovation of a proposed village committee and holding community/ village meetings to support VHTs in their work,
   - Perceptions of the role of the village committee, i.e., how the village committee will improve the work of the VHTs.
   - The selection and representation of the village committee – who to include, who to exclude.
   - How to best organize committee meetings
   - Sustaining of committee meetings over time.
   - Effect of village committee on supervisor’s work with the VHTs and with the community.
   - Organizing village meetings – whether people will attend, who to attend, how to ensure meeting is not dominated by a few people, whether people be able to discuss, make plans and solve VHT problems through the village meetings
5. Collecting, collating and presenting data to the community
   - Sort of information would be most useful for the committee and the community to have in order to understand VHT work, and the problems and successes VHTs have.
- Source of data – VHT, supervisor
- Best way to present data – verbal information explaining the data, visual representation of data such as charts and graphs, etc.
- Who should present this information to the committee and the community – VHT, supervisors, others?

Data analysis

Interview and FGD ‘fair notes’ transcripts were read and coded into themes. Relevant quotes were cut and paste from transcripts into a master copy coded data set for VHTs, supervisors, and community members (LC1 Chairpersons, caregivers, male household heads). Summaries were made for each theme and formed the basis for the report in accordance with a thematic data analysis approach.
Results and discussion

Section 1: perceptions of VHTs. Source - community interviews and group work

Section aim:
- To establish the key barriers and facilitators to VHT support mechanisms
- To determine whether there is opposition, suspicion or support for VHTs as this will influence the potential for communities to support VHT activities and the messages to be developed for the inSCALE innovation that will be given to communities in the meetings.

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various types of support – including non-financial - is required.

1.1 Community awareness and use of VHTs

All community respondents had heard of the work of iCCM VHTs. The most commonly cited function of VHT work was their ability to treat children and dispense drugs. All respondents said that community members used VHTs when their children are ill however some indicated that they had been initially sceptical as to the effectiveness and indeed the qualifications of VHTs but that over time their confidence had built. Some suggested this was due to the persuasion of the chairman (LC). Some respondents also referred to VHTs as ‘doctors’ or ‘community doctors’.

“When these doctors had just started working in our community, people used to fear taking their children for treatment because these were people who didn’t study like doctors in hospitals and just after a few months they were saying that they treat children which surprised many people and they didn’t trust their work therefore could not take their children to get treatment from these doctors(VHTs). However with the help of the chairman and the doctor at this hospital, people got to know of the work these village doctors do and they started taking their children for treatment”
(Caregiver 1, 30 year old male)

The main reasons given for using VHTs were that they had drugs, these drugs were free and that, being based in the community, they were more easily accessible than the health facility – especially at night (see table 1). All respondents also noted that VHTs engage in a great deal of health promotion and raise awareness of health risk factors in the community. Many cited patient referral and follow up home visits to check on sick children.

Some respondents admitted some initial resistance to utilising VHTs. Reasons given for this was that they did not feel the level of training they had received was sufficient compared to facility based health professionals. For some this was vindicated by their frustration when not being given drugs for their children when they had a fever due, according to the VHT, a negative result on a malaria test. Through the support of the LC1 and the encouragement of health facility workers – who on occasions reportedly refused to see children who had not first seen the VHT – community members reported VHTs were now the first place parents took their children when they fell ill. It was noted that many do not bother and instead go to the health facility when it is known that the VHT has run out of drugs.

“The problem is that people are not satisfied with the test kits that are being used to test different diseases in children because many people have gone to these village doctors with sick children but when tested, the results are negative which means that the VHTs cannot treat but rather refer the child to hospital.”
(Male head of household 4: 36 year old male)

“Yes they are commonly used today though in the beginning people doubted their training and shunned their services but through continuous sensitization that has changed and people use them so much”.
(LC1 3: 60 year old male)
Table 1: Reasons community members use iCCM trained VHTs

VHTs are local and accessible compared to the health facilities – 5 male heads of household, 4 LC1s = 9/18 respondents

“These VHTs are commonly used in the community because they are nearer compared to the health centres, they can be approached easily even when it is late and they have drugs with them which cure the children”.
(LC1 2: 54 year old male)

They dispense drugs that are effective – 2 male head of household, 3 LC1s = 5/18 respondents

“These VHTs are utilized a lot because they tend to give out medicines especially anti malarials like coartem free of charge and this is good because most of our people in the community are poor, they cannot afford buying medicines that is why when they go to clinics, they are told to buy medicines so I think that is why they like the services of VHTs”.
(Male head of household 5: 27 year old male)

They dispense free drugs – 1 caregiver and 2 LC1s = 3/18 respondents

“What I know these VHTs are given medicines like for cough and anti malarial medicines so that means that even if a parent does not have any money, they can be approached first.”
(Caregiver 6: 37 year old female)

They have drugs and will treat children – 2 caregivers, 1 LC1 = 3/18 respondents

“Yes indeed their services are greatly utilized because they always give out treatment and medicines for malaria according to how they were trained to treat children, and can be approached first by the community members to seek treatment before going to the health facility.”
(Caregiver 2: 34 year old female)

VHTs are approachable and friendly – 1 caregiver, 1 male head of household, 1 LC1 = 3/18 respondents

“They are approachable, are social and friendly to the community members because if you go to them to get medicines, they welcome you politely and in case there are no medicines available, they politely advise you to go the health facility”
(Caregiver 6: 37 year old female)

Other reasons given were: the VHTs are trusted (1 caregiver), they set a good example with their own health and hygiene (1 male head of household), they treat disease (1 caregiver), health facility workers send community members back to the VHTs for treatment (1 LC1) and it is the law (1 caregiver).

1.2 Problems VHTs face and how their work could be improved

Transport, drug stock outs and the right equipment for the job

From the perspective of community members, the main problems facing VHTs as they go about their work relate to transport and the lack of drugs and other equipment required for their job. Transport and movement was a commonly noted challenge for VHTs particularly in the context of often large and scattered communities. People noted that it takes a long time to walk around on foot to visit families and also to go to the health facility to collect drugs. While identified as a key challenge it did not automatically follow that community members felt the community could or should do something to assist VHTs in this regard as will be seen later in the paper (see section 1.3 below).

“VHTs have many problems but the most pressing one is the long distance that they have to move while carrying out community sensitization. Most of the villages are big and houses are scattered yet they have to go to almost all the homes in the village. These people are volunteers who are not given means of transport like a bicycle to do this work. This means that they cannot
get enough time to do their other activities so that they earn some money if most of the time is spent moving to different homes and treating children.”
(Male head of household 4: 36 year old male)

The impact of drug stock outs was explained in terms of it complicating VHT’s work by necessitating costly (both in terms of time and money) travel to collect supplies. It was also noted that there was no guarantee drugs would be available at the health facility upon their arrival. One respondent (caregiver 3) suggested that there was nothing VHTs could do about this situation. This did not seem to be the prevailing view though with many suggesting that the VHTs were not doing such a good job because they did not have drugs and may even be stealing or hiding them. The LC respondents in particular felt that such a view, commonly held in the community, indicated that there was a need for community sensitisation around the challenges VHTs face and that it was not as simple as if there were no drugs it means they are not doing a good job.

“I think the problems VHTs face are the drugs get out of stock and this interrupts the service they give the community and people usually think she/he may have hidden the drugs.
(Male head of household 2: 38 year old male)

“There seems to be a very big challenge in the communication especially between these VHTs and the health facility where they get their medicines as this hinders their work especially in giving out medicines because at times these VHTs go to the health facility to get medicines without consulting their Supervisors, and at times reach there when there are no drugs in stock”.
(Male head of household 5: 27 year old male)

Community members had concerns about other supplies that VHTs were often seemingly short of such as testing kits, umbrellas and gumboots. One LC1 noted that VHTs ‘are not at all motivated by anyone’ (LC1 6, 51 year old male) meaning that they were not paid and that in the context of the demands placed on them this represented an intolerable burden. This LC1 uses the word ‘motivation’ here as a synonym for payment. Respondents commonly use words such as ‘support’, ‘understanding’, ‘facilitation’, ‘consideration’ and ‘motivation’ as euphemisms for some form of central (i.e. government or agency supported program) payment. Methodologically this presents challenges when trying to understand what sort of non financial ‘support’ community members currently or could potentially provide to VHTs.
Table 2: Main problems faced by VHTs

Lack of transport and associated challenges related to time spent and cost of moving around – 4 caregivers, 5 male heads of household, 5 LC1s = 15/18 respondents

Drug stock outs – 4 caregivers, 3 male heads of household, 3 LC1s = 10/18 respondents

Not having the right equipment or enough of it – 2 caregivers, 2 male heads of household, 1 LC1s = 5/18 respondents

High community demands often based on misunderstanding – 2 caregivers, 1 male heads of household, 1 LC1s = 4/18 respondents

Over committing and not having enough time for own work – 2 caregivers, 1 male head of households = 3/18 respondents

Too much work / over worked due to large size of the community – 1 caregivers, 2 male heads of household = 3/18 respondents

Low community credibility (often based on community misunderstanding of role) – 1 caregivers, 1 male heads of household, 1 LC1s = 3/18 respondents

Over committing but little sympathy as they volunteered – 2 caregivers = 2/18 respondents

Other reasons given were: storing drugs in open air containers (2 male heads of household), not being paid (2 LC1s), being called on at night (1 caregiver and 1 LC1), VHT theft of drugs (1 caregiver and 1 male head of household), VHTs stealing drugs (1 caregiver and 1 male head of household), VHTs training their children to cover for them (1 caregiver), not being skilled enough for the job (1 caregiver), Not being easily identifiable (1 male head of household), having poor communication with supervisors (1 male head of household), and language challenges with people in their community (1 male head of household).

Suggestions related to transport, drug stock outs and the right equipment for the job

As issues related to transport were the most commonly mentioned, solutions to this challenge were also commonly put forward. Most respondents suggested supplying means of transport for VHTs in the form of bikes or a transport allowance. One male head of household even suggested the LC1 could encourage each household to contribute 5,000UGX so that a bike could be contributed. Such initiatives where community members are asked to make contributions were not otherwise popularly received (see section 1.3 below).

“LC could call a meeting of community members and tell them that each household contributes 5000/= to buy a bicycle for the VHT to solve the transport issue.”
(Male head of household 6: 42 year old male)

Ensuring a consistent drug supply (e.g. by encouraging health facilities to deliver them to VHTs) and furnishing VHTs with the tools for the job were also common suggestions. Such tools were commonly viewed as lights, kerosene, mobile phones, drug storage units and test kits for malaria as well as having designated work areas and t-shirts or uniforms that clearly marked them as VHTs.

“These drugs should be brought nearly so that VHTs don’t have to spend their money on hiring boda bodas and bicycles (motorcycles) or walk long distances to pick these drugs.”
(LC1 6: 51 year old male)

Community pressure and misunderstanding of VHT role

Several community members noted the community pressure brought to bear on VHTs to deliver their services. This area of community concern related to the time VHTs have available for their work. Some felt that VHTs had often taken on too much by undertaking to deliver VHT services on top of their own, revenue generating, work. As they had volunteered some felt that it was the VHTs responsibility to solve the problem. Others saw it as putting intolerable pressure on VHTs as they felt
bad if they had to deny treatment or not be on call as they pursued work to support their livelihood. Several respondents noted that VHTs were overworked and that community demands on them were high – often based on misconceptions around their role as a ‘village doctor’. Others noted that the credibility of VHTs in the eyes of the community could suffer often (but not always) based on such misunderstandings.

“The community thinks the VHT treats all fever even when these fevers are not malaria related. These parents just bring their children for treatment and when blood test is done and there is no malaria, parents start doubting whether these VHTs can really treat their children. I was thinking the community could be sensitized what diseases VHTs treat.”

(LC1 2: 54 year old male)

This pressure to deliver and the time demands on VHTs (e.g. often being called on at night) was thought to be exacerbated by the transport challenges noted above. While several respondents had little sympathy for VHT pressures and commonly attributed them to VHT’s own shortcomings (e.g. taking too much on and even trying to get away with it by training their children to cover for them), others noted that they were overstretched and often under intolerable pressure from (often misguided) community members. Others still saw the key challenges as VHTs not being provided with the necessary support especially in terms of drugs, equipment, transport means and even salary. The responsibility for this support was most commonly seen as external to the community rather than something community members could or should contribute to addressing.

Suggestions related to community pressure and misunderstanding of VHT role

There were a range of suggestions made relating to the pressure on VHTs and community misunderstandings and what could be done about them. Many related to adequately resourcing VHTs with knowledge through more training while others suggested incentives such as certificates for this training, payment (a very common suggestion) and frequent and impromptu supervision visits. The rationale was if VHTs were more skilled and motivated they would enjoy greater levels of respect in the community. It was also commonly assumed that VHTs were paid anyway. The solution was therefore seen as either paying them or sensitising the community to the true situation.

“The community usually argues that if VHTs are not paid, then how do they benefit from that work? Community members always have a belief that a normal human being does not work where there are no returns. That is why they don’t respect the VHTs but if community sensitization is done, they will be able to understand the work of VHTs.”

(LC1 4: 52 year old male)

Other respondents recognised the community’s role in the work of the VHT and suggested that with increased community understanding VHTs could experience a greater level of respect and collaboration (e.g. parents moving to VHTs with their sick children). Several respondents suggested a community meeting to sensitise community members to the VHTs work and challenges and encourage support. One LC1 suggested the establishment of a local committee tasked with supporting VHTs.

“The LC1 chairman should call for a meeting in the village and then he explains to the people the roles and responsibilities so that they know the limits of her work and be able to support her by going to her place in particular hours and if they find that she is still finishing her other work, then they should talk to her well and wait for her to finish. If the child is very sick and the matter can’t wait, even the VHT can notice that and immediately help. Otherwise people should respect these village doctors because they are doing a good job.”

(Caregiver 5: 32 year old female)
“I think it would be better in case there is a committee of people who can monitor the performance of these VHTs and also know their challenges and in case of any problems they can report to these people because as you know, people these days are not trusted, in case they are given medicine, they can decide to sell it so when there is a team monitoring these VHTs, they will fear to do so”.

(LC1 5: 58 year old male)

Table 3: Community suggestions for support to VHTs

- Supply means of transport such as bicycles – 4 caregivers, 4 male heads of household, 4 LC1s = 12/18 respondents
- Provide some sort of financial payment / salary – 3 caregivers, 3 male heads of household, 2 LC1s = 8/18 respondents
- Supply means of transport such as bicycles – 4 caregivers, 4 male heads of household, 4 LC1s = 12/18 respondents
- Ensure consistent and adequate supply of drugs – 3 caregivers, 2 male heads of household, 2 LC1s = 7/18 respondents
- Provide VHTs with general equipment for their work such as lights, test kits, kerosene, phones and storage cupboards for drugs – 5 caregivers, 1 male heads of household, 2 LC1s = 7/18 respondents
- Provide VHT refresher training and certificates – 4 caregivers, 1 male heads of household = 5/18 respondents
- Conduct frequent and impromptu supervision visits – 3 caregivers, 1 LC1 = 4/18 respondents
- Conduct a community sensitisation meeting – 1 caregivers, 1 male heads of household, 1 LC1 = 3/18 respondents

Other suggestions made were: employ more VHTs (1 caregiver), oblige VHTs to produce monthly reports so disease prevalence can be tracked (1 caregiver), provide VHTs with identifiers of their role such as t-shirts and uniforms (1 caregiver and 1 male head of household), increase the age of treatable children to increase community respect for VHTs (1 male head of household), conduct a local community fundraiser of 5,000UGX per household for a bicycle for the VHT (1 male head of household), re-train VHTs (1 LC1).

1.3 What the community currently does to support VHTs and what they think they could do

Problematic nature of ‘support’

As noted above, exploring the nature of community ‘support’ to VHTs was problematic due to the meaning ‘support’ had to respondents. As for many the suggestion of support indicates financial support the suggestion commonly met resistance and led to an undeveloped exploration of non-financial support that is, could and should be provided.

Support neither provided nor should be and would not be acceptable to the community anyway

For some the very notion that VHTs as volunteers should be provided with ‘support’ verged on the offensive. The nature of this resistance of the notion to the point of offence took a number of forms. For some it was because VHTs had volunteered to serve the community understanding the terms, while for others it was due to the poverty of the community. For others still, they wouldn’t consider supporting VHTs as they assume they are already being paid. For these reasons a number of respondents said that no support was given (7) and indeed none should be given (7).

“We selected her that was enough support …. (silence)… as long as the community members believe in her that is good enough because if people don’t believe in you and your work- you get problems”. She added that “…there is no support we as community members give to the VHT because we were told that she is a volunteer. This is what we were told when selecting them
that they are going to be working as volunteer and we were advised that if you cannot manage it leave it for others”
(Caregiver 4: 48 year old female)

“people...will ask why did she put herself in that position?”
(Female respondent 6 from pilot FGD, Bukomero)

In the FGD pre-test respondents discussed the ramifications of community members providing support in the form of a small amount of financial assistance to VHTs. The suggestion was made that really this would once again penalise the poorest. They argued that while those with means could afford private treatment for their children, the poorest, who the VHT program was designed to assist for free, would have to now foot the bill for VHTs without those with the most money making a contribution. This did not seem right or fair to the group.

“me as an individual who is a low income earner will benefit from the services of nurse Esther but someone rich will take their children to a bigger hospital, so its the poor who will give”
(Female respondent 6 from pilot FGD, Bukomero)

For some of the groups there was potential for fundraising for the VHT while in others it was not considered a viable option. The suggestion was made that if there was money to be raised it would have to come from the committee members themselves but that they may in fact need more support than the VHT! Others suggested that while it could be enforced it would not be accepted and would not last.

Woman 3: the help has to come from the committee itself
Woman 4: you may find even those on the committee need more help than Esther herself
(Pilot FGD, Bukomero)

 Contributing money may work but it will not be accepted. The reason is that even when people used to be asked for just 1000/= for treatment at the hospital they refused claiming it’s a government hospital meant to be free. So one of them decided to take the child to a local herbalist who instead charged her 5000/=. So even this one they will think she was trained to treat their children free of charge.
(Female respondent 2 from pilot FGD, Bukomero)

For one LC1 the suggestion that support should be given to VHTs was encouraging corrupt practices and he would seek to prevent it in his community. He said that if any form of support were to be provided to VHTs then those VHTs would feel obliged to favour the community members who had provided the support.

“It is not a good idea for the community to help the VHT because it will make the VHTs start misbehaving by asking money that if you don’t give money, you don’t get any treatment and this will lead to death of many children and spoil the whole program as people will no longer get the services. If not checked it can also lead to the VHTs to sell the drugs, it should not be encouraged ... I have not heard about it and if it happened it would be corruption and is highly condemned”.
(LC1 3: 60 year old male)

Even for the greatest need of VHTs – transport – raising funds locally was not considered workable. It was argued that it would be interpreted by the community as a charge for treatment and they would stay away from the services offered by the VHTs.

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1 ‘Esther’ was the name of the fictional VHT in a case study presented to the FGDs. See Appendix 3 for the topic guide.
“The issue of transport is necessary because the VHT in most cases have to travel long distances to treat patients and in doing their daily activities...I think the organization should be the one to facilitate the transport because if we charge the people they will not pay up”
(Male respondent 2 from LC1 FGD, Dwaniro)

“How do you tell them to contribute money to buy bicycle for the village nurse it looks impossible really”
(Male respondent 3 from male head of household FGD, Dwaniro)

The people in the community cannot be charged for the treatment. It will be a blockage for bringing children for treatment because people will know they are going to be charged. Just 200UGX for a book at the hospital some parents stopped taking their children there”
(Male respondent 1 from LC1 FGD, Dwaniro)

Support already being provided and could be even more in the right circumstances
While in some sections there was strong resistance, others identified that support of sorts was already being provided. Some for instance felt that a vote of thanks – either verbal or in the form of some food or drink - following the successful treatment of a child was already happening. Others felt that simply bringing their children to see the VHT was a form of support which enabled them to do their job and receive status and respect as a result.

“The community members normally give support to these VHTs by bringing these VHTs for treatment because in case the community members were not bringing sick children to these VHTs, actually they would not be having any work as VHTs so this community helps them”.
(Male head of household 5:27 year old male)

It was suggested that there was the potential for further support being provided under the right circumstances. Such circumstances were felt to be if the need was well explained to the community – ideally by the LC1 – and the type of support was deemed reasonable and within the means of the community. In such case respondents across the three categories of community members suggested the potential was there for support, on a reasonable scale, to be provided (7 respondents in total – 3 caregivers, 1 male head of household and 3 LC1s). One caregiver respondent suggested there was a precedent at community level for such support when the LC1 rallied the community to raise money for a storage box for the VHTs drugs. Seemingly there is the recognition that community support in the form of a financial contribution for the VHT is appropriate but that over time such an approach is unlikely to work.

it is the chairman of the area that mobilized the community who gave them money and then made boxes where medicines where kept all this was before malaria consortium came to help them”.
(Caregiver 6: 37 year old female)

We have to be in position to appreciate her time that she sacrifices to attend to our children because she could have been else where looking for some money. So get something and give her to buy herself food. So it is in order to carry some money at least 500/= to appreciate her work to encourage her.
(Female respondent 3 from pilot FGD, Bukomero)

The suggestion was made in the caregiver FGD that perhaps a committee could look at linking with other locally active groups to reward the VHT for their health work. The suggestion made was that

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2 This is a reference to Malaria Consortium which is often assumed to be funding the VHT program when conducting research into it.
VHTs could be at the front of the queue for agricultural products from NAADs and thus enjoy some livelihood support.

...good example is NADDs program if only the VHT's would be the first people to benefit, like giving them coffee seeds, maize then it would be encouraging for her to do her job. Instead of giving it to parish chief. Should be giving it first to the person who has contributed to health of the community
(Female respondent 3 from caregiver FGD, Kiboga)

Need for community sensitisation

The range of views described is likely to impact upon inSCALE efforts to generate community support for VHT work. For instance, while some recognise the challenges faced by VHTs and encourage greater community sensitisation in a bid to increase respect for VHTs, others feel they have brought the workload on themselves by being unrealistic. In addition, while some strongly resist community support of VHTs, sometimes for ideological reasons, others are, with the right information willing to entertain the idea of providing support. It is clear that there will need to be extensive community sensitisation related to the nature of VHT work, their voluntary status and the challenges they face in order to elicit support (non financial and potentially financial) for VHTs. In addition inSCALE will need to develop a rationale for the approach that addresses the concerns raised at community level.

Through the current research and indeed in other qualitative enquiry in Uganda both on the inSCALE project (Technology Arm FR) and other projects, it is the experience of the researcher that Ugandan respondents are reluctant to discuss hypothetical scenarios. This is relevant here as given the interpretation of community ‘support’ being almost exclusively of the financial variety, if non-financial support is what is being suggested under the inSCALE innovation then it will be necessary to step out in detail exactly what is being proposed. It may well be that developing a shortlist of possible types of community support including ways in which they can be introduced to the community – through the LC1 who is highly trusted and influential – need to be developed.

“If the community leaders such as church leaders, LCs and other leaders in the area suggest solving the problems VHTs have, people could listen. As for now nobody has come up with the suggestion. [she said, she cannot talk for the future when there is no one who has come up with an issue presently. She said its only when something comes up that the community will see how they can help in the future]
(Caregiver 3: 47 year old female)

If the chairman is involved then people will support everything
(Female respondent 2 from pilot FGD, Bukomero)

Section 2: community meetings that currently take place: community, supervisor and VHT perceptions

Section aim:
- Determine what currently happens in the context of community meetings
- Identify areas where inSCALE can build on and learn lessons from what currently happens in the development of community interventions

Summary of key findings

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3 These are the fieldworker's notes paraphrasing the respondent.
**Types of meetings that take place**

- Range of local meetings.
- Most common are local council (LC) meetings which are regular but also agricultural meetings, local clean up meetings and food and security meetings. Health campaign meetings such as for mosquito net distributions also mentioned.

**Who leads and participates**

- The LC chairman plays a key role in mobilising and running community meetings. When not chairing the meeting himself / herself it is run by either the chair of a specific interest group or an external party such as the police in the case of a security meeting.
- While community members typically suggested it was the LC1 who organised, LC1 respondents also credited their committee for their mobilisation role.
- Women were reportedly more commonly in attendance than men.

**Effectiveness and popularity**

- Popularity dependent on interest and relevance of issues under discussion but most critically, whether there were any free items on offer. The least popular meetings were where there was nothing being given but there were requests for ‘support’ (interpreted as payments).
- Many community respondents noted that positive change had come from community meetings but slowly. Examples given were of greater community awareness and knowledge leading to higher school enrolments and better water sanitation and hygiene behaviours.
- Supervisors suggested that community meetings had led to a greater level of engagement with issues at the community level e.g. VHT selection and resolving conflicts. Meetings also an effective forum for getting to know ones fellow community members and receiving information.

**Challenges**

- The main challenges to community meetings were mobilisation due to spread out communities (for supervisors people may not be aware of meetings) and people being too busy to make the time, frustration at the slow pace of change, low levels of perceived relevance of the topics being discussed and poor time keeping of participants. All were suggested as contributing to increasingly poor attendance over time. Community respondents suggested that meeting attendance was low while supervisors said it was around 80% of community members.
- Supervisors noted that meeting attendance was influenced by seasons – especially the rains – where people are commonly preoccupied with agriculture.

2.1 Types of meetings that take place

**Community**

There were a range of meetings described by community members that took place at community level. The most commonly cited were the local council (LC) meetings (4 caregivers, 3 male heads of household and 3 LC1s – 10/18 respondents) and then a wide range of agriculture meetings such as NAADs (2 caregivers, 2 male heads of household, 1 LC1 – 5/18), local clean up meetings, food and general security meetings and various health meetings such as for malaria campaigns (e.g. mosquito net distributions or immunisations) and other NGO driven meetings – AMREF, Malaria Consortium and World Vision all mentioned as well as UNICEF.
Issues discussed at meetings very much depended upon the meeting type. For instance LC meetings depended upon the agenda and the most pressing issues locally such as security, migration or local well maintenance for instance. Some meetings were regular such as LC meetings while others were called for specific, time bound purposes such as for establishing the best approach to clearing the local well (LC1 2).

Supervisors

Community meetings currently held in communities

Community meetings are mobilized by the LC1 Chairman and their executive held thrice a year especially when there are serious issues to discuss about like theft in the area, disease outbreak (Supervisor 3, Supervisor 6).

The Issues discussed during these community meetings include health (the way health facility staff handle of community members lack of medicine at health units), education, theft in the community, land wrangles, and disciplinary issues including warning those involved in disobedient acts (Supervisor 3).

2.2 Who leads and participates?

Community

According to community members it is the LC chairperson (LC1) who most typically organises and runs meetings. Where this is not the case it is usually the LC1 who mobilises for the meeting and the chairperson of whichever group is meeting who acts as chair. Interestingly, while care givers and male heads of households seemingly assumed it was the LC1 acting on their own the LC1s spoken to commonly credited the roles of their fellow council members – especially with regard to mobilisation. A single respondent (male head of household) noted that often meetings are chaired by external partners such as the police if it is a meeting to do with security.

With regard to meeting participation, respondents across groups suggested that while meetings were typically open to all, they often did not attract strong attendance. This was thought to be due to the issues being discussed not always being of interest or relevance – a key factor identified in the determination of whether someone attends (2 caregivers, 4 male heads of household, 2 LC1s – 8/18 participants).

“All people within the village attend, it depends, if the issue to be discussed in the meeting concerns you as an individual for example when having conflicts and wrangles in the community with some body, the best place to resolve such conflicts may be through community meetings, then you can decide to be part of that meeting”.
(Caregiver 2: 34 year old female)

Many respondents also noted that women were more likely to attend than men. For one LC1, for men to attend it was more often necessary for there to be an incentive.

“For men uh…. these attend many when they hear there is something they are going to get from these meetings. When they are promised local brew (tonto), lunch allowance or physical lunch and transport allowance they will attend in a big number.”
(LC1 2: 54 year old male)

2.3 Effectiveness, popularity and challenges

Community

While several participants suggested that community meetings were popular due to being a forum for increasing ones local knowledge (3 caregivers, 2 male heads of household, 1 LC1 – 6/18 participants).
participants), the majority of respondents chose to focus on material reward as an incentive for attending. The equation was commonly presented as simple – if participants stood to gain materially from attendance through for instance transport allowance, food and drinks, loans, agricultural hand outs such as livestock and / or seeds (typically from AADs) or mosquito nets, the meetings would be popular and well attended. If there was nothing given out they stood to be less popular with those meetings which gave nothing material but requested contributions being especially unpopular.

“The only problem that I can see is the ability to get people together because community members naturally do not like attending meetings especially those that do not give lunch and transport allowance.”
(Male head of household 4: 36 year old male)

Many respondents suggested that change had come of the back of community meetings but often slowly. Some pointed to a greater general level of knowledge which translated into a variety of benefits such as better water sanitation and hygiene and improved school enrolments. Several respondents highlighted the negative impact of the slow pace of change however (5/18 participants). The main challenge flagged was mobilisation though (10/18) followed by frustration at the poor time keeping of participants (4/18). Both were in part attributed to the scattered nature of communities meaning meeting attendance often involved considerable travel both for mobilisers and attendees.

Supervisors

The success of village meetings is gauged by

– Issues discussed are resolved

These village meetings do well because the issues are brought from the community and then issues resolved like in case one had wrangles in the community of may be on land, they are solved by these meetings, because if the community’s demands were not being attended to, then there would be very few people still going to these village meetings. These village meetings help a lot in resolving conflicts and wrangles among the community members, in case members had wrangles, they reach a compromise (Supervisor 6).

– Effective communication/ information on existing programmes and upcoming meetings is passed on to community members

The village meetings help the community to get messages directly since they participate physically in the meetings and receive information such as health related on sanitation and existing programmes in the area (Supervisor 3).

– Village meetings enabled community members to know each other

These village meetings have helped the community to know each other and pass information to others (Supervisor 3).

– Village meetings have made it possible for the community to be involved in decision making and implementation

There is now a lot of community involvement in decisions and different programmes like recently the community was involved in the VHT/ICCM selection exercise where they voted for the VHTs they wanted because during the selection exercise of the VHTs, the community was involved and sensitized about voluntary work, that it is voluntary work which was good (Supervisor 3)

The main challenges with community meetings

– Not all people attend community meetings
Not all people attend these meetings when they are called upon and this is brought about may be due to poor mobilization, but at least 80% of the community attends (Supervisor 3). Some people do not attend these meetings because they are not responsible, others may be busy and others are may be not aware of the meetings (Supervisor 6).

Community members being busy during certain months of the year like the rainy season

During the rainy periods like in March, April, May, most of the community members are always busy especially with cultivation because most of them are farmers and therefore even if they are called to participate in meetings, they cannot attend as they would be busy ... But other months like in December, January and February are better, because at that moment they are always not busy since it is a dry season (Supervisor 3).

Section 3: village committees that currently convene: community, supervisor and VHT perceptions

Section aim:
- Determine what currently happens in the context of village committees
- Identify areas where inSCALE can build on and learn lessons from what currently happens in the development of community interventions

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<td>Types of village committees that convene</td>
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<tr>
<td>- Respondents identified a range of committees operation at community level. The main ones were the local council, agricultural groups such as NAADs, small loan groups and World Vision committees commonly focused on child welfare and school attendance.</td>
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<tr>
<td>- Committees addressed issues of local relevance depending on their special interest.</td>
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<tr>
<td>Who leads, selects and participates?</td>
</tr>
<tr>
<td>- Committees typically elect a chairperson and committee. They often charge membership fees – especially those with a loan function.</td>
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<tr>
<td>- Committees are usually selected by the community (e.g. local council) through nominations and show of hands at a community meeting.</td>
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<td>- Popularity of groups linked by respondents to relevance of information they provide, their ability to produce prompt and positive local change and the likelihood of material benefit – e.g. NAADs providing livestock</td>
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<tr>
<td>- Community respondents indicated a strong dislike for requests to contribute to committees. They also indicated a lack of trust in committees handling any raised funds appropriately.</td>
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<tr>
<td>- The perception of lack of representativeness of committees can impact on their ability to inspire change in the community regardless of the level of consensus within the committee.</td>
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<tr>
<td>- Attendance of committee meetings linked to perceived effectiveness and the likelihood of benefiting personally.</td>
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<tr>
<td>- Some committees criticised for excluding poorest members of the community by charging membership and ongoing fees and thereby excluding those whose need is greatest.</td>
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<tr>
<td>- World Vision committee that sought to implement a matched funding scheme in the creation of a school found community contributions were challenging to secure.</td>
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3.1 Types of village committees

Community

There were a variety of community committees highlighted by community respondents. Women’s and youth groups were frequently mentioned as were NAADS and World Vision groups focussed on child welfare and development including school attendance. Groups with local loan functions were also apparently common. Groups tended to address issues of particular interest to them with most reporting only to their own members rather than the community at large.

VHT reported

Current community groups: VHTs reported the existence of several village ‘committees’; these were mostly focused around agriculture, income generation and saving money. The agricultural groups were most common and were largely linked to NAADS (National Agriculture Advisory Service) and included training, provision of seedlings, communal renting of land and communal hiring of a tractor.

‘In my village we have a NAADS group which normally trains the community on better farming... providing them with seedlings for planting’ (61 year old female VHT).

Only one committee ‘Gogonya group’ focused on health: ‘Four of us are VHTs and one member is from the local council.... We meet every month to plan and see how we can move in the next month as far as promoting health issues’ (27 year old female VHT).

One community had committees supported by World Vision to ensure that children attend school.

Supervisor reported

<table>
<thead>
<tr>
<th>Table xx: Types of village committees existing in the communities – according to supervisors</th>
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<tr>
<td>- Community Care Coalition (CCC) supported by World Vision</td>
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<tr>
<td>- Community Based Monitors (CBM) all supported by World Vision</td>
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<tr>
<td>- VHT committee</td>
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<tr>
<td>- Naads Group</td>
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<tr>
<td>- Mothers Union</td>
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<tr>
<td>- Youth group under the church</td>
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<tr>
<td>- Hunger project</td>
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<tr>
<td>- Health Unit Management Committee</td>
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Four of the six supervisors interviewed reported existence of village committees in the communities of VHTs they supervise. These committees were affiliates of churches, non-governmental organizations or government:

- Community Care Coalition (CCC), supported by World Vision, mainly protect children from any form of abuse by going to different homes and assessing the lives of children in those homes. They make sure that children get the basic necessities like food, shelter, clothing and education and those parents that don’t provide any of the above necessities are sensitized about children’s rights such caregivers usually reform (Supervisor 2).

- Community Based Monitors (CBM), supported by the World Vision, works mostly with orphaned and Vulnerable Children (OVCs) who are registered under World Vision programs as beneficiaries. They ensure that children are in good health and that they are going to school, that is all I know about this group (Supervisor 2).

- Naads Group: formation is to access agricultural) services. NAADS encourages the community to form groups with similar interest such as crop farmers and cattle keepers in order to benefit from their services such as getting free improved seeds and crossbreed animals such as cows and goats (Supervisor 4, female, medium community).
Members receive improved animals on a rotational basis (‘These groups requests for an enterprise say a cow or goat from NAADS once the goat or cow calves, the calf is given to the next group member. This goes on until all the members have got the enterprise (Supervisor 4, female, medium community).

The success of NAADs groups is attributed to positive results in people’s livelihoods, i.e., increased food production and improved nutrition among group members both for home consumption and sale (Supervisor 4, female, medium community). The main challenge reportedly faced by NAADs groups is the high cost of maintaining animals received, for instance, the group that received hens didn’t do well all their chickens died because NAADS gave them a breed which the group could not manage to feed and provide the costs of treating them (Supervisor 4, female, medium community).

- Mother’s Union, Church of Uganda
- Youth group under the Church of Uganda
- Basic-trained VHT Committee normally composed of 5 members. The Committee meets every month to discuss issues related to their work and then give a report to the supervisor and also share the information with iCCM trained VHTs (Supervisor 2).
- VHT committee
- Hunger Project
- Health Unit Management Committee

**Any support given to current committees**

- LC1 Executive Committee
  
  Supervisors noted that current LC1 Executive Committee receive no support from the community (Supervisor 1, Supervisor 5), but have devised ways to support itself by charging money in form of fines and commissions when a member of the village sold something like land, plots and vehicles or in some cases cattle and it requires the authorization of the committee members such as land,

  *The community members do not in any way support the committee of LCI but the members devised means of getting some money from them through fines in case of reported cases, and percentages for those who sell or buy properties such as plots, land and cattle for the deal to be authentic (Supervisor 1, male, medium community).*

  *The local council committee ... don’t get any support from the community members. The sources of income for the committee are charging some fees as a result of the services they offer to the community members say settling cases, when one is selling land, plots of land and in some cases animals especially cattle (Supervisor 5, male, large community).*

- NAADS

The NAADS groups are being supported by government in the form of improved seeds and crossbreed animals and advisory services. The communities liked this support because it has enabled them to grow high yielding crops and rear high milk yielding animals (Supervisor 4, female, medium community).

- The Health Unit Management Committee is supported by the government in terms of facilitation/ allowances especially transport refund after meetings.

- Church-founded committees are supported by religious leaders.

**Community perception of support received by committees**

When asked what the community thinks about the support the committees get, respondents said some committees have not involved all the households so they feel left out, while other people choose not to participate:
Some of these committees have not involved everybody that is why some of the members of the community feel that they are isolated like the Naads committee normally deals and gives seedlings to only members of the group, those who are non members feel isolated (Supervisor 3, Male, large community).

Those members of the community who are not part of a certain committee may not have interests and concern saying that the support and help does not concern them, like when there are health related seminars on immunization, others may say may refuse to attend them saying that is only meant for VHTs not them (Supervisor 3, Male, large community).

3.2 Effectiveness and popularity

Community

Popularity linked to perceived benefits

Local community groups were on the whole popular with community respondents based on the perceived benefits they brought to the community. For many, especially LC1 respondents, there had been noticeable positive change brought about by local village groups or committees in the form of behaviours and practices of community members. One LC1 used the example of people in the community commonly digging pit latrines in their homes at the encouragement of village committee members who make home visits.

“some changes in the community have happened though small because people are very difficult to handle but many homes now have pit latrines and generally clean environment as a result of the committee’s work through home visits”

(LC1 3: 60 year old male)

Many community respondents reported that people in the community were more knowledgeable and active after the establishment of community groups. Those involved in groups with local loan strategies saw the tangible benefits to fellow community members of these loans such as through putting a new roof on one’s home or travelling to visit one’s family. Such opportunities to address needs through revenue generation were seen as a key benefit of the groups but it was apparent that with these benefits comes heightened expectation regarding the functioning of these groups. Many community members for instance suggested that attendance at groups is frequently dependent upon the type of handouts that are given with expectations high. Once it has been established that there is little or nothing on offer – relative to expectations - and actually what is being asked for is ‘support’ – interpreted as a financial contribution - several respondents warned that declining attendance would be inevitable.

“I normally notice a major problem of people losing trust and hope in these groups especially when their expectations are not met like having improved incomes because some people join these groups with that aim and in the end they end up getting demoralized as a result of no actions resulting from the groups.”

(Caregiver 2: 34 year old female)

Challenge of asking for ‘support’

While people enjoyed being informed, trained and the knock on effects to their community as described, they strongly disliked being asked to contribute. Especially poorly viewed was the management of such funds when contributions were made – either through nepotism / tribalism or corruption. There was a seeming anticipation of mismanagement and corresponding mistrust of any groups seeking funding.

“The main problem with the local council committee is tribalism and discrimination in the way how they do their work”.

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Trust, prompt action and representativeness

Such loss of trust – described as commonly stemming from any actions from village committees not being prompt enough – presented a major challenge for committee participation and mobilisation. People seem less willing to engage with community committees as both levels of trust and the perception of their effectiveness declines. Such poor participation was identified as also commonly stemming from a perception that the groups were not representative of the community. Poor participation, trust and the perception of non-representativeness was suggested as likely to result in poor cooperation from the community to any decisions taken by that committee – no matter how unanimous the agreement inside the committee!

“On views being heard by the members and reaching a decision that is not a problem the problems usually comes when implementing what has been agreed upon in the group meeting by the members.”

A causal relationship of poor functionality, where poor trust and effectiveness leads to lack of participation and further declines in trust and effectiveness as a result is seemingly compounded by the perception of committees being non-representative as described above. Such a situation is to be avoided by the inSCALE innovation. A critical component will therefore be the representativeness of committees, the perception of this representativeness and the ability to both implement prompt and positive change and be seen to do so.

Exclusivity

A further criticism of some committees related to their perceived exclusivity. Some community participants noted that membership was for those already of means – i.e. often those who were able to make a contribution by way of membership or ongoing fees. This was particularly so for loan based schemes.

“The only problem with this Mukisa Women’s group is the fall out of its members because of the monthly contribution. When a member fails to raise that money he/she automatically drops out of the group”.

Matched funding

Matched funding endeavours such as those implemented by World Vision also seemingly had limited success in generating community contribution and ownership.

“World Vision wanted to construct staff quarters at Kamira Mpango Primary School. It entered into a partnership with the community to contribute 30% of the project cost in form of stones and bricks but the community didn’t contribute much. World Vision ended up doing most of the work”
- Determine the potential feasibility and acceptability of the village committees proposed under the inSCALE community intervention
- Determine the potential feasibility and acceptability of the community meetings proposed under the inSCALE community intervention

### Summary of key findings

#### Potential of village committees for positive impact
- Respondents recognised the potential for the VC to effectively generate community support for the VHT in the form of small financial contributions and goods and services. It will be necessary for the approach to be designed with sensitivity the resistance to financial contributions that is evident.
- Greater community understanding of the VHT role and responsibilities and VHT understanding of community issues and expectations was thought likely to increase respect and support for VHTs resulting in greater VHT motivation.
- It was felt that the VC could assist the VHT by:
  - sharing sensitisation and mobilisation duties.
  - taking on responsibility for drug collection and storage and as a result share some of the burden of community expectation and disappointment around drug supply.
  - act as a sounding board for VHTs between supervision visits and also advocate for VHT needs – especially the need for drugs – to the health facility
  - acting as a monitoring mechanism to which VHTs would feel a level of accountability.

#### inSCALE components
- **Component 1 – raising awareness in the community of VHT work**
  - Had spontaneously emerged as an approach from community respondents.
  - Challenges anticipated with lack of VHT credibility due to drug stock outs and the community becoming jaded over time with repetition of messaging
  - Suggested using radio and appropriate training in mobilisation for VHTs
- **Component 2 – working with VHTs to review their records and understand their challenges**
  - Was not suggested by participants but upon reflection was considered of value. By reviewing records it was suggested that the VC could help identify and solve challenges, monitor the VHT and to check data before submission.
  - Supervisors felt it could assist VHTs between supervision visits
  - The risk of the activity being viewed as a performance assessment was raised by respondents from all groups who advised that this perception could lead to a lack of cooperation from VHTs
  - Concerns were raised as to the VCs ability to navigate the VHT records. Training was suggested with some expressing concerns about the feasibility of VC members acquiring the necessary skills. Some respondents felt review of records should remain a technical task for the supervisor.
- **Component 3 – solving VHT problems at the community level and communicating with**
supervisors about broader problems

- Problem solving was spontaneously mentioned by community members and supervisors as a means of reducing VHT workload and improving communications between the community and the health facility. A clear role definition for both supervisor and VC was advised
- Several key challenges were raised:
  - It was not considered feasible for the VC to lobby for support (commonly assumed to be financial) when they don’t themselves receive any according to community respondents. The community was considered likely to be unwilling to contribute anyway and be of the view that ‘volunteers’ should receive support from their programs (i.e. government or NGOs)
  - Across respondent groups it was considered unlikely the VC would be able to help solve problems – especially those related to community adherence. A more worthwhile function was considered to be lobbying for change to higher authorities. Such an approach was considered to potentially have more traction than a lone VHT voice
  - Community respondents often assumed that prompt reporting of problems would lead to prompt resolutions. If solutions are not forthcoming VHTs and community members are likely to become demoralised.

- **Component 4 – arranging village meetings to discuss VHT work and develop plans to solve VHT problems**
  - While community meetings were considered a valuable and worthwhile forum for xx doubts were raised as to both the will and ability of community members to solve VHT problems. Some VHTs insisted that supervisors should continue to provide technical support
  - There was little confidence around the sustainability of community meetings despite initial curiosity and enthusiasm driving attendance. This was due to:
    - Meetings being time consuming, expensive and impractical – due to distance and geography – to organise
    - Needs to be a varied agenda and tangible and prompt benefits to participants to sustain interest of busy community members
    - At present content focuses on problems rather than benefits to community members

Village committee participation – making them work

- A formal structure to the VC was recommended across respondent groups with a chairperson, vice chairperson, secretary and treasurer
- Involvement of the LC1 was considered critical to success of the VC either by assisting with mobilisation or as a full member. Some supervisors warned that LC1s were already stretched so should not be called on for VC membership
- Other suggestions were that:
  - the existing LC structure should be utilised instead of establishing a new mechanism (community respondents)
  - two members of the VC should participate in every other community group to raise awareness of the VHT program (community respondents)
  - VC members be incentivised with transport allowances and / or lunch and sodas (all
**Interacting with supervisors**

- Supervisors suggested that the VC should interact with supervisors face to face by coming to VC meetings, VC members visiting the HF or creating a special meeting. Creating a report for supervisors to use for advocacy was a popular suggestion.
- VHTs stressed the importance of being kept informed of ongoing communications between the VC and supervisors.
- Supervisors advised that when presented with problems by the VC such as drug stock outs they would forward the concern to Malaria Consortium or the district malaria focal person and explain to the committee the cause of the drug stock out.
- Supervisors also suggested they could mentor VC members and provide them with technical assistance. They suggested they should be involved in VC and community meetings to raise awareness and build confidence but that they would need advance warning.
- Supervisors envisaged the key risks to be:
  - Rising community expectations that supervisors will solve all VHT problems including drug stock outs.
  - Committee members expecting sitting allowance and transport refund for attending committee meetings from the supervisor.
  - The community raising complaints about the health facility.

**Village meetings – making them work**

- It was universally agreed that it should be the VC chairperson and their vice chair person who organise meetings and that they should be open to all.
- Key features of successful meetings were seen to be:
  - A strong chairperson who has rules and procedures for who talks.
  - Extensive advance mobilisation – for some it was critical to involve the LC1 while others suggested supervisors – with a meeting agenda made available ahead of time.
  - Providing refreshments for attendees as an incentive to attend – seen as critical by many respondents.
  - Keeping meetings brief and locally relevant.
  - Ensure that actions from meetings are followed and people see the impact.

### 4.1 Potential of village committees for positive impact

All respondents were of the belief that village committees (VC) would be beneficial to VHTs. Many of the key themes from community interviews focused around the impact of a VC raising awareness.
about VHTs and their work. Key themes from VHT interviews focused more on the committee easing VHT workload. The following ideas for the role of a VC were given:

- Sensitize the community to increase levels of community support for VHTs (all groups)
- Ease VHT workload by conducting sensitization and mobilization activities (all respondent groups)
- Finding solutions to VHT problems and advocating for VHT needs (community and supervisors)
- Monitor VHTs and increase their accountability (community and supervisors)

4.1.1 Increase levels of community support for VHTs:

**Financial support:** Support was commonly interpreted as providing goods and services (most typically assistance with transport) in the context of questions around the VC. In other areas of questioning, and particularly for the community participants (both interview and group work), support was commonly viewed as a financial contribution to which there was resistance (see section 1.3). The majority of community members and supervisors nevertheless felt that a committee would, if handled appropriately, increase levels of community ‘support’ and that this ‘support’ would motivate VHTs.

‘These VHTs need some motivation like some gifts, for example soap, sugar which can be given by the community so that they are motivated’ (Supervisor 3, male large community).

Community respondents reported that the provision of ‘support’ would be facilitated by increasing community understanding of VHT work and challenges. They felt that a VC could help generate ‘support’ from the community simply by raising awareness of the VHTs work. Supervisors suggested more formal ways of ensuring support:

‘This committee will help to mobilize the community so that they can motivate the VHT like deciding that each household should give something to the VHT in form of a bylaw passed’ (Supervisor 3, male large community).

Raising awareness that the VHTs need support was considered particularly important as many community members assume that the VHTs do not need support as they are volunteers and supported by their program or the government. As has been seen, raising support may not guarantee support as a section of respondents were of the view that as volunteers VHTs should have understood the consequences of putting themselves forward for the role. Appropriately designing and introducing the VC mechanism is clearly a fundamental concern for the inSCALE intervention.

**Community sensitization:** It was felt that if the community had a greater awareness of what VHTs do this would lead to a better understanding of when to engage with VHTs and would also make the community more appreciative as they would see that VHTs do good work. The importance of addressing common misconceptions such as the age of children VHTs treat, drug stock outs and whether they are paid or not was also considered key as these often led to conflict:

‘The committee will sensitise the community members ... and this will help in changing the mind of those who have been despising the work of the VHTs and enable the community members to appreciate and acknowledge the relevance of the services rendered by the VHT’ (Supervisor 5, male, large community).

‘They sometimes talk rudely to these VHTs so I think in case they are sensitized, they would understand how to maybe handle VHTs very well and make the VHTs work easier’ (Supervisor 6, female, medium community).
All respondent groups felt that increasing community understanding of VHT would lead to increased respect and appreciation from the community and commitment by the VHT:

‘You see if there are many people talking well about the work I do... this will make me more known and more respected... this will make them appreciate our work’ (30 year old female VHT).

‘If the VHT see that the people s/he serves are concerned they will be more committed and love their work more unlike today when all the time they are complaining because of lack of this assistance from the community’ (Supervisor 1, male, medium-sized community).

Some community members suggested that the function of the VC to sensitise should not be one way only. If the VC could engage effectively with the community and understand their issues and expectations and feed them back to the VHT, then greater community support was considered possible:

‘The committee can work together with the community to bridge the gap between the VHTs and the community. For example this can be done by female committee members approaching fellow female community members so that they can openly share their problems and then the committee can explain to the VHTs’ (Caregiver 1: 30 year old male)

4.1.2 Easing VHT workload:

Easing VHT workload was most often described in relation to the VC taking on the role of sensitising and mobilising the community. This was commonly mentioned by the VHTs themselves who also felt the VC could provide practical support such as collecting drugs. Involving the VC in sensitization and mobilization activities was also reported as having the added advantage of increasing the likelihood that families would follow advice on hygiene and other preventive behaviours.

‘They [committee] can help me in visiting homes... if we are many it will take a shorter time........ if you tell people to improve their health at home on your own they don’t take it serious but if we are many people talking about it they will accept’ (27 year old female VHT).

Another task that one male head of household suggested the VC could take on was being in charge of drug storage. Such an approach may alleviate some of the unpopularity VHTs reportedly endure due to unreliable drug supply. It may even result in greater community appreciation for the health system challenges faced when the VC, after taking the issue up with the local health facility, reports the current status back to the community.

‘I think these Village Committee members should be given extra responsibilities of keeping medicines, that responsibility of keeping medicines should not be left to VHTs alone because at times there some VHTs who little spaces in their homes, may be they sleeping in a one bed roomed house’ (Male head of household 3: 37 year old male)

4.1.3 Finding solutions and advocating for VHT needs:

A potential suggested role of the VC was offering advice when VHTs had challenges, liaising with the LC1 to find local solutions to challenges and advocating for VHT needs at the health facility.

‘I can easily explain to the members the challenges I experience and would also get their own views and ideas and together we can get a way forward..... it creates a level of understanding and togetherness (61 year old female VHT).

‘For example when some community members prefer to get treatment from one VHT and not another, or in situations where pregnant women do not want to be visited by these VHTs, such issues can be handled by the committee who would take an extra effort to sensitize these pregnant women; you know even these VHTs are supposed to monitor
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pregnant women but others refuse to be reviewed (Supervisor 6, female, medium community).

Supervisors and VHTs pointed out that this role would be useful given the time between supervision contacts:

‘All the VHTs have problems ... by the time they reach us supervisors, it is too late but if the committee is there ..., it will help. The VHTs need back up of this committee to perform well their work’ (Supervisor 5, male, large community).

The suggestion that VCs could take VHT challenges to the health facility came mainly from community respondents and was made in the context of drug stock outs.

4.1.4 Monitoring VHT activities:

It was suggested by the community and supervisors respondents that the VC could act as a monitoring mechanism to which VHTs would feel a level of accountability.

‘Once these Village committees are in place, the VHTs will be forced to work harder as they would think this committee is partly there to monitor their activities ... The community would gain confidence in the VHT work because they would be seeing a bigger team assisting the VHT, so they will begin to trust the VHT’S work’ (Caregiver 6: 37 year old female)

4.2 The inScale components

The potential role of a VC was described to respondents who were asked to comment on potential benefits and challenges of each component. Respondents were told that inSCALE is thinking of helping communities select a group of people from their community who would meet every three months to support VHTs in their work. This village committee, respondents were told, will support VHTs in their work by:

1. Raising awareness in the community of VHT work,
2. Working with VHTs to review their records and understand their challenges,
3. Solving VHT problems at the community level and communicating with supervisors about broader problems,
4. Arranging village meetings to discuss VHT work and to develop plans to solve VHT problems

Overall community members tended to be optimistic about the successful implementation of the key components of the VC over time as long as key requirements were fulfilled (see 4.3) whilst the VHTs and supervisors were more cautious. It was noted that all components would be challenging to implement and maintain should there be (or continue to be in some cases) drug stock outs.

4.2.1 Component 1 - Raising awareness in the community of VHT work:

As described in section 4.1.1 this activity was suggested spontaneously and was believed to have many potential benefits.

Despite the perceived potential benefits of raising awareness some respondents felt that as an approach it was likely to be challenging due to the community being difficult to convince, especially as VHTs lack credibility in some communities due to drug stock outs:

‘I think the community will be able to work and support VHTs if they are sensitized about the work of VHTs but all I know is that it will not be easy because our community has a poor attitude towards VHTs since they have not been giving them drugs for a long time’ (LC1 4: 52 year old male)
It was also felt that over time the committee and the community may become jaded by repeated messages with the impact becoming diluted. Utilising a variety of methods was suggested as a solution with radio in particular put forward.

‘At least there should be different forms of displaying information and increasing awareness such as charts displayed, radio announcements and programmes like say twice a week on radio’(Caregiver 6: 37 year old female)

‘After some time both the committee and the community may think that everybody now knows and there is no need to continue raising awareness’ (Supervisor 5, male, large community).

The importance of training, which was mentioned several times in relation to the various possible roles of the committee, was stressed if the committee is to do a good job sensitizing the community

‘Without training the committee may not know what awareness to rise in the community.. thus they need to be trained on what the VHT does and grasp the idea very well to be able to educate other community members about the VHT’ (Supervisor 5, male, large community).

4.2.2 Component 2 - Working with VHTs to review their records and understand their challenges

This was not mentioned spontaneously by any groups as a potential VC activity but was thought to be potentially beneficial on probing. It was felt that by reviewing records the VC could help identify and solve challenges, monitor the VHT and to check data before submission.

‘There are still so many VHTs who find trouble in filling the register and keep making mistake after another. So the presence of this committee will help a lot in that area’ (Supervisor 5, male, large community).

‘The information got from the register ... will inform the committee on how to handle the challenges of the VHTs. For example through the review of the records it could be found out that diarrhea cases are many and questions asked why that is so and solutions be found to solve such a problem which has been identified through reviewing the VHTs records (Supervisor 5, male, large community).

Supervisors felt that this component could be beneficial given that it can take them a long time to get to a VHT for supervision:

This will help the committee to be able to monitor and see how each VHT is working and this will encourage each VHT to work harder because us supervisors... our overall supervisors take long to supervise’ (Supervisor 3, male, large community).

Respondents warned that if handled poorly such an activity could be viewed negatively by VHTs as a performance assessment rather than adding anything to their work. If this occurred it could lead to a lack of cooperation from the VHTs

‘VHTs will feel that by the committee reviewing their records, they would be assessing their performance and some of them will not feel comfortable with that idea since it will not be adding anything good to their work..... the VHT should also be assured that the review is not for purposes of checking performance but rather identifying problems and possible solutions to those problems’ (Male head of household 4: 36 year old male)

‘If the committee members start blaming me and exposing my mistakes to the whole community instead of correcting me.... If the committee do not appreciate the work I am doing... this will demoralize me so much’(27 year old female VHT).

‘I foresee a situation where the committee may face a challenge of lack of cooperation from the VHT; the VHT may fail to cooperate and be difficult to manage. This will automatically make the work of the committee difficult’ (Supervisor 5, male, large community).
There was also a high level of concern that the committee would not be able to understand the records, especially in areas of low literacy, and that even where the committee were literate extensive training would be required. Some VHTs and supervisors felt that checking of records is a technical task best left for the supervisor:

‘Some committee members may not understand my reports because they are not trained... they will just look at the report and not make sense out of it..... (27 year old female VHT).

‘These people don’t know the language we use while doing our work... unless they are trained very well I think this [reviewing records] should be left for the supervisor’ (30 year old male VHT).

‘They should handle information like number of drugs given out, balances of drugs left, these can be handled by them [committee] and technical terms handled by supervisors (Supervisor 3, male, large community).

The feasibility of training committee members was questioned by supervisors

‘These [records] are a bit technical which could not be known by some members of the committee and it is not easy to train the committee members to have the same training like the one we gave VHT, it would be like forming another set of VHTs’ (Supervisor 3, male, large community).

4.2.3 Component 3 - Solving VHT problems at the community level and communicating with supervisors about broader problems

Problem solving was spontaneously mentioned as a potential role of a VC by community members and supervisors. It was welcomed by supervisors as a means of reducing their workload and improving communication between the community and the facility. The need for clear role definition between the committee and the supervisor was stressed:

‘My duties and responsibilities are reduced because the committee will handle most of my responsibilities ... However, both the committee and VHTs should clearly know their specific roles and duties to avoid contradictions like when a VHT goes to the supervisor and makes contradicting statements and also the committee member does the same’ (Supervisor 3, male, large community).

Many problems related to this component were raised. These focused around the assumed financial nature of problem solving and the ability of the VC to solve more general problems.

Financial problem solving: Despite suggesting this as a potential role of the VC (see 4.1.1) some community respondents felt that the VC lobbying for community financial support would not be appropriate or effective as the VC members will not receive financial support themselves. One LC1 suggested in such cases committee members may be tempted to take some of the funds raised for the VHTs. The perception here is that committee members will need to feel they are benefitting before they are likely to participate in, not to mention drive, a campaign to provide support to VHTs.

‘It will be difficult for the committee members to look for support for the VHTs when for them they are getting nothing. They will be tempted to share on the support solicited for the VHTs from the community ... To avoid that, the committee members should also be considered for some support say when the VHT is given 15,000 shillings each member should also be given at least 5000 shillings on a monthly basis. If this is not done the work of the committee and the VHT will be spoilt, that is what I foresee in future’ (LC1 3: 60 year old male)

Many respondents felt that community members would be unlikely to be willing or able to make contributions.

‘That is very impossible, I tell you the truth and I dare you try it and you will see the results. Why I say that is because the people are very poor in that they do not have their own food, soap or
Some respondents suggested that such ‘volunteers’ would never gain community ‘support’ as people feel these volunteers should be provided for by their programs anyway.

The ability of VCs to problem solve: Both VHTS and supervisors raised concerns that the committee (and the community) would be unable to solve VHT problems - especially those relating to community adherence to hygiene and sanitation advice.

‘To me the community and the committee are unable to solve VHT problems because people don’t have money to solve these problems... the only problem they can solve is the sensitization and mobilization’ (38 year old female VHT)

‘The committee can solve problems related to some members in the community refusing to build latrines or failing to use mosquito nets ... but those will be the very few and simple problems because most of the problems faced by VHTs are related to facilitation’ (Supervisor 2).

Advocating for identified problems to be solved at higher levels was considered to be a more worthwhile function of the VC, especially as it was felt that problems brought to higher levels by a larger group would be more likely to be solved than those bought by the VHT alone.

‘The committee and the community can’t handle technical issues and drug stock out they can only note it and forward it to the VHT supervisor’ (Supervisor 4, female, medium community).

‘We can together write a report and many people can sign it... the supervisor will see the gravity of my problem and take action’ (27 year old female VHT).

Reporting problems to the supervisor was seemingly discussed with the assumption that supervisors would be able to do something about this challenge once aware of it. The risk is that an intervention which speeds communication is likely to be accompanied by an expectation at community and VHT level that the problem will be promptly acted upon and solved. It was reported that problems being reported but not being solved would be demoralizing:

‘I will be difficult to keep going if the forwarded problem to the supervisor is not responded to in time or no feedback is given at all. If this happens for a long time the committee members will lose morale ...they may even stop solving those which they can because even the supervisor is not solving his part’ (Supervisor 5, male, large community).

4.2.4 Component 4 - Arranging village meetings to discuss VHT work and to develop plans to solve VHT problems

The usefulness and value of community meetings was advocated by some in that they are a good arena for informing the community about VHT Work, solutions are more likely to be found when many people are discussing a problem and because they would provide an arena for VHTs and the community to air any grievances.

The ability/will to problem solve: As documented above respondents felt that community members would be unlikely to provide any financial contribution to VHTs and some respondents felt that they would be unwilling to problem solve at all as the VHT program is perceived as a government program that provides free health care.

‘These services when they were introduced in the communities nothing was mentioned of supporting them(VHTs) they were looked at (by the community)as free services and which is voluntary. The community expected whoever employed these VHTs could support and even motivate them. (Caregiver 3:37 year old female)
‘The community expects the entire VHT problems to be solved by those who give the VHT drugs such as Malaria Consortium. People in the community are not interested in solving problems’ (Supervisor 4, medium community).

‘The community cannot solve my problems they think it is the government’s duty to provide health care... and for me I accepted to volunteer.... They will say... why did I accept if I couldn’t do it...... they could even ask what the government will do’ (40 year old male VHT).

Even if communities are willing to problem solve several respondents felt that the community would not have the power or skills to solve broader problems and VHTs and their supervisors stressed that the supervisor must continue to provide technical support:

‘The committee could do the mobilization and sensitization part whilst the supervisor could support me in the technical part’ (38 year old female VHT).

The feasibility of arranging meetings: Overall there was not a great deal of optimism that meetings would be functional over the long term (NB: refer to the pile sorting activity report for MoH reservations about the implementation and maintenance of community meetings).

Respondents felt that it is time consuming and expensive to mobilise the community meetings and that whilst curiosity would ensure at least the early meetings would be well attended enthusiasm would most likely wane over time because of an absence of tangible benefits, a lack of time, boredom or because the purpose of the meeting was around problem solving rather than general health which would create more interest:

‘The community will start fearing to come for these village meetings thinking they are invited to discuss the VHT problems and finding solutions’ (Male head of household 4: 36 year old male)

‘The challenge is inviting people ...and them not coming because they do not want to leave their work... people only want to go to meetings where they sign at the end and get money (27 year old female VHT).

‘Community members generally don’t like meetings... they only want to attend where they are given transport allowance and lunch’ (30 year old male VHT).

‘People in the community usually are easier to mobilize ... for health related issues.... When it comes to mobilizing them for facilitation ... and problem solving then the community will not come’ (38 year old female VHT).

Other challenges related to community meetings that were identified was that distances make mobilization a problem in some areas, that the community would get bored if the agenda is the same for each meeting and if they saw no benefit or change from the meetings.

4.3 Village committee participation – making it work

4.3.1 General structure:

There were several suggestions put forward for the best way to structure community meetings. Most respondents suggested a formal structure with a chairperson, vice chairperson, secretary and treasurer. The suggestion was made by one LC1 that the existing LC committee should be utilised for the work of the VHT supporting VC as they are already established and understand their roles. In order to avoid setting up a parallel system and competition for the best members, perhaps this option should be explored. It was also suggested that two members of the VC attend every other community gathering in order to increase awareness of the work of the VHT.
I think it would be very important for the committee to select two people amongst them who will make sure that they attend every community meeting so that they can have consistent information sharing with the community about VHTs. People will learn more about their work and make plans of solving some of their problems.”
(Caregiver 5: 32 year old female)

Several factors were mentioned that would improve the likelihood that a VC would function effectively:

- Providing an incentive to members
- Not taking up too much time
- Training members and ensuring they have a good understanding of their role
- Selecting members well
- Involving people in authority

Providing an incentive
The most frequently mentioned challenge related to a VC was that the committee would not be sustainable as it is voluntary and will have few benefits for the members (5 VHTs). It was felt that initial curiosity would ensure early participation but that this would wane over time – especially if it became clear there would be no material incentive to attend such as transport facilitation, food and sodas or commodities. These are provided to other existing committees.

‘The committee members may ask what they are going to get out of doing that…. They are not mandates to supervise us and after some time one by one they will pull out and end up abandoning us’ (27 year old female VHT).

It was thus suggested that committee members should receive something for their work, this could be in the form of transport or lunch allowance, certificates or items for mobilization:

‘If the committee is given things that will ease their work such as t-shirts, raincoats or umbrellas, gumboots and bicycles. This will motivate them to work hard and serve the community’ (LC1 4: 52 year old male)

“If the committee and VHTs are motivated by providing transport and lunch allowance or even giving them certificates or any other motivator, then they will work …. but if they are not given anything, then I think they will get to a time when they will feel exhausted and demoralized to continue providing the service to the community”
(Caregiver 5: 32 year old female)

Not taking up to much time
As the work is voluntary it was felt that the role could not be too demanding, it was suggested for example that VC meetings could occur every three months so as not to overburden the committee members. It was also suggested that an agenda be circulated ahead of the meeting so each VC member can assess the relevance of the meeting to them.

Training committee members and ensuring they understand their roles
Training was discussed as important to ensure the VC can conduct tasks such as record reviews and sensitizing the community about VHT work.

‘The people to be selected on the committee should be equipped with some basic skills in ICCM and general knowledge about the VHT policy or strategy as stated by the Government of Uganda, and role of VHTs in the community’ (Supervisor 1, male, medium community

If VC members are not trained it was felt they could actually cause harm to the VHT program, especially if they give negative feedback to VHTs:
‘If the committee members are not well trained and take themselves as fault finders to the VHT it may be a problem to some VHT and some may get tired and give up their roles as volunteers which will affect their work as VHTs. (Supervisor 1, male, medium community).

The need for VC members to understand their roles was also stressed, for example while recruiting potential members need to be informed in advance that they are going to be working as volunteers and this will prevent them from running away or refusing to attend the meetings.

‘For the committee meetings to be attended always, the members need to be informed right from start that they are working as volunteers and are expected to attend those meetings without fail and if one sees that he/she cannot manage be allowed to decline the offer right away’ (Supervisor 1, male, medium community).

The supervision of the committee was mentioned by few participants.

Selecting the committee well
Selecting VC members who are respected by the community and who have appropriate personalities and skills was reported as key for the committee to be sustainable and effective. As described in 4.4.3 it was also reported that the roles and voluntary nature of the job should be made clear so only those willing to do the work are selected.

Most respondents felt that the committee should be selected by the community in a similar way as the VHTs were selected (through sensitization and a village meeting and by setting criteria), the involvement of the LC in this process was stressed. Some participants stressed that committee members should represent the diverse communities they serve. If they do not have representation of all these groups it was considered likely people would not view the committee as fair, balanced and representative.

When describing the preferred characteristics of committee members personal characteristics such as being well behaved, respected, committed, responsible and trusted were mentioned by all respondents as was the need for a gender mix. Other frequently mentioned characteristics were being educated and able to read and write, being present/residing in the community and being approachable and friendly.

‘Obviously they will come because they will be given individual responsibilities and to ensure that this happens only those who are seen to be responsible and active will be included in the committee”. (Caregiver 4: 48 year old female)

‘If the committee is selected with members that are fit for the job then everything will move on fine but if they are chosen without any criteria there might be some problems’ (30 year old male VHT).

Reasons commonly given for the need for a gender balance were that women had better insight into the needs of children while men were more respected in the community.

Some also suggested a mix of abilities and experience so the committee would be desirable arguing that if there was diversity in representation on the committee then it would be easier for the committee to mobilise diverse groups.

In terms of other representation on the committee, respondents had many ideas. For some age was relevant as older people were considered more difficult to corrupt and therefore should be targeted for inclusion. Others felt that the LC, as a person of influence should be on the committee while one
respondent felt the LC1 was too busy. The most common response was that committee membership should be open to all (7/18).

In terms of those respondents felt should be excluded from participation on the VC there were once again a range of views. Drunkards, those without children, old people or children, those who are overly money focused those with ‘hot tempers’, and corrupt people, thieves and adulterers were all nominated.

**Involving people in authority**

It was felt that if the committee was not respected it would not be successful, many participants suggested that the LC1 should be involved in, or be a member of, the committee

> ‘The committee will face challenges if it gets in bad books with the chairperson LCI who is the political head of the village’ (Supervisor 1, male, medium community).

> ‘Unless the committee involves the LC1 chairman because community members respect him than committees. Otherwise if the chairman is not the lead mobilizer, people will ask who the committee is and even the chairman will feel disrespected if meetings go on without his knowledge’ (Supervisor 2, female, large community).

One supervisor felt strongly that the LC should not be on the committee as they are in charge of monitoring all committees in the village.

The VHTs felt that they would need to be a member of the committee so that they can share information, exchange ideas and describe challenge and so they know what is going on and are not caught off guard. ‘I know more about the project than any of them... beside I was trained in this project’ (40 year old male VHT). Whilst one supervisor suggested that the VHT attends some but not all meetings so VC members can discuss privately how best to advice the VHTs.

### 4.3 Interacting with supervisors:

**How should the committee interact with supervisors:** VHTs and supervisors felt any liaison with supervisors about problems should be done face to face either by inviting the supervisor to a committee meeting, visiting the facility or by organizing a special meeting. Two VHTs and 3/6 supervisors felt a written document should be given to the supervisor to ensure that all views were captured and so information could be forwarded to higher levels

> ‘A report detailing the challenges of the VHT and recommendations so that I can act on what I can and forward those I can’t to other concerned officials who are above me like the health facility in-charge, Malaria Consortium staff and the district officials in charge of malaria issues’ (Supervisor 1).

The importance of informing the VHTs about the content of any meetings with the supervisor was stressed:

> ‘It would be important that they first discuss it with me before going there [to see the supervisor] so at least I know what is being done’ (61 year old female VHT).

**How supervisors would respond the problems bought to them by the committee:** When asked what they would do if the committee came to them with a problem they could not solve such as drug stock outs the supervisors reported that they would forward the concern to Malaria consortium or the district malaria focal person and explain to the committee the cause of the drug stock out.
The role of the supervisor in the committees and village meetings: Other roles that the supervisors envisaged regarding the VC was providing technical assistance, oversight and building capacity of committee members.

‘I can support the committee to come up with good plans and possible solutions that can help in solving VHTs problems, giving feedback for any inquiries they have made to me’ (Supervisor 5, male, large community).

Most supervisors suggested that they should attend committee and village meetings to provide clarification on any issues, increase attendance and community confidence in the VHTs, improve relationships and to be involved in discussions about VHT problems. Supervisors reported that they would need to be informed in advance so they could plan ahead.

‘Attending committee meetings will help me to give some new information to the VHTs and committee concerning issues like drug stock outs, referral forms and any other problem that they will have presented in their reports. I will also be in position to see where things are moving slowly and give them advise or find means of making them active once again’ (Supervisor 2, female, large community).

Attending these meeting improves my relationship between the VHT, supervisor, community and the committee. These interaction meetings could point out mistakes I make and the ones the VHT make.... I could help the committee make plans to solve the problems the VHT has and help them make plans to solve them. As a Supervisor I could make awareness of the VHT work know more. As I don’t stay in the village, people could listen as I am a new face’ (Supervisor 4, female, medium community).

‘It would bring a sense of confidence among the members of the community especially if they see a staff from the health facility talking to the VHT’ (Supervisor 3, male, large community).

Despite their desire to attend the committee and village meetings most supervisors envisaged some problems:
- Rising community expectations that supervisors will solve all VHT problems including drug stock outs
- Committee members expecting sitting allowance and transport refund for attending committee meetings from the supervisor
- The community raising complaints about the health facility

4.4 The village meetings - making them work:

General structure

Several respondents suggested that the VC chairperson and their deputy were best placed to organise the meeting attendance and chair. It was universally felt that the meetings should be open to all community members.

Several factors were mentioned that would improve the likelihood that a meeting would function effectively:
- A good chair person who sets rules for who talks
- Extensive advanced mobilization
- Incentives
- Not taking up too much time
- Seeing an impact

A good chair person
Many felt a strong chairperson was required to ensure the meetings were orderly and all got their chance to speak, for example by setting rules such as a person needing to raise their hand to speak. The importance of an unbiased chair who allows all members to equally participate was stressed.

**Extensive advanced mobilization**

The importance of intensive mobilization, for example through door to door visits, was stressed. It was also suggested that the LC1 should be utilised to mobilise the community up to three days ahead of the meetings. The LC1 was felt to have the power to ensure the meeting is taken seriously and attended and that if they were not involved they could disrupt the process.

‘it will hard to for the committee to call for a community meeting and people turn up ....community members respect more the chairman than any committee. The chairman will also feel like he has been degraded if the committee does not involve him’ (Supervisor 2, female, large community).

It was also suggested that supervisors could play a role in mobilizing and organizing the meetings to increase the likelihood of attendance:

‘The supervisors should organize the community meeting... this will make people believe in them [committee] and give them more respect (27 year old female VHT).

To be successful mobilization would need to include explanations of what the meeting is about. The need to plan how the meetings will be presented to the community and to involve the LC1 was also stressed. It was felt by some that an agenda would increase the likelihood of attendance

‘What is important is the way the explanations are made, the schedule, time of the meeting among others so that they are aware’ (Supervisor 3, male, large community).

‘For the village meetings to succeed the agenda presented to them matters a lot.....If possible the proposed committee members must first meet with the LC1 committee members and agree on what together they should present to the community members’ (Supervisor 1, male, medium community).

In communities where there is a divide between community members the need for community mobilization and even separate meetings for the different groups was reported as important

‘The committee could first concentrate on sensitizing the community and then think of making plans and solving VHT problems. Otherwise this community is hard and divided between herders and farmers, it is known in the community that bringing these two groups together ... is hard. Herders despise the farmers and vice versa unless each of the group is met separately’ (Supervisor 4, medium community).

**Incentives**

Only one respondent suggested refreshments should be available though several respondents were quite vocal that community members would be unlikely to attend the meeting without an incentive. One respondent proposed that NGOs make funds available for meeting attendance allowances.

**Not taking up too much time**

The timing and length of the meeting was considered important. For example the meeting should not be on a market day and Sunday was suggested as the best day

‘There are some days of the week that should be considered when organizing community meetings, ........ the best day of organizing a communal meeting should be a Sunday because households are distant from each other but on a Sunday people gather together for prayers so it becomes easy to inform them that after prayers (Supervisor 6, female, medium community).
It was also felt that the meetings should not run for too long, and take place infrequently (monthly or only when there was a specific and relevant need). Important issues should be raised at the beginning otherwise people will start leaving the meeting before it comes to an end.

‘People would be able to discuss, make plans and solve VHT problems especially if the meetings take a short time because people do not want to take long in meetings because they complain that they have a lot of other responsibilities to do’ (Supervisor 3, male, large community).

One respondent felt it was important meetings not be held at the health facility as it would disrupt the work taking place there, another suggested locations should be rotated to ensure a different mix of attendees at each meeting.

Seeing an impact

The success of the meetings was linked the community perception of the program as being important and working well:

‘If people see that the programs are working very well, they will come for the meetings but if the committee is not active, people will only attend the first meetings and as time goes on they will stop attending the meeting’ LC1 6:32 year old male)

Section 5: current data use practices and preferences. Source – supervisor interviews.

Section aim:
- To understand current data use by VHT supervisors
- To understand the facilitators and barriers of data use methods for supervisors that may potentially be implemented under the inSCALE community intervention

Summary of key findings

<table>
<thead>
<tr>
<th>Presentation and use of data - VHTs</th>
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<tbody>
<tr>
<td>VHTs suggested data to be presented to the community related to their work should focus on the number of children who fall sick and have been treated to highlight both the need for preventive behaviours and the good work VHTs do.</td>
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<tr>
<td>Some VHTs suggested verbal summaries would be better for community members while some suggested graphical aids – pasted on the wall – could be beneficial. The need to work in the local language was highlighted.</td>
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<td>VHTs mostly felt it should be them to create and present data summaries to the community and suggested if someone else were to do it they would feel undermined.</td>
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<tr>
<td>Some VHTs felt supervisors should be involved in presenting data to the community as it would assist in establishing credibility.</td>
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<td>VHTs felt the data to be presented</td>
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<th>Most useful information to present to village committees and the community - supervisors</th>
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<tr>
<td>Supervisors felt that the most useful information for the village committee to be presented with related to the concept of iCCM, the basic facts about malaria, how the committee members should relate with the VHT, causes of illnesses among children – for the Committee to pass on to the community and the community in turn to act to reduce these illnesses, disease prevention of in the community, the number of children seeking treatment from the VHT, the number of cases followed up by VHTs of those treated and the quantity of drugs received, stored and dispensed by the VHTs.</td>
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<tr>
<td>Supervisors felt that the most useful information for the community to be presented with related to diseases treated by VHTs, for instance, showing the number of diseases</td>
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(malaria cases, measles, cholera) handled in a week, names of treated children by VHT per week to build community confidence in VHTs the age bracket of children treated by VHTs, signs of different illnesses among children, disease prevention in the community especially among children, the number of children treated by VHT (per month) to help the community to know the treatment patterns of a VHT, information on amount of medicines used, medicines available, the number of children referred by VHT, the number of children seeking treatment from VHT, the number of cases followed up VHTs of those treated, the quantity of drugs the VHT has remaining and information related to the role of the VHT.

**Who should develop and present the data - supervisors**

Supervisors had conflicting views on who was best placed to produce and present the data to VCs and the community – the supervisors themselves or the VHT. Those who argued for the supervisors suggested that:

- they could provide more technical information than VHTs if required, they have experience in collecting and presenting data and summarise all the data received from VHTs anyway. The identified risk with VHTs was that they may exaggerate the figures relating to the number of children treated. It was also suggested there would be no cross check on VHT data should the supervisors not be involved.

Those who argued for the VHTs suggested that:

- they are the source of the data; they in the best position to talk about any successes or challenges as they live in the community they serve and they would be able to provide a firsthand account. They also suggested that the supervisors were too busy.

3/6 supervisors suggested that a member or members of the VC should present data when the supervisor was not available to do so. They argued this would assist with community exposure and understanding of both their role and that of the VHT.

**How to best present data - supervisors**

- 4/6 supervisors interviewed argued that data should be presented verbally due to the low levels of literacy in the community. They added that the risk with visual aids was they may intimidate community members if pitched at an inappropriate educational level.

- 2/6 supervisors suggested the use of flip charts to present simple graphs could be meaningful for the community if accompanied by an adequate verbal explanation. If adopted as an approach, training for the in the development of charts and their presentation was considered essential.

**VHTs**

**Views on data presentation and use:** When asked what data could be presented to the community related to VHT work the focus was on the numbers of children treated or the number who fall sick. Reasons for wanting to present this was for the community to understand both that they need to engage in preventive behaviours and that VHTs work hard.

All respondents reported that information should be communicated verbally in Luganda as not all community members will understand graphs, however, 5/6 VHTs felt that the data should also be presented graphically and one suggested that the information should be pasted on a wall.

Most respondents felt the VHT should summarize the data and indeed that should someone else summarise the data they may feel marginalised.
‘I am the one who knows how I record so I am in a better position to summarize it’ (40 year old male VHT)

‘If this happened [supervisor summarizing the data] I would feel undermined as the original producer of the data’ (30 year old male VHT).

Half of the respondents felt the VHT should present the data to the community as they understand best what is going on, are closer to the community or because they would feel undermined if the supervisor presented the information. The other half felt that the supervisor should come and present the information as they would be more respected and would be more likely to get the attention of the community.

‘Of course the information should come from me because I am the one who directly deals with the community and know most of their concerns’ (61 year old female VHT).

‘The supervisor should present the data to the community because they are more respected than the committee and VHTs’ (30 year old male VHT).

‘It should be the supervisor because people will listen to her more because she is a leader who is coming from outside the community (30 year old female VHT).

Supervisors
Most useful information for the village committee (VC) and the community to have

- Village committee
  Supervisors were of the view that the most useful data for the VC to have was that which helped them to understand VHT work, the problems they face and their successes. Specifically they suggested:
  - The concept of iCCM (1/6 supervisors).
  - Basic facts about malaria (1/6 supervisors).
  - How the committee members should relate with the VHT (1/6 supervisors).
  - Causes of illnesses among children (1/6 supervisors).
  The committee should be in position to understand the causes of the different illnesses in the community and share this information with people. This information will give them a picture of the standard of their sanitation and hygiene during the community meetings, sensitizations and mobilization so that people can act accordingly (Supervisor 1, male, medium community).
  - Prevention of diseases in the communities (1/6 supervisors).
  - Number of children who come for treatment (1/6 supervisors).
  - Number of cases VHTs follow-up on those treated (1/6 supervisors).
  - Quantity of drugs left with the VHTs (1/6 supervisors).

The argument was that once the VC understands this information they can pass it on to the community during community sensitization, mobilization, and community meetings, it was hoped that the community could in turn finds solutions to the VHT’s challenges.

- Community
  In order to increase community respect for the work of VHTs supervisors suggested that the community receive information on:
- Number of treated children (per month) treated by VHT (4/6 supervisors).

  VHTs should summarize information such as the number of treated children per month like can say that last month I received 6 sick children and out of these I tested 4 children with malaria parasites whom I treated because this would help the community to know the treatment patterns of a VHT, information on amount of medicines used, medicines available (Supervisor 6, female, medium community).

- Diseases treated by VHTs (2/6 supervisors).

  What is important is to have weekly surveillance reports showing the number of diseases handled in a week like malaria cases handled, measles, cholera so that the community can see how many cases of diseases have been handled like a VHT can tell the community that ‘look at my records, I have not registered any diseases in the community and this will show that the VHT is doing their work (Supervisor 3).

- Names of treated children (1/6 supervisors).

  The names of the treated children in the community maybe per week can help to bring confidence in the community towards VHTs as there would be evidence to look at or even getting testimonies from some of the parents who had their children treated by the VHT and got cured telling and sharing their experiences with the community (Supervisor 6, female, medium community).

- Age bracket of children treated by VHTs (1/6 supervisors).

- Signs of different illnesses among children (1/6 supervisors).

- Prevention of diseases in the community especially among children (1/6 supervisors), “for instance, the importance of sleeping under a treated mosquito net, boiling drinking water, having proper disposal manners, having clean latrines, ensuring that children use the latrine and wash their hands after visiting a latrine. This will help in the prevention of many diseases. “If this is done, then the community awareness of sanitation and hygiene will increase and hence reduce on disease out breaks in our communities” (Supervisor 2).

- Number of children referred by VHT (1/6 supervisors).

- Number of children who come for treatment (1/6 supervisors).

- Number of cases VHTs follow-up on those treated (1/6 supervisors).

- Quantity of drugs left with the VHTs (1/6 supervisors).

- What the VHTs do (1/6 supervisors).

**Where data should come from**

**Best data source**

Supervisors had different views on the best source of data to present to the VC and community with 4/6 opting for the VHT and 2/6 the supervisors themselves. Those that pushed for the VHT tended to highlight their local knowledge and ability to present challenges meaningfully and ideally engage in practical discussions related to solutions. Some warned that letting supervisors summarise data may in fact lead to exclusions.

...if the VHTs summarise the data and give it to the committee it will show the committee the actual problems which the VHT is facing and since they are living in the same village they can agree or disagree on some and come up with a best way to help the VHT. The advantage is that first-hand information on the challenges will be given to the committee and the committee will have a chance to verify the challenges since they live in the same community
with the VHT and therefore s/he cannot tell lies or exaggerate the problems (Supervisor 1, male, medium community).

The supervisor sending data to the committee will be an act of underestimating VHTs because they will be the source of the data and giving it to someone else in summary might even mean removing some important information (Supervisor 2).

It was also pointed out that VHTs create monthly summaries for the health facility anyway and are therefore well placed for the task.

... VHTs give the supervisors or health facility summaries every month. If they can give summaries to the above then why should the same summaries not come from VHT to the community and the committee?” (Supervisor 4).

Those that felt the supervisor was better placed argued that with their greater level of technical expertise they would have a superior ability to meaningfully collate and synthesise the data. It was also suggested the supervisor playing such a role may increase the credibility of the data in the eyes of the community.

... in case of more technical information to be collected, it would need the supervisor or somebody from the health facility because we have got experience in collecting data since we as supervisors normally summarize these data” (Supervisor 3).

... in case this data is summarized by somebody from the health facility, it would help the community trust this data and information presented to them from us the staff at the health facility because we are the ones who trained these VHTs, you know all of us are health workers but the community see us staff from the health facility as being superior to these VHTs “ (Supervisor 6, female, medium community).

**Least appropriate data source**
The supervisor was pinpointed as the least source of data (4/6 supervisors) because they were viewed as being too busy to effectively compile data.

The disadvantage there is that the supervisor is very busy with so many villages to supervise and other activities. So the supervisor may fail to get time to summarise the data or if s/he did may omit some relevant information since he will be making a summary from many reports of VHTs (Supervisor 1).

The VHT ... do their summaries and are in a better position to explain these summaries if something is not understood in this data (Supervisor 4).

While only two of the six interviewed supervisors pointed out the VHT as the least appropriate source of data. This was largely due to them exaggerating the facts if no-one is checking on them or that they may make errors if not cross checked.

If the VHT is to summarise the reports and nobody has seen what they are doing, they may end up exaggerating the figures like they may say they have i treated 5 children in the past week, but when you analyse the figures critically you find that actually they could have just added on other figures (Supervisor 3).

You know two heads are better than one, there is no way a VHT summarises data and again presents it alone, because in case it is the VHT collecting this data, they cannot know their mistakes, but if you work with somebody such errors are reduced (Supervisor 6, female, medium community).
How best to present data

On the best way to present data four of the six interviewed supervisors stated that it should be verbal information given due to the low literacy levels of the communities. Some supervisor respondents warned that use of visual aids may be threatening to the community if pitched too high. Clearly any visual aids developed by inSCALE for this purpose will need to be market tested thoroughly to protect against this effect during the development phase.

The data should be presented in verbal form using figures to explain more. For example the person presenting the data can say that out of 40 children treated, 20 of them were malaria cases and out the 20 malaria cases, 10 children healed without being referred. I think if the data is presented like that, people will understand and attach meaning to it. Graphs and charts are not important because these people will not understand what is being said. They will even feel undermined since they are not learned people (Supervisor 2).

... At the health facility, I normally handle so many pregnant women, they cannot interpret these charts and if you ask them their education level most of them are illiterate and stopped in P.7 (Supervisor 6, female, medium community).

For other supervisors, writing figures on flip chart paper was the best data presentation method (Supervisor 3, Supervisor 4)

The best way to present this data to the community and the committee is writing figures on the manila charts and a small report explaining the children who have in treated of malaria, diarrhea and pneumonia each month. The one presenting the data should explain verbally for these people to understand the data and in a language they understand (Supervisor 4).

Those arguing for simple graphs noted that they were useful for showing trends but advise additional training for VHTs in creating and presenting these graphs (Supervisor 1, Supervisor 5)

... simple graphs such as line graphs ... show trends. From experience even the committee or community members can give you explanations as to why the trends are the way they are like they can say this time malaria was high because we did not have drugs. However, if the VHTs are the ones to summarize the data and give it to the committee it may call for more training as the current training they have cannot enable them to analyze the records and worse still generate graphs from that data (Supervisor 5).

Who to present information to committee and community

On the best person to present data to the community, two supervisors suggested it should be the VHT as they live in the community and best understand the community dynamics and context. Others argued that the supervisor was best place reasoning that he/she is more respected, more knowledgeable and more experienced in handling meetings (Supervisor 2, Supervisor 5). It was proposed that supervisors could mentor VHTs through demonstrating the most effective methods of presentation.

The VHT is the best person to present this data because s/he lives in the same community and know its dynamics better than anyone else (Supervisor 1).

The supervisor should be the one to present this data to the committee and the community for the start as the VHT learns so that they can be in position to do it in subsequent meetings (Supervisor 5).

Three of the six supervisors interviewed suggested that a member of the village committee (for instance the Secretary) (Supervisor 3) should presented the data when the supervisor was not available. The reasoning was that it would assist with their exposure and recognition with the community and promote both the VHT and the role of the VC in the VHT’s work (Supervisor 2).
was pointed out that since VC members review VHT records they would be able to answer any questions from the community (Supervisor 6).
### Appendix 1 – interview and FGD participant information

#### Community interview participants - caregivers

<table>
<thead>
<tr>
<th>Int No.</th>
<th>Gender</th>
<th>Age</th>
<th>Education</th>
<th>Number of children and age of youngest</th>
<th>Community size</th>
<th>Distance to the health facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG 1</td>
<td>Male</td>
<td>30</td>
<td>Primary 2</td>
<td>Two. Youngest 3 months</td>
<td>Medium</td>
<td>Approx 10 km</td>
</tr>
<tr>
<td>CG 2</td>
<td>Female</td>
<td>34</td>
<td>Primary 3</td>
<td>Seven. Youngest 1 year</td>
<td>Medium</td>
<td>Approx 1 mile</td>
</tr>
<tr>
<td>CG 3</td>
<td>Female</td>
<td>47</td>
<td>Senior 2</td>
<td>Thirteen. Youngest 1.5 years</td>
<td>Medium</td>
<td>15 minutes walk</td>
</tr>
<tr>
<td>CG 4</td>
<td>Female</td>
<td>48</td>
<td>Senior 2</td>
<td>Nine. Youngest 8 years</td>
<td>Large</td>
<td>2 km</td>
</tr>
<tr>
<td>CG 5</td>
<td>Female</td>
<td>32</td>
<td>Senior 4</td>
<td>Five. Youngest 3 weeks</td>
<td>Large</td>
<td>3 miles</td>
</tr>
<tr>
<td>CG 6</td>
<td>Female</td>
<td>37</td>
<td>Senior 4</td>
<td>Five. Youngest 4 years</td>
<td>Large</td>
<td>5 miles</td>
</tr>
</tbody>
</table>

#### Community interview participants – male heads of household

| MHHH 1  | Male   | 35  | Senior 4 | Three. Youngest 2.5                    | Small          | 1 mile                          |
| MHHH 2  | Male   | 38  | Senior 2 | Five. Youngest 1.5                     | Large          | 4 miles                         |
| MHHH 3  | Male   | 37  | Primary 4| Eight. Youngest 2                      | Medium         | 2 miles                         |
| MHHH 4  | Male   | 36  | PTC      | Five. Youngest 7 months                | Large          | 2 km                            |
| MHHH 5  | Male   | 27  | Senior 5 | One. Youngest 1 month                  | Large          | 3 km                            |
| MHHH 6  | Male   | 42  | Primary 3| Eight. Youngest 5 months               | Medium         | 2 miles                         |

#### Community interview participants – male heads of household

| LC1 1   | Male   | 32  | Senior 2 | Two. Youngest 7 months                 | Medium         | Approx 3 km                     |
| LC1 2   | Male   | 54  | Primary 7| Eight. Youngest 8 years                | Large          | ¾ mile                          |
| LC1 3   | Male   | 60  | Primary 7| Seven. Youngest 15 years               | Large          | 2.5 km                          |
| LC1 4   | Male   | 52  | Primary 7| Nine. Two below 5                     | Medium         | 13 km                           |
| LC1 5   | Male   | 58  | Primary 7| Eleven. Youngest 12 but grandchild of 3 years that lives with | Medium         | 7 miles                         |
| LC1 6   | Male   | 51  | Senior 3 | Ten. Youngest 15 years                 | Large          | 3 miles                         |

#### VHT interview participants

<table>
<thead>
<tr>
<th>Int No.</th>
<th>Size of community</th>
<th>Gender</th>
<th>Age</th>
<th>Marital status</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Regular occupation</th>
<th>Literacy</th>
<th>When trained as a VHT (iCCM)</th>
<th>Type of supervising health facility</th>
<th>Distance supervising facility</th>
<th>Length of time living in community</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHT 01</td>
<td>Large</td>
<td>Female</td>
<td>27 years</td>
<td>Married</td>
<td>Muganda</td>
<td>Senior Three</td>
<td>Crop farmer</td>
<td>Reads and writes English and Luganda</td>
<td>2009</td>
<td>Kikwatambogo HCII</td>
<td>2 Kms</td>
<td>10 years</td>
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</tr>
<tr>
<td>VHT 02</td>
<td>Large</td>
<td>Female</td>
<td>30 years</td>
<td>Married</td>
<td>Munyoro</td>
<td>Senior Four</td>
<td>Tailor</td>
<td>Reads and writes Luganda and English</td>
<td>September 2010</td>
<td>Kambugu HC II</td>
<td>1km</td>
<td>12 years</td>
</tr>
<tr>
<td>VHT 03</td>
<td>Large</td>
<td>Female</td>
<td>61 years</td>
<td>Separated</td>
<td>Muganda</td>
<td>Senior Three (in 1968)</td>
<td>Peasant mixed farmer (crop and animal rearing)</td>
<td>Reads and writes Luganda very well and able to read some words in English</td>
<td>May 2010</td>
<td>Kikwatambogo HC II</td>
<td>5 miles</td>
<td>18 years</td>
</tr>
<tr>
<td>VHT 04</td>
<td>Medium</td>
<td>Male</td>
<td>40 years</td>
<td>Married</td>
<td>Murundi</td>
<td>Senior Four</td>
<td>Cattle keeper</td>
<td>Reads and writes Luganda excellently and fairly well in English</td>
<td>July 2009</td>
<td>Katwe HC III</td>
<td>4 Kms</td>
<td>11 years</td>
</tr>
<tr>
<td>VHT 05</td>
<td>Medium</td>
<td>Male</td>
<td>30 years</td>
<td>Married</td>
<td>Muganda</td>
<td>Senior four</td>
<td>Mixed Farmer crops and animal farmer</td>
<td>Reads and writes English and Luganda</td>
<td>Can’t remember</td>
<td>Katwe Health Centre III</td>
<td>½ Km</td>
<td>10 years</td>
</tr>
<tr>
<td>VHT 06</td>
<td>Medium</td>
<td>Female</td>
<td>38 years</td>
<td>Married</td>
<td>Muganda</td>
<td>Primary 6</td>
<td>Subsistence farmer</td>
<td>Reads and writes in Luganda</td>
<td>2009</td>
<td>Katwe HC III</td>
<td>6 miles</td>
<td>20 years</td>
</tr>
</tbody>
</table>

**Supervisor interview participants**

<table>
<thead>
<tr>
<th>Int No.</th>
<th>Size of community</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Type of health facility</th>
<th>Title/role at health facility</th>
<th>Length of time working at current</th>
<th>No VHTs supervised</th>
<th>Length of time supervising VHTs</th>
<th>Distance travelled/time taken to supervise VHTs</th>
<th>Existence of Village Committees</th>
</tr>
</thead>
</table>

57
<table>
<thead>
<tr>
<th>Sup 1</th>
<th>Medium</th>
<th>Male</th>
<th>37 years</th>
<th>Muganda</th>
<th>Certificate of Public Health done after Senior Four</th>
<th>Katwe HC III</th>
<th>Health Assistant</th>
<th>14 years</th>
<th>48 ICCM VHTs</th>
<th>Can’t remember</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sup 2</td>
<td>Large</td>
<td>Female</td>
<td>30 years</td>
<td>Munyankore</td>
<td>Diploma</td>
<td>Kibiga Sub-County Headquarters (supposed to be attached to Kambugu Health Centre II)</td>
<td>Sub-County Health Assistant</td>
<td>7 years</td>
<td>32 ICCM VHTs and over 100 basic trained VHTs</td>
<td>Jul-10</td>
<td>Community Care Coalition (CCC) supported by World Vision - Community Based Monitors (CBM) all supported by World Vision - Basic trained VHTs committee</td>
</tr>
<tr>
<td>Sup</td>
<td>Category</td>
<td>Sex</td>
<td>Age (years)</td>
<td>Name</td>
<td>Certificate</td>
<td>Experience</td>
<td>VHTs</td>
<td>Shortest Distance</td>
<td>Longest Distance</td>
<td>Groups</td>
<td>Notes</td>
</tr>
<tr>
<td>-----</td>
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</tr>
<tr>
<td>3</td>
<td>Large</td>
<td>Langi</td>
<td>35</td>
<td>Kambugu Health Centre II</td>
<td>In-charge</td>
<td>5 years</td>
<td>32 ICCM trained VHTs but does not remember the number of basic trained VHTs</td>
<td>Jul-10</td>
<td>Shortest distance is 20 minutes using motorcycle or 40 minutes by bicycle. Farthest is 13 miles 2-3 hours by bicycle 1 hour by motorcycle</td>
<td>Naads Group, Mothers Union, Youth group under the church, VHT committee, Hunger project, Health Unit Management Committee</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Medium</td>
<td>Female</td>
<td>30</td>
<td>Muyenje Health Centre II</td>
<td>Nursing Assistant</td>
<td>4 years</td>
<td>16 ICCM VHTs and 3 basic VHTs</td>
<td>Jul-10</td>
<td>Shortest distance is 1 km away. Longest distance is 10 kms away.</td>
<td>NAADS</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Large</td>
<td>Male</td>
<td>40</td>
<td>Kikwatambogo and Kambugu Health Centre II</td>
<td>Medical Records Assistant, Health Management Information System Focal Person, Kiboga Hospital</td>
<td>9 years</td>
<td>8 ICCM VHTs and 16 basic VHTs</td>
<td>Can’t remember</td>
<td>½ hour to shortest distance and 1 hour to longest distance during dry season; if it is rainy the time doubles</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Sup 6</td>
<td>Medium</td>
<td>Female</td>
<td>30 years</td>
<td>Munyoro</td>
<td>Certificate in Nursing (Registered Nurse)</td>
<td>Katwe Health Centre III</td>
<td>Assistant In-Charge and Nursing Officer</td>
<td>2 years</td>
<td>8 iCCM VHTs on rotational basis</td>
<td>Jul-10</td>
<td>Shortest time travelled 3 minutes walk. Longest time is 30-40 minutes using a vehicle and 45 minutes by motorcycle.</td>
</tr>
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</tbody>
</table>

**Focus Group Discussions**

1. The caregivers’ FGD was conducted in the large-sized community comprising of 8 women and 2 men.
2. The male household heads’ FGD was conducted in the mediums-sized community.
3. The LC 1 Chairpersons’ FGD was conducted in a medium-sized community comprising of 3 women and 4 men.
Appendix 2 – community member interview topic guide

COMMUNITY ARM

inSCALE community member interview guide

Date of interview: __________________________
Time interview started: ____________________
Time interview finished: ____________________
Fieldworker number: ______________________
Number of VHTs in the community: __________
Community member ‘strata’ (i.e. LC / care giver / male head of household):
__________________________________________________________________________

Demographic and village information

1. Community (include geography, accessibility and other key features):
2. Main occupation:
3. Age:
4. Education:
5. Number of children and age of youngest child:
6. Marital status:
7. Ethnicity / tribe:
8. Languages spoken:
9. Length of time living in community:
10. Name and type of closest health facility:
11. Distance to nearest health facility:
12. Comments:
DRAFT REPORT – DO NOT CITE

Theme 1: Perceptions of VHTs

Say: I would like to talk to you about your community and the work of the ICCM VHTs

1.1 Are you aware of the ICCM VHTs that work in the community? What do you know about the work that they do?

1.2 Are the ICCM VHTs commonly used by community members? Why/Why not?

1.3 What are the main problems that the ICCM VHTs face in doing their work?

1.4 How could the work that the ICCM VHTs do be improved?

Does the community provide any support to the work that the ICCM VHTs do? **Probe:** give advice, encouragement or physical help such as transport?

1.5 Do you think the community could do anything to help the ICCM VHTs solve the main problems they face?

Theme 2: Views on community meetings

Say: I would like to talk to you about any meetings that occur in the community where the village gets together to hear about or discuss an issue.

2.1 Have any meetings occurred in this community in the last two years where the village gets together to hear about or discuss an issue? Please list the different types of meetings that have occurred. **For each type of meeting**
  - What are the issues discussed in these meetings?
  - Are they one-off meetings or do they occur regularly?
  - When do they occur (specific days / time of day)? How often?
  - Who decides? Who organizes and runs the meetings?
  - Who attends the meetings? Who does not attend the meetings? Why?
  - Are the meetings popular with the community? Why/Why not? **(Probe: what people like and dislike about the meetings)**
  - What happens at the meetings? **Probe:** Are there talks? Discussions? Question and answer sessions? Who speaks at the meetings? Who does not speak? Why/Why not?
  - Do the meetings lead to any changes in the community? Why/Why not?

2.2 What are the main problems with the meetings? **Probe:** Difficulties getting people together? Difficulties ensuring views are heard? Difficulties making a decision? No actions resulting from the meetings?

Theme 3: Views on village committees

Say: I would like to talk to you now about any village committees where selected community members meet to discuss and make decisions about village issues (**NB:** such groups do not need to be called a committee to be of interest).

3.1 Do such groups currently exist in this community? Please list the different groups that are currently active. **For each type of group**
  - What are the issues discussed by these groups?
  - Who organizes and runs the groups? How often do they meet?
  - Who attends the groups? How were these people selected?
  - Are there other people you think should attend the groups? Who? Why?
- Do the groups report back to the community? How?
- Do the groups lead to any changes in the community? Why / why not?

3.2 What do people in the community like and dislike about the groups and how they function?

3.3 What are the main problems with the groups? **Probe:** Difficulties getting people together? Difficulties ensuring views are heard? Difficulties making a decision? No actions resulting from the groups?

**Theme 4: Perceptions on inScale innovation**

**Say:** *We are thinking of helping communities select a group of people from their community who would meet every three months to support VHTs in their work. We are calling this group the village committee. This village committee will support VHTs in their work by:*

- **Raising awareness in the community of VHT work,**
- **Working with VHTs to review their records and understand their challenges,**
- **Solving VHT problems at the community level and communicating with supervisors about broader problems,**
- **Arranging village meetings to discuss VHT work and to develop plans to solve VHT problems**

4.1 Based on your knowledge of the community do you think the work of this committee would improve the work of the VHTs? Why/Why not? **If yes:** How do you think they would improve the work of the VHTs?

4.2 Do you think this committee would improve community support for the VHTs? Why / why not?

4.3 Are there any components that you think would be challenging to set up (**remind respondents of each component – the four bullets in introductory part of theme 4**)?

**If yes** Why? What could improve the chance that they are set up successfully?

4.4 Are there any components that you think would be difficult to keep going over time? **If yes** Why? What could improve the chance that they keep going over time? **Probe:**

- Would people attend the committee or the meetings? Why/Why not?
- Would people be able to discuss, make plans and solve VHT problems through the committee and the meetings? Why/Why not?

4.5 Are there any components that could be added to help support and improve VHT work?

4.6 How do you think the members of the committee group should be selected? Are there any people who definitely need to be in the group or who should definitely not be in the group?

4.7 How do you think the community meeting could best be organized?

- Should the meeting be attended by everyone or only by some members of the community? Which few? How should they be selected? Why?
- How could we ensure that the meeting is not dominated by a few people?
Appendix 3 – community member group discussion topic guide

COMMUNITY ARM
inSCALE community member group discussion guide

Say:
We are thinking of helping communities select a group of people from their community who would meet every three months to support VHTs in their work. We are calling this group the village committee. This village committee will support VHTs in their work by:

- Raising awareness in the community of VHT work,
- Working with VHTs to review their records and understand their challenges,
- Solving VHT problems at the community level and communicating with supervisors about broader problems,
- Arranging village meetings to discuss VHT work and to develop plans to solve VHT problems

I would like to introduce you to Esther. Esther is a VHT. I will explain to you some of Esther’s challenges and then ask you how you think the VHC may be able to help.

Esther has lived in the village all her life and is now is responsible for treating children under five years of age when they are sick. She is a VHT trained in iCCM. Esther is motivated to bring better health to her community but sometimes she is frustrated that she is unable to travel to all those people that need her help and to the far-away health facility to pick up the medicines. She gets no money for the work she does as a VHT. She has to dig so she can earn enough money for her family and this doesn’t leave her with enough time for her VHT work.

Ask:
Does Esther need any help? Why / why not? If yes, ask: what sort of help? Who can provide this help?

Say:
Here is a list of possible actions the village committee could take:

A. The village committee calls a village meeting to explain the challenges faced by Esther and the work she is trying to do and to ask whether and how the community can support Esther.

B. The village committee talks to Esther about her work and her challenges to see if they together can come up with some ways to make her work more manageable.
C. The village committee meets to discuss Esther’s challenge and develops a plan to help her by collecting a contribution from families Esther sees.

D. The VHC speaks to Esther’s supervisor and explains the challenges she is facing. Together they develop a strategy to help Esther.

Ask:

1. Which action (1-4) would be most acceptable to Esther’s village? Why?  
   (probe: any issues that may influence whether a particular action would be acceptable)

2. Which action would be least acceptable to Esther’s village? Why?  
   (probe: any issues that may influence whether a particular action would not be acceptable)

3. Which action is likely to be most effective? Why?  
   (probe: any issues that may influence whether a particular action would be effective)

4. Which action is likely to be least effective? Why?  
   (probe: any issues that may influence whether a particular action would not be effective)

5. Are there any other actions that you think would / might be effective? Why?
Appendix 4 – supervisor interview topic guide

COMMUNITY ARM

Supervisor in-depth interview guide

Date of interview:______________________
Time interview started: _________________
Time interview finished:_________________
Fieldworker number: ___________________
Supervisor research number: ______________
Supervisor ‘strata’ (i.e. Kiboga or Hoima, medium or large communities supervised):
____________________________________

Demographic information
  13. Community operate in (include geography, accessibility and other key features):
  14. Number and type of VHTs supervised (basic training, iCCM trained):
  15. Name of health facility (include type e.g. HCII or HCIII):
  16. Distance/time to VHTs supervising. **Probe:** longest and shortest:
  17. Age:
  18. Title (i.e. role at the health facility):
  19. Ethnicity / tribe:
  20. Education (highest level attained):
  21. Length of time working at current location:
  22. Length of time supervising VHTs:
  23. Comments:
Theme 1: Views on the inSCALE innovation

**Say:** We are thinking of helping communities select a group of people from their community who would meet every three months to support VHTs in their work **and discuss and make decisions about village issues.** We are calling this group the village committee. This village committee will support VHTs in their work by:
- Raising awareness in the community of VHT work,
- Working with VHTs to review their records and understand their challenges,
- Solving VHT problems at the community level and communicating with supervisors about broader problems,
- Arranging village meetings to discuss VHT work and to develop plans to solve VHT problems

**Supervisors would continue with their normal supervision, would attend the village meetings and would need to be ready to help solve the problems that cannot be solved at community level.**

1.1 Do any groups like this already exist in the community? (Probe: village members meeting to discuss village issues) If yes what do they do? **How well do they work? What are their main successes? What are their main challenges?**

1.2 Based on your knowledge of the VHTs and the communities do you think the work of this committee would improve the work of the VHTs? Why/Why not? **If yes: How do you think the village committees would improve the work of the VHTs?**

1.3 Are there any particular components that you think would be beneficial or not beneficial to VHT work? Why/Why not? **(Remind the respondent of each component).**

1.4 Are there any components that you think would be challenging to set up? **If yes: Why? What could improve the chance that they are set up successfully?**

1.5 Are there any components that you think would be difficult to keep going over time? **If yes: Why? What could improve the chance that they keep going over time?**

***Probe:***
- Would people attend the **committee meetings**? Why/why not?
- Would people attend the **village meetings**? Why / why not?
- Would people be able to discuss, make plans and solve VHT problems through the **committee**? Why/Why not?
- Would people be able to discuss, make plans and solve VHT problems through the **village meetings**? Why/Why not?

1.6 Are there any components that could be added to help support and improve VHT work? **(Probe for details of any suggested additional components)**

1.7 How do you think the members of the village committee should be selected? Are there any people who definitely need to be in the group or who should definitely not be in the group? Why?

1.8 How do you think the community meeting could best be organized? **- Should the meeting be attended by everyone or only by some members of the community? Why?**

1.9 What about the committee, how could that best be organized?
1.10 How do you think the work of this committee would affect your work with the VHTs and with the community?
- How could you best be involved in the committee and the village meetings?
- What would be the benefits and the problems of you attending the committee and village meetings?
- Do you think such a committee could improve the support and supervision provided to VHTs? If yes, ask: how? If no, ask: why not?

1.11 If the committee came to you with problems that the health facility needed to address to ensure the VHT could work better:
- What would be the best way for the committee to interact with you about these problems?
- Who would you involve? What would you do?
- What would happen if the problem was hard to solve like drug stock outs? What would you do?

Theme 2: views on collecting, collating and presenting data to the community

Say: We think one of the best ways for the committee and the community to understand the work of VHTs is for them to review VHT records. We would now like to talk to you about the information that you think would be most useful for the committee and the community to review on a quarterly basis.

2.1 What sort of information would be most useful for the committee and the community to have in order to understand VHT work and the problems and successes VHTs have?

2.2 The data could come from a number of sources. These are:

   a) The VHT summarises the data themselves?
   b) The parish supervisor summarises the data and sends it to the village committee?
   c) The supervisor or someone from the health facility summarises the data?

Which data source would work best? Why? Which one would work least? Why?

2.3 How could this data best be presented? (probe: verbal information explaining the data, visual representation of data such as charts and graphs, other ideas) In addition, probe for any of the data formats that haven’t come up that could have been mentioned. For instance, probe by asking ‘you didn’t talk about graphs, why was that?’

2.4 Who should present this information to the committee and the community? (Probe: VHT, supervisors, others?)
Appendix 5 – VHT interview topic guide

VHT in-depth interview guide: iCCM VHTs

Date of interview:______________________
Time interview started: _________________
Time interview finished:_________________
Fieldworker number: ___________________
VHT research number: __________________
VHT ‘strata’ (i.e. Kiboga, medium or large communities supervised): ____________

Demographic information

24. Community operate in (include geography, accessibility and other key features):
25. Number and type of VHTs in community:
26. Name of supervising facility:
27. Distance to supervising facility:
28. Age:
29. Regular occupation:
30. Ethnicity / tribe:
31. Marital status:
32. Literacy (ability to read and write in any language):
33. Education:
34. Length of time living in community:
35. When trained as a VHT (iCCM):
36. Comments:
Theme 1: views on village committees

*Say:* We are thinking of helping communities select a group of people from their community who would meet every three months to support VHTs in their work and discuss and make decisions about village issues. We are calling this group the village committee. This village committee will support VHTs in their work by:

- Raising awareness in the community of VHT work,
- Working with VHTs to review their records and understand their challenges,
- Solving VHT problems at the community level and communicating with supervisors about broader problems,
- Arranging village meetings to discuss VHT work and to develop plans to solve VHT problems

Supervisors would continue with their normal supervision, would attend the village meetings and would need to be ready to help solve the problems that cannot be solved at community level.

1.12 Do any groups like this already exist in the community? *(Probe: village members meeting to discuss village issues)* If yes what do they do? *How well do they work? What are their main successes? What are their main challenges?*

1.13 Based on your work and your knowledge of the community do you think the work of this village committee would improve your work as a VHT? Why/Why not? *If yes: How do you think the village committees would improve your work as a VHTs? What problems do you have that may be solved by such a committee?*

1.14 Are there any particular components of that you think would be beneficial or not beneficial to VHT work? Why/Why not? *(Remind the respondent of each component).*

1.15 Are there any components that you think would be challenging to set up? *If yes: Why? What could improve the chance that they are set up successfully?*

1.16 Are there any components that you think would be difficult to keep going over time? *If yes: Why? What could improve the chance that they keep going over time?* *(Probe:)*

- Would people attend the committee meetings? Why/why not?
- Would people attend the village meetings? Why / why not?
- Would people be able to discuss, make plans and solve VHT problems through the committee? Why/Why not?
- Would people be able to discuss, make plans and solve VHT problems through the village meetings? Why/Why not?

1.17 Are there any components that could be added to help support and improve VHT work? *(Probe for details of any suggested additional components)*

1.18 How do you think the members of the village committee should be selected? Are there any people who definitely need to be in the group or who should definitely not be in the group? Why?

1.19 How do you think the community meeting could best be organized? *Should the meeting be attended by everyone or only by some members of the community? Why?* *How could we ensure that the meeting is not dominated by a few people?*

1.20 What about the committee how could that best be organized?
1.21 How do you think this idea would affect your work with the community and your supervisor?
- How could you best be involved in the committee and the village meetings?
- What would be the benefits and the problems of you attending the committee and village meetings?
- Do you think such a committee could improve the support and supervision provided to you and other VHTs? If yes, ask: how? What problems do you have that may be solved by such meetings? If no, ask: why not?
  (NB: allow respondent to answer the question. When they have finished talking probe: support and supervision from the community and support and supervision from the health facility based supervisor)

1.22 If the committee approached your supervisor with problems that the health facility needed to address to ensure you could work better:
- What would be the best way for the committee to interact with your supervisor about these problems?
- How do you think your supervisor would react?
- What do you think would happen if the problem was hard to solve like drug stock outs?

Theme 2: Views on collecting, collating and presenting data to the community

Say: We think one of the best ways for the committee and the community to understand the work of VHTs is for them to review VHT records. We would now like to talk to you about the information that you think would be most useful for the committee and the community to review.

2.5 What sort of information would be most useful for the committee and the community to have in order to understand your work and the problems and successes you and other VHTs have?

2.6 Where should the data come from? Probe for the advantages and disadvantages of each of the following:
- You (the VHT) summarise the data yourselves every three months?
- The parish supervisor summarises the data and sends it to the village committee?
- Your supervisor or someone from the health facility summarises the data?

2.7 How could this data best be presented? (probe: verbal information explaining the data, visual representation of data such as charts and graphs, other ideas)

2.8 Who should present this information to the committee and the community? (Probe: VHTs, supervisors, others?)

2.9 What language(s) should the presentations be in?