MC/iNSCALE/10.01

iCCM in Uganda

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iNSCALE Stakeholder Analysis Report

May 2010

Acknowledgements

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Contents

Preamble

During the last decade child mortality has reduced significantly in a number of African countries. Scale up of appropriate management of diarrhea, pneumonia and malaria was partly the reason behind the success. As a way of increasing access to treatment for sick children where health services are geographically and financially inaccessible, several African countries are currently investing in community based agents (CBAs) to deliver treatment. Uganda was one of the first to take this policy to scale through the Home Based Management of Fever (HBMF) strategy, which aimed to improve prompt and appropriate treatment of presumptive malaria using volunteering community medicine distributors (CMDs). Recently, the HBMF strategy was integrated into the more holistic Village Health Team (VHT) strategy. As part of the this new strategy, VHTs do not only provide health promotion / health education and treatment for malaria, but also treatment of diarrhea and pneumonia – so called "integrated community case management" (iCCM). However, experiences from HBMF indicate that VHT supervision and motivation are critical constraints that limit coverage of community-based delivery of health care. It was also observed that proper collection, flow and use of data between VHTs and the health system is another major challenge that hinders optimal implementation.

Recently, Malaria Consortium was awarded a grant from Bill & Melinda Gates Foundation to better understand work motivation, attrition and better use of data, and to find feasible and acceptable solutions to VHT retention and performance which are vital for successful implementation of iCCM at scale. This programme – entitled "innovations at scale of community access and lasting effects" (iNSCALE) will complement a project funded by CIDA which Malaria Consortium is implementing in Uganda and Mozambique.

The overall goal of the iNSCALE is to demonstrate that government-led iCCM programmes in 2 African countries (Uganda and Mozambique) can be scaled up to 33% of the districts and reaching 50% of the children in these districts, primarily resulting in greater access to standard case management for children with diarrhea, pneumonia and malaria.

Operational definitions

Key stakeholders: Individuals or groups who can significantly influence or are important to the success of an activity. In the case at hand, *key stakeholders* include officials at the Ministry of Health (MoH), World Health Organization (WHO), United Nations International Children's Fund (UNICEF), District Health Officers, (DHOs), Chief Administrative Officers (CAOs), district malaria focal persons, and district secretaries of health.

Primary stakeholders: Individuals or groups who are ultimately affected—positively or negatively—by an activity. In the case at hand, the *primary stakeholders* are the Village Health Team (VHT) members.

Abbreviations

CAO	Chief Administrative Officer
DHO	District Health Officer
HBMF	Home-based Management of Fever
iCCM	Integrated Community Case Management
MoH	Ministry of Health
NMCP	National Malaria Control Programme
NMS	National Medical Stores
SCiUG	Save the Children in Uganda
UNICEF	United Nations International Children's Fund
VHT	Village Health Team
WHO	World Health Organization

Introduction

In 2002, Uganda became the first country to scale-up Home Based Management of Fever/Malaria (HBMF) in an effort to improve prompt and appropriate treatment of presumptive malaria using volunteer community medicine distributors (CMDs). Recently, the Uganda Ministry of Health (MoH) integrated the HBMF strategy into its more holistic Village Health Team (VHT) approach. Under this approach, VHTs support the implementation of "integrated community case management" (iCCM), which consists of health promotion & education *and* the treatment of malaria, diarrhoea and pneumonia at the community-level.

In late 2009, Malaria Consortium was awarded a $10 million grant from the Bill and Melinda Gates Foundation to explore and better understand the factors influencing VHT performance and retention—namely: motivation, attrition, and use of data. By identifying and testing feasible and scalable solutions for VHT retention and performance, the *iNSCALE* programme aims to demonstrate how governments in two African countries (Mozambique and Uganda) can successfully implement iCCM *at scale*. The overall objective of the project is to scale-up iCCM to 50% of the districts in each country, leading to a sustained increase in the proportion of children with diarrhoea and other common diseases receiving standard appropriate treatment.

In order for Malaria Consortium and its partners to achieve this goal, a Stakeholder Analysis was conducted in Uganda in December 2009 to inform the design of the *iNSCALE* programme. Stakeholder Analysis is a process of systematic gathering and analysis of qualitative information to determine whose interests should be taken into account when developing and or implementing a programme or project.

Stakeholder Analysis and Mapping is used in the design and management of development programmes to identify:

- The interests of all stakeholders who may affect or be affected by a programme;
- Potential conflicts and risks that could jeopardise a programme;
- Opportunities and relationships to build upon in implementing a programme to help make it a success;
- The groups that should be encouraged to participate in different stages of the activity cycle and;
- ways to improve the programme and reduce, or hopefully remove, negative impacts on vulnerable and disadvantaged groups.

Methods

One-on-one interviews of key stakeholders and Focus Group Discussions (FGDs) with VHT members were the primary methods used in this Stakeholder Analysis.

Interviews were conducted with the following agencies, groups, and individuals:

- World Health Organisation (WHO)
- Uganda Ministry of Health (MoH)
- United Nations International Children's Fund (UNICEF)
- Save the Children in Uganda (SCiUG)
- National Medical Stores (NMS)
- Chief Administrative Officers (CAOs) in the districts of Buliisa and Kibaale
- District Health Officers (DHOs) in the districts of Buliisa, Kibaale, and Kiboga
- Assistant Chief Administrative Officer in Kiboga district
- Secretary of health in the districts of Kiboga, Buliisa and Kibaale

FGDs were conducted with VHT members in Kiboga district.

Tools

Interview and FGD guides are attached in ***Appendix A***. All interviews were digitally recorded and transcribed verbatim by the consultant afterward.

Findings

In conducting the Stakeholder Analysis, the consultant examined the key contextual and programmatic factors *as perceived by stakeholders* in order to better understand the dynamics that will impact the scaled implementation of iCCM in Uganda.

This section of the report presents key findings from the interview and FGDs on each of these factors, as well as a summary of additional findings.

The following factors were explored in the interviews and FGDs:

- Stakeholder interest, readiness and power
- VHT implementation and iCCM scale-up
- Training
- Motivation
- Volunteerism
- Supervision
- Use of data
- Drug supply

Stakeholder interest, readiness and power

When asked about the nature and level of their interest in scaling iCCM, all stakeholders interviewed and engaged in FGDs expressed strong and positive interest in the programme. Stakeholders consider iCCM a highly effective method for the provision of health services at the community level, and view the scale-up of iCCM as critical to reducing child mortality through the prompt treatment of common killer diseases.

In assessing stakeholders' interest in the programme, it was also important to measure their respective levels of *readiness* and *power* to support implementation. *Readiness* is understood as a stakeholder's *preparedness* to implement a programme. *Power* is understood as a stakeholder's *capacity* to support and ensure the success of said implementation in light of key contextual and programmatic factors. The matrix below presents readiness and power rankings for the two stakeholder groups engaged in this analysis.

Box 1: Stakeholder Readiness/Power Matrix	**Readiness**			**Power**		
	High	*Medium*	*Low*	*High*	*Medium*	*Low*
Key stakeholders		**x**		**x**		
Primary stakeholders			**x**		**x**	

Based on a holistic analysis of the interviews conducted, key stakeholders are ranked at a *medium* level of readiness and a *high* level of power to implement the iCCM programme at scale. Though their interest and support of the program is *high*, key stakeholders require additional support in terms of financial and material resources in order to act on this interest, hence the *medium* readiness rating. Despite this, key stakeholders occupy the most powerful position to influence the programmatic, policy, and funding decisions required for successful and sustained implementation of iCCM at scale, hence the *high* power rating.

Based on the FGDs and the information gathered through consultations with key stakeholders, primary stakeholders are ranked at a *low* level of readiness and a *medium* level of power. Though there are indeed certain districts where the primary stakeholders (here, the VHTs) could be ranked at higher levels of readiness, the group *as a whole* is still at a low level, mainly due to disparities in the level, quality, and frequency of trainings offered *and* the varying levels of access to key supports, such as drug supplies, supervision, and effective data management systems. As such, the primary stakeholder group readiness remains *low*. In regard to the power ranking,

despite the various practical challenges to successful implementation facing the VHTs and despite the fact that they are not, as a group, well-placed to affect change at the policy and planning level, the success or failure of implementation ultimately depends on them, as they are the individuals actually completing the work required for effective iCCM. This fact, coupled with their relative dependence on key stakeholders for material and strategic support, is the basis for the *medium* power ranking.

VHT implementation and iCCM scale-up

The essence of the *iNCSCALE* programme is the scale-up of iCCM through more effective, consistent, and sustainable implementation of the VHT model. In exploring this area with the stakeholder groups, the consultant focused on opportunities, risks, and key perceptions of VHT implementation and iCCM scale-up in the current context.

Implementation of iCCM through the formation, training, and mobilization of the VHTs is a policy commitment of the MoH. Though planning and day-to-day implementation is supervised at the district level, national-level MoH policies and strategy documents guide district-level activities. As such, the MoH is perhaps the most important key stakeholder to consider when analysing this broad programme component. During consultations, members of the MoH Health Education Department noted that the VHTs fall under their purview, particularly in regard to the community mobilisation and public education activities implemented by the VHTs. The department thus understands its responsibilities *vis-à-vis* iCCM as supervisory in nature, and sees this support of the VHTs as its primary link to the success of the programme. Similarly, the MoH Child Health Division acknowledges shared responsibility for the VHTs, as their department is working closely with key MoH officials to promote iCCM as a policy commitment and to streamline the implementation guidelines at a national level. The Child Health Division thus views its role in the programme as strategic in nature; their current focus is streamlining the VHT model and harmonizing it across all districts of implementation. Though it recognizes that this process must be effective in order for the overall implementation and scale-up to succeed, the Child Health Division believes the core MoH responsibilities for scaling iCCM rest within the Health Promotion Division. Finally, all divisions of the MoH engaged in the analysis support the scale-up of iCCM, but stress that the programme must be properly managed to ensure effectiveness and sustainability.

As the focal points for operationalising MoH policies and programmes at the district-level, DHOs are critical to the success of implementing iCCM at scale. Encouragingly, each of the DHOs interviewed acknowledged the VHT model as critical to increasing access to health services at the community level in their respective districts. The key challenge to VHT implementation identified in discussions with DHOs is the disparate level and quality of training that VHTs have received to-date, and the correspondingly variant levels of operational preparedness of VHTs. DHOs attribute these operational challenges to limited resources and health budgets at the district level; often, VHT members are selected by their communities but districts are unable to train them due to insufficient funds. As a result, VHTs are either formed but non-operational *or* they operate for a limited period of time and are then forced to stop due to shortfalls in funds or material resources. An example of this was shared by the DHO of Buliisa, where VHTs were active under the HBMF programme but are no fully longer operational because the district has insufficient supplies of Coartem. Clearly, though DHOs recognize the importance of implementing MoH policies and programmes and are confident in the *potential* of the VHTs to effectively scale iCCM, they remain concerned about the risk of insufficient financial & material resources over time.

As the organization with the most direct mandate to support the MoH in adopting and implementing effective policies and programmes at scale, the WHO holds a very important position in terms of driving support for iCCM. Positively, officials interviewed at WHO express keen interest in the VHT model and regard it as a sound strategy for realizing universal coverage of basic health services at the community level. Similarly, WHO supports the scale-up of iCCM as a short-term measure for giving communities access to prompt and standard treatment of malaria, diarrhoea, and pneumonia. Perhaps the most important point raised by WHO officials in relation to scaling-up iCCM is that VHTs should be considered an *interim measure* and not an end in themselves. Otherwise stated, WHO believes that MoH should maintain a long-term vision of having universal, full-scale, high-quality health care services available through standing health units rather than viewing VHTs as a permanent component of the Ugandan health care system. In any case, WHO fully supports the scale-up of iCCM and views it as the best short-term strategic move for the MoH. According to one official, it is better to give universal access to basic health care services than very limited access to full-scale, high quality services; WHO believes iCCM is the best option at present for realizing this universal access.

Among the implementing partners engaged in the Stakeholder Analysis, UNICEF has been involved in implementing, evaluating, and refining the VHT model for the longest period of time. Recently, UNICEF supported a national mapping and situation assessment of VHTs, during which it identified best practices in VHT implementation that can be scaled for effective iCCM. In addition, UNICEF is currently engaged in a cooperative agreement with SCiUG to develop iCCM training & supervision guidelines, as well as a pneumonia policy. As an active member of the iCCM working group, UNICEF maintains a vested interest in supporting the successful scale-up of iCCM through VHT implementation, and remains committed to working closely with the MoH and Malaria Consortium to identify the best policies and programmatic approaches for doing so.

Training

Effectively training VHTs to ensure consistency and quality of the services comprising iCCM is critical to the success of the programme, and has proven a key stumbling block in past interventions—particularly with the implementation of HBMF. As such, the consultant engaged stakeholders in discussions of the key challenges faced with VHT training in the past in order to identify the most effective and scalable training model for the scale-up of iCCM.

As the actors directly responsible for overseeing VHT training, DHOs have tremendous insight into the challenges and opportunities associated with the process. Based on past experience, in which VHTs have struggled to understand key components of the training and often felt unprepared to utilize the skills trained due to lack of practical experience, DHOs in each of the districts visited recommend that the VHT training modules be made simpler, more practical, and ongoing—allowing VHTs to access periodic 'refresher' support and refine their skills. MoH echoes this concern, pointing to the fact that VHTs need more competency-based training as they will be handling more drugs and responding to a wider range of health challenges in the expanded iCCM model. In addition to the style of training, DHOs suggest that the training manual and materials be tailored as much as possible to a 'low-literacy' audience, as the majority of VHT members are illiterate. This recommendation is being acted already upon by SCiUG, who is working to revise and simplify the entire package of VHT training materials.

According to the DHOs interviewed, the main practical challenge in training VHTs effectively and consistently is insufficient funding in district health budgets. Funding gaps force districts to rely on the interests of donors and development agencies, and generate persistent uncertainty in regard to the long-term sustainability of the programme. In Kiboga, for example, VHT trainings

are currently supported by AMREF; if and when AMREF stops supporting these trainings, the district will be unable to continue. One option cited by the DHOs as a potential cost-reduction measure would be to focus training on preventative rather than curative measures, as the former are much less costly than the later, and therefore more sustainable in terms of funding. However, DHOs are in consensus that the real solution to this funding gap is not relying on donors or reducing the cost of delivery, but rather ensuring a steady flow of funding support for VHT training from the MoH.

Key implementing partners cite the same challenges as the DHOs and MoH, and are already engaged in responding to them. SCiUG, UNICEF, and WHO concur that VHT training must be more 'hands-on' in style, offering participants on-the-job opportunities to *learn while doing*. As part of their new partnership agreement, SCiUG and UNICEF are revising the training materials and guidelines to include more practical instruction in response to this identified need. In addition, recognizing the large funding gap in district health budgets, UNICEF is currently investing in VHT training through direct support to the districts in an effort to bolster MoH efforts to scale iCCM.

Though the key stakeholders' concerns and efforts in relation to VHT training are indeed important to the scale-up of iCCM, the stakeholders in the best position to comment on the training approach are the VHTs themselves. Encouragingly, VHTs request support of the modifications to the training approach that the MoH, DHOs, and implementing partners recommend. On the whole, VHTs are eager to receive more comprehensive training in terms of the range of skills taught and the number of diseases included in the training. Because many VHTs view themselves as the equivalent of a Health Centre I, they wish to receive training in other medical procedures not included in the current iCCM package, such as blood testing for malaria and weighing children. In addition, VHTs are interested in being trained in counselling, as they believe some parents may need counselling depending on the health of their children. Though this interest in learning a wider range of skills is reflective of the VHTs' commitment, it also indicates that they feel inadequately prepared to deliver the services expected of them by the communities they serve; this must be taken into account as the revised training materials and guidelines are prepared.

Motivation

VHT motivation is perhaps the most complex factor in implementing a sustainable and effective iCCM programme, as it is difficult to assess and define parameters for in hard and fast terms. This complexity came out clearly in the interviews and FGDs. Key stakeholders have a range of opinions about what *should* motivate VHTs and, in turn, what can reasonably be provided *as motivation* to VHTs in the context of limited funding supplies and the need to focus the majority of resources available for iCCM on drug supply and other direct implementation costs. Similarly, VHTs have their own opinions on what they need and deserve as motivation for the work that they do, but tend not to consider the programmatic implications of these desired 'motivations' in a strategic manner.

Due largely to the cost implications of various proposed motivations for VHTs, the MoH Health Education Department believes that motivation should be derived strictly from the core components of the programme. In other words, VHTs should be motivated by the fact that their communities have selected them (*pride*, *a vote of confidence*) and by the training and skills provided to them (*capacity building*, *empowerment*). The MoH Child Health Division holds a similar position for strictly practical reasons; despite research supported by the division, through which performance of health workers under HBMF was measured against incentives and shown to

improve with material/monetary motivation, funding shortfalls and human resource challenges make it infeasible to pay VHTs for the work that they do. One additional option for motivation that could serve as a compromise is the use of recognition in various forms; branded t-shirts, training certificates, acknowledgement at community meetings, and other forms of recognition for VHTs are all options that the MoH supports as feasible forms of motivation.

Based on their experience interacting regularly with VHTs on this issue, DHOs have a very practical understanding of the implications of limiting or expanding VHT motivations. Much like the MoH, DHOs argue that VHTs should be motivated primarily be the fact that their own community members have selected them. DHOs argue with reason that providing monetary incentives is a slippery slope; if VHTs are provided 5,000/= UGX per week when they begin participating in the programme, they will inevitably come to expect a higher stipend as they take on more responsibility and perform their jobs more effectively, rendering such incentives unsustainable in the long-term. In addition, DHOs suggest that a more effective use of funds would be to ensure that adequate medical supplies are always available to VHTs; in addition to ensuring the effectiveness of the programme, the steady provision of supplies to VHTs is motivation in itself, as it empowers them to do their work effectively and consistently.

Given that VHT motivation packages have no direct cost implications for WHO, its officials are able to take a more objective stance on the question. As one official remarks, "While motivation can work for a short time, it will wither away over time." WHO believes that sustainability and effectiveness of VHT implementation depends, in the long run, on more concrete motivations than voluntarism or recognition. These incentives need not be extensive—proposals include meal allowances and transport refunds—but simply can ensure that VHTs have their basic expenses covered as they are going about their work. Regardless of the motivation package ultimately selected, WHO stresses the importance of harmonizing motivation at the national level and across all programmes; otherwise, there is a risk of VHTs receiving disparate motivation packages depending on which donor is supporting their district, which would undermine efforts to sustain iCCM at scale.

In a recent situation analysis of VHT motivations, UNICEF concluded that the core motivating factors are recognition and supervision. Based on this finding, and in-line with WHO recommendations to ensure *standardized* motivational packages for VHTs, UNICEF advocates a more systematic approach to recognition and—perhaps more importantly—more robust systems for VHT supervision (discussed in detail below).

Not surprisingly, VHTs identify all of the possible forms of motivation recognized by key stakeholders. However, they advocate most strongly for monetary motivation—both as facilitation to perform their work and as compensation for their efforts. Interestingly, VHTs in Kiboga expect different levels of monetary support depending on where they live; the VHTs from the urban centre expect 100,000/= UGX every month, while VHTs in the rural areas expect just 20,000/= UGX. This suggests that the expected compensation *as motivation* is based more on cost-of-living than perceived value of the work performed. In addition to monetary motivation, VHTs strongly favour various forms of recognition—from acknowledgement at community meetings to sign posts ("VHT member lives here") at their homes—and preferential treatment for themselves and their families at district-level health centres.

Volunteerism

The notion of VHT volunteerism is somewhat controversial amongst key and primary stakeholders alike. Though most stakeholders acknowledge voluntarism as a potential motivation for VHTs, most also question its efficacy over an extended period of time. As one malaria focal person notes, the spirit of volunteerism has its limitations. These limitations came out very clearly in FGDs with VHTs, as described below.

VHTs in Kiboga both acknowledge that they began their work out of a sense of volunteerism and that, after serving their communities faithfully for several months, they expect to be appreciated for this volunteerism in more concrete ways. Though it is important to promote volunteerism amongst VHTs, it is unfair to *force* volunteerism on them as a justification for the absence of other motivations or incentives. Some VHT members note that community recognition of their work reinforces their commitment as volunteers, and imagine that sustained community recognition and support would empower them to continue working in this spirit. However, such a scenario will require communities to continuously recognize and encourage the VHTs, which may be unrealistic; what's more, VHTs note that communities often think VHT members are paid for their work, leading them to develop expectations from VHTs rather than appreciating their work as volunteers. It is for this reason that community sensitisation about VHT volunteerism is essential to maintaining this notion. Similarly, VHTs request that communities be fully informed about the role VHTs are meant to play as a way of ensuring that VHTs are fully utilized to ensure prompt and proper care.

Supervision

Supervision of VHTs at various levels is critical to successfully scaling iCCM, and will likely need to be more robust as the programme is spread to a greater number of districts.

With the introduction of new diseases for home-based care under iCCM, DHOs believe that the VHTs need close supervision and mentoring—at least once every month—to ensure retention of skills acquired in training and, in turn, proper care of children. DHOs note that their districts now have established supervision systems at the sub-district and sub-county levels, but that these systems are difficult to maintain due to the transport costs entailed. Given the current funding gaps, DHOs advocate an alternative system of on-site supervision, which would greatly reduce transport costs but may have cost implications in terms of staffing. Yet another alternative, proposed by a malaria focal person, would entail VHTs reporting collectively to the main district health facility on a quarterly basis; during this gathering, VHTs would receive the latest information on proper treatment, receive refresher training from health workers, and share data collected over the course of the quarter, and replenish their drug & medical supply stocks. This method is compelling, as it combines training, supervision, and drug restocking into a single activity, minimizing costs and providing VHTs with a regular opportunity to share experiences. The one drawback to this, as noted by various district officials, is that quarterly supervision be insufficient in terms of frequency and impact.

As the implementing partner most closely involved in supporting VHT supervision, SCiUG is designing a tool to support process through a two-tiered structure. SCiUG advocates a *supervision of supervisors* system, through which a team of supervisors at the district level provides supervision at the sub-district level to health workers, who in turn supervise VHTs. The new tool will enable health workers to effectively supervise VHTs and provide skill-building on-site during the supervision process. To ensure that this tool is effectively utilized, SCiUG advocates including supervision of VHTs in the health workers' work plans.

From a policy standpoint, WHO is involved in developing national guidelines for supervision of VHT implementation and iCCM scale-up. Though WHO advocates a standard, national guideline for supervision, it recognizes the importance of allowing for innovative approaches to supervision at the district level. The key element of supervision in whatever form it takes on is that it is *consistent* and *regular*, rather than haphazard, as it often has been in the past.

Use of data

The use of data collected by VHTs has proven one of the most challenging components of VHT implementation to-date. This matter relates both to the way that VHTs themselves use the data they collect and, in turn, how districts and the MoH use the data submitted by VHTs.

The National Malaria Control Programme (NMCP) believes that data is critical to influencing and informing more effective national policies on care and treatment. As such, it has instituted a system of district-level record assistants meant to compile and submit data collected by the VHTs to the centralized district health information service, which in turn can utilize this data for programming purposes and also submit it to the MoH for use in policy decisions. Though this system is effective in theory, it does not exist in many districts, and has encountered several challenges to-date in those districts where it exists. To be effective, this system thus needs to be refined, and also expanded to include other facts and figures. For instance, the MoH Child Health Division proposes including stock management of commodities in the data tracking systems in districts, down to the VHT level. The division also proposes tracking VHT performance as a component of data management, with the belief that performance indicators linked to data collection would ensure more comprehensive and consistent data collection on key health indicators by the VHTs.

Efforts to improve VHT data collection and use are being supported by WHO and UNICEF. Both agencies are currently supporting the MoH to develop an integrated register for VHT and health worker data collection that will be integrated into the national Health Management Information System. This register should be available for use beginning in June 2010. Through this integration of data collection tools, WHO and UNICEF aim to support more effective analysis and use of data in management of the health care system—including iCCM scale-up and associated issues related to drug supply.

One other issue related to the use of data by VHTs is that the VHTs themselves must appreciate the importance of the data they collect in order for this data to be consistently collected and utilised. SCiUG is advocating for an emphasis on the importance of data in the revised VHT training materials, as a way of helping VHTs realize the value of data and utilise it more effectively.

Drug Supply

The final factor considered in this Situation Analysis is the drug supply required for effective scale-up of iCCM. In many ways, the assurance of a steady and adequate drug supply is the most critical factor to successful VHT implementation, as VHTs simply cannot perform their duties without the necessary supplies. Though the majority of stakeholders express concern—based on past experience—about maintaining sufficient drug supply, these concerns can inform a more effective approach to drug supply if responded to properly.

As the government body responsible for coordinating the procurement and centralized delivery of drug supplies in Uganda, the National Medical Stores (NMS) has the greatest capacity to

ensure steady and adequate drug supplies for VHT implementation. At the same tame, several practical challenges identified by NMS officials suggest that a their work requires intricate coordination with other key implementing partners—including the MoH, district governments, donors, and VHTs—in order for it to be effective. The two challenges with drug supply identified by the NMS are ensuring delivery *to the VHTs* and ensuring that NMS receives the information needed for accurate procurement and distribution. On delivery, NMS is concerned that they fulfil their responsibility of delivering drugs to the districts but that districts often fail to then deliver drugs down to the health unit level, where VHTs source their supplies. This district level delivery challenge must be resolved for the supply-chain to function smoothly. On accurate stock figures, NMS officials note that they often are unable to deliver drugs on time or in the appropriate quantities because they lack district-level information required for this purpose. As such, NMS requests more coordination with MoH and district health teams to ensure a steady and accurate flow of information on drug stock needs. In addition to these practical challenges, the question of adequate resources at the national level to ensure a steady in-flow of drugs *to NMS* is a major concern; under HBMF, MoH received support for drugs from the Global Fund, and the entire programme was jeopardised when Global Fund support ended. This must be avoided by proper planning and adequate allocation of funds to the MoH, and is an issue that key policy-makers and donors should address together.

DHOs echo the concerns of NMS, and emphasise the need to improve the delivery system or risk failure of iCCM scale-up. Based on their experience implementing HBMF, DHOs express concern that drug supply shortage not only limits the work that VHTs can provide, but also severely de-motivates VHTs *and* communities, generating scepticism about the programme's efficacy. DHOs believe that their responsibility is to plan effectively and provide NMS with comprehensive procurement plans; in turn, they request more financial support to sustain their delivery systems and ensure that their planning efforts are matched with practical modalities for implementing the programme fully. This will require increases in the district-level health budgets, with specific funding allocations to delivery of drugs from the district to the sub-district and sub-county levels. Though there is some concern amongst DHOs that NMS may be unable to fully deliver on their drug supply needs, they remain willing to cooperate more effectively in the interest of more effectively utilizing VHTs in their districts.

Implementing partners recognize the concerns raised by NMS and the DHOs as key risks for implementing iCCM at scale. As WHO notes, drug supplies may be available at the outset of a programme but shortfalls will ultimately undermine the sustainability of iCCM. As such, programmatic planning must be based on realistic estimates of available funding and supply, and the MoH must lobby for long-term support of this key programming cost—support that should ideally come not from the donors but from the health sector directly. UNICEF recognizes the need to mitigate drug supply challenges by providing buffer stocks in the short-run, but advocates for an increase in direct support to the health sector to make such temporary measures unnecessary in the long-term.

In-line with the concerns raised by DHOs, VHTs note that erratic drug supplies lead to challenges at the community level and generate attrition among the teams. When VHTs begin working in a community, community expectations shift; parents come to rely on VHTs and expect care immediately, leading to backlash and de-motivation when VHTs are unable to offer care due to inadequate supplies. As such, VHTs request that implementation only begin once a steady drug supply can be ensured.

Conclusion

This Stakeholder Analysis indicates clearly that there is widespread support for VHT implementation and iCCM scale-up in Uganda. All key and primary stakeholders engaged in the analysis are confident in the efficacy of the VHT model, and remain committed in principle to the implementation of iCCM *at scale*. Despite their interest, however, stakeholders have several practical concerns that must be addressed in order for the programme to be scaled effectively and sustainably.

As implementing partners work in partnership with the Uganda MoH to revise national iCCM guidelines, VHT training materials and data tracking tools, and the overall approach to iCCM, they must remain aware of the practical risks and opportunities identified in this report. The revised guidelines and tools must reflect all of these concerns and propose functional solutions, or otherwise risk leading the VHT model into similar challenges in the future as it has faced in the past.

Just as the lessons learned from past implementation of the VHT model must be fully integrated into the strategic effort to scale-up iCCM, the VHT model and iCCM programme must be fully integrated into the Uganda MoH health care delivery system. The approach will only work if it is seen *not* as a parallel programme by health workers and beneficiaries but as a *complimentary* component of the system at large.

Perhaps the greatest challenge to successful and sustained implementation remains the severe funding gaps in current MoH budgets—funding gaps for VHT training, motivation, and supervision, as well as drug supply and delivery. National and district-level health budgets will require significant increases in order to cater for the effective systems, and these funding increases should ideally come from direct expansion of the health sector budget, rather than from discrete contribution by donors to support certain components of the programme.

Given the goal and design of the *iNSCALE* programme, Malaria Consortium, the Government of Uganda, and other implementing partners now have a tremendous opportunity to address these practical challenges and devise effective solutions for sustained programming over the next five years. The *will* to scale iCCM is very strong in Uganda, and this will must be harnessed and leveraged into practical action *now* in order to ensure that VHT implementation and iCCM scale-up can drive health promotion & education *and* the treatment of malaria, diarrhoea and pneumonia at the community-level effectively and sustainably.

APPENDIX A: Interview and FGD Guides

Stakeholder Interview Guide: *Implementing Partners*

Target group: i) WHO, ii) UNICEF, iii) the district health officials, iv) Chief Accounting Officers (CAOs), v) District Secretaries for Health, vi) IRC, vii) Save the Children, viii) Malaria Consortium

Village Health Teams (VHT) and Integrated Community Case Management (iCCM)

a) How are you involved in national decision making in relation to the VHT programme?
b) What are the main opportunities you see for the VHT programme?
c) What barriers/threats do they see or experience?
d) How will you be involved in finding the solutions to these barriers?
e) What areas do they feel are priorities for improvement of the VHT programme and why?
f) How are you involved in the changes needed to improve drug supply? What changes would you support? Why?

Supervision

a. What is your involvement in the supervision strategy for VHTs? In finding solutions for improved supervision?
b. What is your willingness to try new innovations to improve VHT supervision?
c. What changes would you support in relation to VHT supervision and why?

Training

a) How are you involved in national decision making for implementation of VHT training and improvements?
b) Are you supportive of changes or happy with status quo?
c) What changes to the training package would you support and why?

Motivation

a. How are you involved in national decision making for implementation of VHT motivational activities and improvements in VHT motivation?
b. Are you supportive of changes to improve VHT motivation or happy with status quo? What changes would you support and why?
c. What is your view on using paid VHT members?

Making use of data

a) What is your involvement in making use of data coming from the VHTs? In finding solutions to improved use of data?
b) What barriers/threats do they see to the use of VHT data?
c) What innovations would you support to improve the use of data and why?
d) What opportunities do they see for better use of data or what are you going to take advantage of?

Stakeholder Interview Guide: *Ministry of Health (MoH)*

Target group: i) NMCP, ii) Child health department, iii) Planning Department, iv) Health Promotion / Health Education, v) HMIS-resource centre, vi) Pharmacy division, vii) National Drug Authorities, viii) National Medical Stores

Village Health Teams (VHT) and Integrated Community Case Management (iCCM)

a) What is your opinion about the VHT strategy? Of iCCM?
b) What is your role in the planning / implementation of the VHT programme?
c) What are the main opportunities you see for the VHT programme?
d) What barriers/threats do they see or experience in relation to national scale up of the iCCM programme?
e) How do you foresee sustained financial support to implementation of the iCCM programme at scale?
f) What are the plans to ensure sufficient national drug supplies to allow the CMDs to function?

Supervision

a) What is your involvement in decision making of VHT supervision at policy level, guidelines development, or monitoring /evaluation?
b) What solutions would you support for better VHT supervision? Not support? Why not?
c) What is your role in supporting implementation partners and districts to improve VHT supervision or ensure it takes place regularly and effectively?

Training

a) What is your involvement in decision making of VHT training at policy level or guidelines development?
b) What solutions would you support for better VHT training? Not support? Why not?
c) What is your role in supporting implementation partners and districts to improve VHT training?
d) What technologies would you support to be used in VHT training? Not support? Why not?

Motivation

a) What is your involvement in decision making of VHT motivation at policy level?
b) What solutions would you support for better VHT motivation? Not support? Why not?
c) What is your role in supporting implementation partners and districts to improve VHT motivation?
d) What are the solutions that you are willing to support in the areas of community engagement and VHT recognition? Not support? Why not?

Making use of data

a) What is your involvement in decision making of capturing and use of VHT data at policy level?
b) What solutions would you support for better collect and use of VHT data? Not support? Why not?
c) What is your role in supporting implementation partners and districts to improve collection and use of VHT data?
d) What technologies would you support to be used in capturing of VHT data? Not support? Why not?

Stakeholder Interview Guide: *Drug suppliers and regulators*

i) National Drug Authorities, ii) National Medical Stores

Village Health Teams (VHT) and Integrated Community Case Management (iCCM)

a) What is your opinion about the VHT strategy? Of iCCM?
b) What is your role in the planning / implementation of the VHT programme?
c) What are the main opportunities you see for the VHT programme?
d) What barriers/threats do they see or experience in relation to national scale up of the iCCM programme?
e) How do you foresee sustained financial support to implementation of the iCCM programme at scale?
f) What are the plans to ensure sufficient national drug supplies to allow the CMDs to function?
g) Are there any special barriers you foresee with regards to pre-packed supply of Coartem? Amoxicillin? Zinc?

Making use of data

a. How do you see the use of VHT data in planning and budgeting for drug supply for the program?
b. What are the main barriers to efficient data flow and use from VHTs for budgeting and planning for drug supply?
c. What is your involvement in decision making of capturing and use of VHT data at policy level?
d. What solutions would you support for better collect and use of VHT data? Not support? Why not?
e. What is your role in supporting implementation partners and districts to improve collection and use of VHT data?
f. What technologies would you support to be used in capturing of VHT data? Not support? Why not?

Focus Group Discussion (FGD) Guide
Target group: VHT members

Village Health Teams (VHT) and Integrated Community Case Management (iCCM)

a) As VHT members, what are the good things about the VHT programme?
b) What barriers / threats do they see or experience?
c) As VHT members, how can you be involved in finding solutions to these barriers?
d) Who else in your community would have the influence to find solutions to these barriers? How could they influence?
e) What areas do they feel are priorities for improvement of the VHT programme and why?

Supervision

a) What you think is good with the way you are supervised? Not so good?
b) As VHT members, how can you influence the supervision activities?
c) Who else in your community would have the influence to improve supervision of VHT members? How could they influence?

Training

a) What do you think was good with tools you were given and content of the training?
b) What was not so good with tools and content of the training given?
c) As VHT members, how can you be involved in improving the training and tools provided?
d) Who else in your community would have the influence to improve training of VHT members? How could they influence?

Motivation

a) As VHT members, what motivates you to do a good job? What demoralizes you?
b) What do you think is good with the motivation and incentives given to VHT members? Not so good?
c) As VHT members, how can you be involved in influencing the motivation and incentives for VHT members?
d) Who else in your community would have the influence to improve motivation of VHT members? How could they influence?

Making use of data

a) What are the good things with the record books that you are using?
b) What are the difficulties you experience with recording and submitting your data?
c) As VHT members, how can you be involved in improving the recording and submission of data?
d) Who else in your community would have the influence to improve capturing and submission of data? How could they influence?
e) As VHT members, how can you be involved in improving other community members' awareness of what you have accomplished as VHT members?
f) Who else in your community would have the influence to increase awareness of VHT members' accomplishments? How could they influence?