UGANDA PROGRAMME FOR HUMAN AND HOLISTIC DEVELOPMENT (UPHOLD)

Action Research on Improving Motivation of Community Medicine Distributors (CMDs) and Other Community Based Health Workers

August, 2007

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Recommended Citation:

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This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of UPHOLD and do not necessarily reflect the views of USAID or the United States Government.

UPHOLD is implemented by JSI Research and Training Institute Inc., with funding from USAID under Cooperative Agreement number 617-A-00-02-00012-00 in collaboration with the Education Development Centre (EDC), Constella Futures, Malaria Consortium, the Manoff Group Inc. and World Education.

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ABBREVIATIONS AND ACRONYMNS

CCF	Christian Children's Fund
CMDs	Community Medicine Distributors
FGDs	Focus Group Discussions
HBMF	Home Based Management of Fever
HSSP	Health Sector Strategic Plan
KIIs	Key Informant Interviews
UPHOLD	Uganda Program for Human and Holistic Development

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EXECUTIVE SUMMARY

This report is an outcome of an action research conducted on behalf of the Uganda Program for Human and Holistic Development (UPHOLD) to explore how Community Medicine Distributors (CMDs) in Uganda can best be motivated. The specific objectives of the study were to:

1. Identify the key factors that affect performance of CMDs,
2. Identify mechanisms used by local governments and communities to facilitate and motivate the CMDs,
3. Explore CMDs views about facilitation and motivation,
4. Determine the attrition levels of CMDs,
5. Explore different stakeholders' (community, health managers as well as local leaders) views about CMD facilitation and motivation.

The study was conducted in the districts of Kamuli, Luwero, Lira and Rukungiri. Data was collected using both qualitative as well as quantitative methods, including 32 key informant interviews, 28 Focus Group Discussions (FGDs) and a quantitative survey of 204 CMDs. All the qualitative data were transcribed, edited and typed into Microsoft Word computer software and manually analyzed for content and recurrent themes within the texts in relation to the study objectives. Quantitative data was compiled using EPINFO 6 and later imported into the Statistical Package for Social Scientists (SPSS) for detailed analysis. Descriptive statistics on the socio-economic and demographic characteristics of the CMDs were generated and where necessary these were cross-tabulated with other variables. Where possible, findings from the quantitative and qualitative analysis were triangulated to check consistency.

Key Findings

Characteristics of CMDs

Fifty eight percent 57.4% (n=117) of the CMDs were female with those of middle age constituting 38.7% (n= 79) of the sample. Other demographic variables were: 87.3% (n= 178) over 40 years, 53.9% (n=110) married, 98.5% (n=200) had attained at least S1-S6 secondary education, 98.5% (n= 200) had received training related to their work and 88.2% (n= 179) became distributors after being selected by the community.

Motivational Factors

Initial

The interest to serve as CMDs stemmed from various factors, including among others; expectation for material and monetary gains, humanitarian reasons, associated community respect, expectation of paid employment in the long term and a desire for skills and experience. Anticipation of monetary gains was significantly higher (*p value = 0.003)* among the male CMDs with 63.6% (n=14) males hoping for monetary remuneration compared to 36.4% (n=8) females as was anticipation of material gains among male CMDs which was found in 66.6% (n=16) males compared to 33.3% (n=8) females. Although no significant differences were noted, more female CMDs (n=47, 61.8%) than males expected respect (n=29, 38.2%) and similarly, more females CMDs (n= 85, 53.5%) than male CMDs (n=74, 46.5%) had the humanitarian spirit to serve their community.

Despite the commitment of CMDs, community support as stated by the community during the interviews is still a remote reality. The CMDs were also clear that communities were virtually unwilling to contribute anything in return for the services. There was a mistaken belief on the part of the communities that CMDs are paid by the government.

Local governments have the will to motivate CMDs but lack resources and this has been compounded by the scrapping of graduated tax. The local government

support is still limited to; technical support, training and support supervision, procurement and distribution of medicines, provision of transport refund for meetings and provision of badges[1].

Challenges

The challenges faced by CMDs included: inadequate logistics and supplies, poor distribution of medicines and treatment, competing time demands on their work, distrust by some caretakers, drug resistance, awkward working hours and drug expiry and under-reporting of children's age by caretakers in order to receive Homapak.

It was noted that the collation of data on CMDs' effective performance is hindered by insufficient and irregular supplies of drugs and lack of transport facilitation. In terms of transport, it was argued that lack of facilitation results into CMDs' failure to make timely submissions of monthly reports, difficulties in effecting home visits to follow up children and above all, delays in picking drug replenishments from the health facilities.

Current Motivators

CMDs indicated they would continue to work despite the current challenges. Whereas the need for money as a token of appreciation was expressed by CMDs especially male ones, there were other similarly important motivators including respect (*being called omusawo [doctor]*), prospects for formal employment and gaining skills. The issue of refresher training was also raised by CMDs themselves who argued that it would enhance their skills in doing their work especially in the wake of the changing malaria treatment protocol.

Children who get better after receiving the treatment from the CMDs was also noted to be a great motivator for the CMDs.

[1] It should be noted most of these activities are largely funded by UPHOLD and other partners

Potential Motivators

CMDs are not sufficiently facilitated in terms of transport, provision of supplies and logistics such as stationery, lanterns, gumboots, gloves and other materials such as uniforms, and storage facilities for drugs. Prominent among CMDs expectations were reasonable and regular monetary allowances, facilitation in terms of transport, recognition and recognition.

Multi-tasking is apparent among CMDs and it reinforces CMDs motivation especially when they participate in other activities that provide good allowance. However, they still expect that HBMF would do as other programs and provide allowances for its community based volunteers.

There were no concrete figures on the current number of CMDs especially the attrition numbers and this was caused by lack of proper records.

According to the key informant interviews, the attrition levels of CMDs were minimal. The few that that dropped out were reportedly due to marriage and subsequent change of residence, death and divorce.

Conclusions

- The communities were adamantly unwilling to facilitate CMDs although they expect CMDs to be efficient in their performance including readiness to provide the services at all times and following up children.
- The Government of Uganda's recognition of CMDs and integration of CMD activities into their work plans remains inadequate and where there are efforts to do so, they are often insufficient. At the moment, because of resource constraints, local governments are only able to budget for technical support supervision for the CMDs.
- Although CMDs appreciate the fact that they were selected to work as volunteers, they still feel that program should adequately facilitate them

especially in ways that enables them to effectively execute their responsibilities. Besides, a token of appreciation in monetary terms would be more encouraging.

- Apparently CMDs are motivated by non-monetary incentives like the social status associated with the job, recognition by the local government, refresher training, certificates, badges, raincoats and gum boots.
- Record keeping among local governments remains a challenge. As such, there was no conclusive evidence on the attrition rates of CMDs. The general perspective across the studied districts was simply that attrition rates are minimal.

Programmatic Recommendations

- There is need for a sensitization strategy to clarify about the working conditions of CMDs and the roles expected of the different stakeholders including the communities.
- Local governments and other partners should work closely with other programs directly using volunteers so that there is a formal integration to maximize a uniform motivational package. The Village Health Team (VHT) strategy of the Ministry of Health (MoH) for instance could be explored to absorb the CMDs. This package should include and not limited to; refresher training, bicycles to ease transport, certificates, badges, gum boots and regular medicine supplies and a token of appreciation in monetary terms.
- The drug delivery system at all levels in the health system should be streamlined to avoid cases of expiry and stock outs. This goes hand in hand with the need to improve record keeping, so that CMDs who drop out are immediately realized and necessary replacements and training can be effected to allow for continuity of services in the villages.

CHAPTER ONE: INTRODUCTION

1.0 Background

This report is an outcome of an action research on improving motivation of community medicine distributors (CMDs) and other community based health workers in Uganda. It was commissioned by the Uganda Program for Human and Holistic Development (UPHOLD) to generate perspectives on motivation of Community Medicine Distributors (CMDs) from the stakeholders in community-directed interventions. The stakeholders included the CMDs themselves, health managers, local leaders and community representatives in general in order to come up with realistic and appropriate recommendations on how the CMDs can best be motivated. The report draws on primary data collected using largely qualitative methods but also supplemented by quantitative data.

1.1 Research Rationale and Background

UPHOLD works with the Government of Uganda to improve the access, quality and utilization of health, education and HIV/AIDS services. As part of its support to the Health Sector Strategic Plan (HSSP), UPHOLD supports among others, the implementation of malaria control interventions. One of these interventions is the Home Based Management of Fever (HBMF) strategy which seeks to deliver prompt treatment (within 24 hours) for fever among children below five years. By design, the treatment is given by lay community volunteers known as CMDs. The CMDs treat fevers using Homapak, a pre-packaged anti-malarial containing a combination of Sulphadoxine/Pyrimethamin (SP) and Chloroquine (CQ). The HBMF strategy assumes that if efficacious drugs are brought nearer to households, this would increase prompt and appropriate treatment of fever (most of which is presumed to be due to malaria) among children under five.

The program is designed in such a way that two CMDs per village are selected by their community members, trained in the treatment procedures, provided with registers and once active, are supposed to collect Homapak from the nearest

health facility stores for use in treating clients who come to their homes. Caretakers of children under five are advised to take any child suspected of having fever to the CMDs for assessment and eventual treatment if no complications are found. This advice is given through many channels, including radio and at any contact point in the facility. CMDs are then expected to treat the children, instruct the mothers on the duration of treatment and the importance of completing the full course of treatment, and record treatment information in the registers. In case of danger signs such as convulsions or loss of consciousness, CMDs are supposed to refer such cases to the health facilities.

According to the World Health Organization (WHO) guidelines, CMDs are supposed to be selected by the communities and at the same time communities are meant to find ways of facilitating them in order to keep them motivated to continue providing such a critical service (Ministry of Health, 2002).

In the available literature there appears to be no agreement on how motivation for community-based volunteers should be approached. In a number of studies, the main argument has been that voluntarism without motivation cannot be sustained (Kironde and Klassen, 2002, Kironde and Bajunirwe, 2002, Nsabagasani et al 2007, Bhattacharyya, 2001) with recommendations of systematic use of multiple incentives based on the different contexts. Some studies have proposed the integration of volunteers into other health and development programs as a form of motivation and sustainability (Katabarwa et al, 2005). The idea of integration however, raises the question of whether multi-tasking as a volunteer does not make one inefficient as a result of many demands. In the literature, there is consensus that more qualitative studies are needed to understand the context in which people are volunteering. It is by understanding this context that we can be able to develop realistic solutions to the problem of motivating volunteers.

The lack of sufficient empirically-based evidence on the experiences of CMDs in the performance of their roles under the HBMF program and other community-

oriented service programs was the main drive behind this study. Issues regarding the feasibility of using CMDs, methods for their motivation, and the question of their sustainability remains at the centre of debate among the academia and policy makers. By commissioning this study UPHOLD sought to fill some of these knowledge gaps.

1.2 Guiding Research Questions

- What motivates an individual to volunteer and to continue working as a CMD?
- How are CMDs being motivated and by who?
- What are the CMDs, leaders, community views regarding recent attempts to motivate them through provision of a free long lasting insecticide treated nets (LLINs), T-shirts, badges, bicycles etc?
- How would CMDs like to be motivated given the realities on the ground?
- Who do CMDs think should motivate them?
- What does the community say about motivating CMDs?
- What do CMDs say about multi-tasking as volunteers and how does it affect their role as HBMF volunteers?

1.3 Objectives of the Study

1.3.1 Overall Objective

The overall objective of the study was to generate perspectives about CMDs motivation from the CMDs themselves, health managers, local leaders and the community and thereafter share these perspectives with the relevant stakeholders in order to come up with appropriate and realistic recommendations on how CMDs can best be motivated.

1.3.2 Specific Objectives

1. To identify the key factors that affect performance of CMDs.
2. To identify mechanisms used by local governments and communities to facilitate and motivate the CMDs.
3. To explore CMDs views about facilitation and motivation.

4. To determine the attrition levels of CMDs.
5. To explore different stakeholders' (including the community, health managers as well as local leaders) views about CMDs facilitation and motivation.
6. Based on field findings, make recommendations on realistic and sustainable ways in which volunteers like CMDs can be retained in community-based programs and motivated to carry out their duties.

1.3.3 Working Hypotheses on Possible Options for Motivating CMDs

The study was conceived hinging on four hypotheses, which include;

1. Government is willing to make contribution to the motivation of CMDs.
2. Communities are willing to contribute to the facilitation of and motivation of CMDs either in kind or cash.
3. CMDs are motivated if they are recognised by the local governments and integrated into the local government plans.
4. CMDs themselves understand the realities regarding the difficulties involved in paying them a regular salary and have other motivational factors such as empathy and altruism that drive them rather than only money.

CHAPTER TWO: METHODOLOGY

2.1 Overall Design and Approach

This was a cross-sectional study design adopting a predominant use of qualitative research methods with supplements of quantitative methods.

2.2 Study Area

The study was conducted in four districts out of the 34 districts which UPHOLD supports, drawing one district from each of the four regions of Uganda where UPHOLD operates. The districts were; Kamuli in the East, Lira in the North, Rukungiri in the West and Luwero in the Central Regions.

2.3 Study Population

The study population comprised of; District Health Officers and their deputies, Secretaries for Health, Malaria Focal Persons, health workers at Health Centre III level, Sub-County Chiefs, District Community Development Officers, Chief Administrative Officers, CMDs and community volunteers in other community-run programs. The choice of study participants was based on the fact that they were involved (directly or indirectly) in community services provision as providers of resources (especially financial), direct providers of the services to the communities, supervisors or direct beneficiaries of the program activities.

2.4 Study Sample

The sample size from which quantitative data was collected was 204**,** comprising 87 male and 117 female CMDs as shown in Table 1. Qualitative data was collected from a total of 28 FGDs and 32 key informants interviews (KIIs). As indicated in Table 2, three categories of groups participated in the FGDs per district; a) Four FGDs per district involving Community Medicine Distributors CMDs; b) Two FGDs involving separately men and women as community representatives who directly benefit from the services of CMDs; and c) One group combining men and women representing other community based volunteers.

Table 1: Study Sample Size Distribution by Districts and Gender

Districts	Gender		Total
	Male	Female	
Kamuli	20	31	51
Luwero	22	29	51
Rukungiri	6	41	47
Lira	39	16	55
Total	**87**	**117**	**204**

Table 2: Number of FGDs conducted per district

FGD Category	Planned	Actual
CMDs	4	4
Volunteers of other programs	1	1
Community representatives (men & women)	2	2
Grand Total	**7**	**7**

2.5 Data Collection Techniques

The study was conducted largely using qualitative data collection techniques supplemented by some quantitative data. The qualitative data collection involved key informant interviews, focus group discussions and dissemination meetings with stakeholders at district level while quantitative data collection entailed face-to-face structured interviews with CMDs.

Structured interviews were conducted using a questionnaire to explore background characteristics of CMDs and related issues. KII guides were used to explore the current motivation mechanisms, existing community programs using volunteers, perspectives on how best to motivate them, experiences with retention of CMDs and CMDs performance in relation to their expected roles. FGD guides were used

to generate FGD data on the perspectives of the volunteers themselves, their experiences, challenges and what they thought can keep the volunteer spirit running in community-led programs. The FGDs also explored the CMDs current forms of motivation, the providers of motivation, who they (CMDs) think should motivate them and the community views about their role in motivating CMDs.

A debriefing session on study results was conducted by the study teams upon completion of the initial data collection during which findings were consolidated and validated. After data collection, a quick analysis of the data was done while still in the field in order to share critical issues with the district and sub-county key decision makers. A half day meeting was then convened in each study district to generate the views of the local government officials on how best to motivate and sustain community-based volunteers with emphasis on CMDs and other volunteers on health programs. The views generated during the dissemination meetings were compiled and analyzed for content regarding themes and emerging issues. A deeper synthesis of these issues informed the recommendations in the report for the sustainability of community-based voluntary service providers with particular reference to CMDs under the HBMF program.

2.6 Data Analysis

All qualitative data collected from FGDs and KIIs was transcribed, edited, and entered into Microsoft Word. The analysis focused on content within the texts in relation to the study themes, based on the objectives and deliverables of the assignment. This evidence is endorsed by verbatim quotes from study participants. Quantitative data was entered using EPIINFO 6 and later imported into the Statistical Package for Social Scientists (SPSS) for more a detailed analysis. Descriptive statistics on the socio-economic and demographic characteristics of the CMDs was generated and where necessary, these were cross-tabulated with other variables such as motivation.

CHAPTER THREE: RESEARCH RESULTS

3. 0 Introduction

Results presented in this report are based on various themes. These include (1) the socio-economic characteristics of the CMDs as collected numbers: (2) CMDs selection, training and understanding of their roles and roles of their partners; (3) key motivators (pull factors) of CMDs; (4) existing motivational arrangements; (5) stakeholder perspectives on motivation; (6) challenges faced by CMDs in their work; (7) potential motivational mechanisms; (8) expectations of the CMDs; (9) and a discussion of emerging issues. Where possible, effort was made to triangulate qualitative and quantitative information.

3.1 Characteristics of CMDs

Information covered under the characteristics of CMDs included socio-demographic variables and socio-economic characteristics. A total of 204 CMDs of which 42.6% (n=87) were males and 57.4% (n=117) were females were interviewed from the four districts. As table 2 shows, the majority 38.7% (n=79) of the distributors were middle-aged (40+ years), followed by those aged between 30 - 34 years representing 21.1% (n=43).

Table 3: Age-group of Respondents/CMDs

Age	Frequency	Percent
Less than 20	1	0.5
20-24	7	3.4
25-29	36	17.6
30-34	43	21.1
35-39	38	18.6
40+	79	38.7
Total	**204**	**100%**

Most (87.2% [n=187]) of the interviewed CMDs were married. The divorced/separated and widow/widowers constituted 6.9% while the singles were 5.9%. The majority, 99.5% (n=203) attained some level of education, the highest level being secondary education (56.3%, n=115). 3.9% (n=80) attained primary, 3.9%(n=8) had attained tertiary education, and only one CMD had no formal education. In terms of occupation, the majority of the CMDs 53.9% (n=110) were peasants, 22.5% (n=46) were self employed, 17.2% (n=35,) were unemployed and only nine (4.4%) had formal employment.

Table 4: Average Number of Months served as CMDs by Gender

Gender	N	Mean	Minimum	Maximum
Male	84	39.82	5	62
Female	113	46.65	12	76
Total	**197**	**43.74**	**5**	**76**

The overall average of duration of service by the CMDs was 44 months with slight variations between female and male CMDs, (40 months for males compared to 47 months for females) as shown in Table 4. The longest period of service by gender was 62 months and 76 months for males and females respectively, while the shortest duration of service was 5 and 12 months for male and female CMDs respectively. Women serve significantly longer periods (*p-value 0.008*).

3.2 CMDs Training

The HBMF program emphasis on training was evident from the structured interviews with CMDs. The study established that nearly all, 98.5% (n=200) of the interviewed CMDs had received training related to their work. This is commendable considering the possible huge investment in training two CMDs per village throughout the country. It is interesting that only four CMDs said they did not receive formal training. It was found, however, that for those that did not receive formal training, they got some basic guidance on what to do when under-

five children are brought to them. This was found to be the case in situations where CMDs dropped out of service for reasons such as search for wage employment, marriage and death among others. Reports from the focus group discussions and key informants reveal that some CMDs entrust their responsibilities to other household members or another village member when they are discontinuing their services for any of the reasons already mentioned above.

> *"During training, we were sensitized to get a family member who know how to read and write and leave him/her with the key and who does not forget easily and he/she distributes the drug"* **FGD, Nyakagyeme,Kahoko Parish, Rukungiri District.**

> *"…….this has not affected us in any way because if a man is selected, he trains his wife about the drugs, how to distribute it and proper dosage so that in case he is not there and a patient is brought the wife can still dispense the drugs"* **FGD, Kyawangabi Parish, Luweero District**.

> "……..*though there are no drop outs, some CMDs die or get married elsewhere so replacement and training needs funding which we do not have. You find CMDs training each other which is not proper"* **District Director Health Services.**

3.3 Selection of CMDs

Most (88% [n=179]) CMDs became distributors after being selected by the community while a few of them were appointed by Parish Development Committee (PDCs) chairpersons, health workers at the health facility and district level health supervisors as shown in Table 6.

Table 5: Selection of CMDs

How did you become a community medicine distributor? No.		%
By community	**179**	**88.1**
By parish development committee Chairman	**14**	**6.9**
By health worker at the health facility	2	1
By District level health supervisor	1	0.5
By LC chairman	3	1.5
By camp leaders	3	1.5
By Christian Children's Fund (CCF)	1	0.5
Total	203	100

As noted earlier, the majority of distributors are married and middle aged, and were selected by the community, at a gathering. They were then assembled, and mobilized by the village leader, (LC1 chairperson). According to the KIIs the community was given hints on the qualities of who should be selected and then they were left to select the two CMDs.

> *"…We went and sensitized them following some selection criteria. We sensitized each village before selection was done. So after sensitization all the members of the village had the picture of who was fit to be a CMD. They elected their own CMDs"* Malaria Focal Person.

According to discussions with the community, marital status, age and education were reported to be central considerations in the selection of these CMDs. The rationale is that people meeting the selection criteria are likely to be trusted, less mobile and likely to grasp the treatment guidelines easily and provide appropriate treatment. Some excerpts from the qualitative data as shown below are illustrative:

> *"…We selected them because we trusted them. We knew they would be able to provide good service. They are people who do not get disgusted*

easily and they are educated. They went to school" **FGD with community members, Nankandulo village, Kamuli District.**

"...The LCs were called at the sub county and given guides on how they should "do the selection. The LCs then went to the villages and selected on the basis of their ability and knowledge and that each person to be selected should know some English and the community gave approval of those selected" **FGD, community members, Ayac Parish, Lira District**.

"…They were selected while people were still in the camp. Each block was called upon to select knowledgeable people to assist in the work" **FGD, community members, Adagawaka Village, Lira District.**

"…First and foremost we were sensitized about by the Local Council (LC) Chairperson that Ministry of Health is interested in volunteers to work as medicine distributors at community level. A letter came from the unit through the LC1 chairperson specifying the date and the kind of people they needed to work with at the health centre. We were taught about first aid treatment to the children with fever. They even told us about the sealed tablets they were to give to the children in management of fever. They went ahead to emphasize that the drugs will be free of charge. After that the selection committee sat which consisted of the health worker from the Mbulamuti Health centre, and the local council. They asked us to nominate names from our communities. However we were challenged because of the different classes of people we have at the community level i.e. the youth, women and men. So for us we decided to nominate a youth and a woman to do the work because normally men are unreliable with work which has no payment at the end of the day. We also needed to cater for the different needs" **FGD, community members, Bugondha Parish, Kamuli District.**

3.4 CMDs' Roles and Responsibilities

In both qualitative and quantitative data, the CMDs were asked to mention some of their roles and responsibilities. Their responses were consistent with the responsibilities spelt out in the policy guidelines (WHO 2004, MOH 2002) as outlined in the Table 7 and as evidenced by verbatim quotes presented.

The common responsibilities included treating children below five years, assessing and monitoring their condition, sensitizing people on drug use and referral of complicated cases. Other responsibilities included; giving advice on completion of treatment course, filling forms and submitting them, and being custodians of drugs.

Table 8 details the responsibilities, while the quotes confirm CMD knowledge of their responsibilities.

Table 6: CMDs' Responsibilities

Responsibility	Frequency	%
Treating children below five years	199	18.4
Advise on completion of the dose	94	8.7
Filling the forms	66	6.1
Submitting reports	80	7.4
Assessing and monitoring the condition of the child	144	13.3
Refer cases	133	12.3
Collect drugs from health unit	112	10.4
Custodian of drugs	74	6.9
Sensitize people on drug use	142	13.2
Others* (provide examples on what these would be)	35	3.2
Total	**1079**	**100%**

> *"…The first responsibility is collecting the medicine from the health facility and takes it to the village"* **FGD, Butuntumula, Kyawangabi Parish, Luweero District.**

> *"…Even the drug itself when I am going to take it I have to look at it to see when it was manufactured and when it is expiring"* **FGD, Butuntumula, Kyawangabi Parish, Luweero District**

> *"…Our responsibility as drug distributors is to see that we educate the people we stay with to avoid diseases and secondly if one falls sick, we have drugs for children, they should be brought when it is still early and they should finish the dose and when the child is badly off, we refer to the trained health workers."* **FGD, Nyakagyeme, Kahoko Parish, Rukungiri District.**

"…The responsibility we have is to treat our children so fast. Because of transport and distance, our children used to die on the way to the hospital but now we treat them as fast as we can" **(FGD, Nyakagyeme, Kahoko Parish, Rukungiri District)**

"…Even if you are busy working, you should give first priority to children" **(FGD, Buyanja, Nakina Parish, Rukungiri District)**

"…Recording the drugs and patients (children) treated was yet another responsibility assigned to us as Community Medicine Distributors. This was for accountability for the drugs and we have been doing it at any point in time" **(FGD, Mburamuti, Parish, Kamuli District)**

"…We also sensitise community members on public health. we encourage them to clear bushes around their homes, drain stagnant water by digging trenches, mobilize them to have pit latrines, drying racks and proper storage for water, especially drinking water" **(FGD, Kisozi, Kakira Parish, Kamuli Distrct)**

"…We also encourage pregnant mothers to go for vaccination". **(FGD, Apala, Amon Omito Parish,Lira District)**

"…Advising mothers on proper ways of swallowing of drugs for their children" **(FGD, Apala, Okwangole Parish, Lira)**

The ability of the CMDs in understanding their roles and responsibilities can largely attributed to the training they received since nearly all (n=200, 98.5%) indicated they had received training before they started working as CMDs. Among the reported trainers were sub-county health workers, district health teams and some NGO officials.

3.5 CMDs' Perspectives on Roles of Other Partners

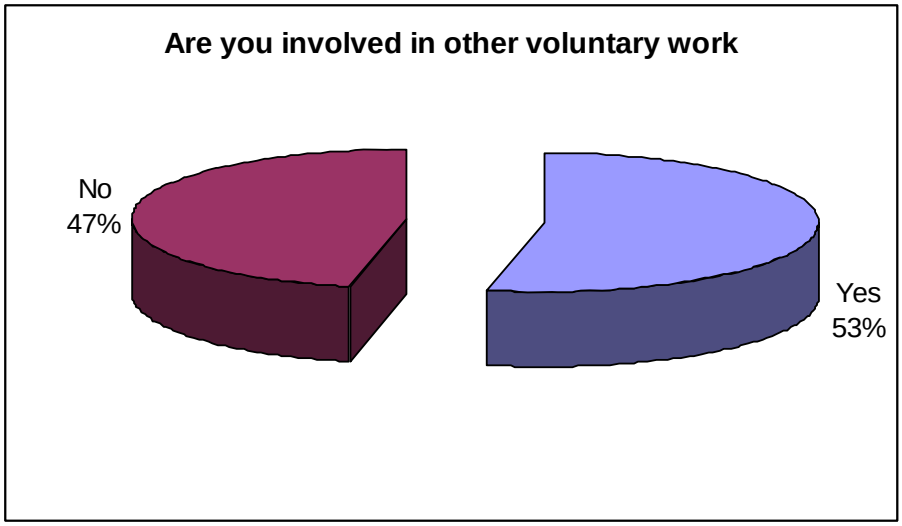
When asked who they are supposed to work with, it was established that they work with other partners to complete the service chain. The commonly mentioned partners included: the health workers at the nearest health unit, the caretakers of under-five children themselves, village health teams, local leaders and other

CMDs. In general, the health facility staffs were reported to be responsible for drug supplies, support supervision and receipts of monthly reports from CMDs. The caretakers were supposed to identify the child with malaria related conditions, report to CMDs and adhere to the treatment or advice given to them. Other partners were reported to be responsible for dissemination of information about the dissemination of information about the availability of Homapak and mobilization of the community to utilize the services of CMDs. The details of the specific roles played by each of the partners are in Table 13 in Annex A.

3.6 Other Voluntary Activities CMDS are Involved in Apart from Drug Distribution

The study revealed that slightly over half (53%) of the interviewed community drug distributors are involved in another voluntary activity as shown in Figure 1. Out of 204 of the interviewed CMDs, 47% were engaged in no other voluntary activity.

Fig 1: Involvement in other Voluntary Activities



The most frequently mentioned voluntary community programs that CMDs work for were immunization related programs (n=49, 31.2%), followed by nutrition promotion activities (n=34, 21.7%) and voluntary work through Plan international (n=20, 12.7%). It should be noted that not all of these programs reported were

running in each of the study districts. Plan International for instance was found to be operational in Luwero and Kamuli Districts while the African Medical Research Foundation (AMREF) was mentioned only in Luwero District. The details are in Table 9.

Table 7: Other Programs for which CMDs are Volunteers (n=204)

Programs	Freq	%
Uganda National Extended Program for Immunisation Related Services (UNEPI)	49	31.2
Nutrition Promotion	34	21.3
Tuberculosis Directly Observed Treatment	6	3.8
Family Planning	8	5
National Agricultural Advisory Services	10	6.3
Community Based Distribution Agent for Family Planning Association of Uganda	1	0.6
Bataka-Burial Association	1	0.6
PLAN International	20	12.5
Community Monitoring & Evaluation	1	0.6
African Medical Research Foundation	11	6.9
Promote Hygiene & Control Malaria		
Dealing with Accident Patients	1	0.6
AFFORD	2	1.3
Village Health Team	2	1.3
Functional Adult Literacy	2	1.3
Member of School Management Committee	3	1.9
Member of Parish Development Committee	2	1.3
Local Council 1 Committee	2	1.3
Church Activities	4	2.5
Mobilization of Net Distribution	1	0.6
Total	**160**	**100**

The number of CMDs involved in other voluntary program activities is evidence of multi-tasking. Interestingly, rather than being a burden, multi-tasking was appreciated for the benefits that accrue to individual volunteers directly and indirectly as implied in the verbatim quotes.

"…We have gained a lot from AMREF. It has helped in supplying people with water, books to children, school fees, when they invite us for seminars and training, they give us allowances from 5000/= and above". ***(*FGD,Village Health Team, Butuntumura Ngogolo Parish, Luweero District*).***

"…I am unfortunate I have not got a cow and water but PLAN has also solved our transport problem by giving us bicycles though no fuel. We have used these bicycles to wake up people about the necessity to register their children at birth".
(FGD, Village Health Team, Butuntumura Ngogolo Parish, Luweero District).

"…We get allowances of about 10,000 to 20,000/= but comes irregularly".
(FGD, None HBMF volunteer, Amach Lira District).

"…We have inadequate transport as every body has not been given a bicycle, only team leaders (4) got it". **(FGD, None HBMF, Amach Lira District).**

"…There were some community volunteers being paid.CCF(NGO) was paying some volunteers at 9,000 on weekly basis yet the drug distributors were for free hence some left". **(FGD,CMDs Apala sub county,Okwangole Parish, Lira District).**

"…CCF used to avail some materials benefits like rain coats, gumboots, torches and would once in a while pay some allowances i.e 2,000 to 3,000/=,so when they left the area, some CMDs dropped out" **(FGD,CMDs Apala sub county, Okwangole Parish, Lira District).**

3.7 Key Motivators (Pull Factors) for CMDs

The study explored factors that attracted the CMDs to work as volunteers. There were diverse reasons mentioned by the CMDs and the commonly cited pull factors across regions included; expectation for material and monetary gains, desire to serve their community, need to address the critical problem of children suffering, expectation of full time employment later and wanting to gain skills and experience.

Although CMDs were expected to work as volunteers, expectation of monetary and material rewards was common. According to the survey CMDs anticipation of monetary gains was higher among male CMDs (14, 63.6%) compared to female (8, 36.4). Conversely, an expectation for respect was higher among female CMDs (47, 61.8%) compared to male CMDs (29, 38.2%).

Table 8: Reasons for Becoming CMDs

Motivated by	Male Freq	%	Female Freq	%	Total	P. Values
Anticipated monetary gain	13	14.9	7	6	20	0.033
Anticipated material gain	17	19.5	9	7.7	26	0.012
Respect from the community members	30	34.5	47	40.2	77	0.407
Anticipated job opportunity	4	4.6	4	3.4	8	0.668
Humanitarian desire to serve the community	75	86.2	88	75.2	163	0.053
Gain experience & skills	31	35.6	37	31.2	68	0.548
Work in line of my profession	6	6.9	3	2.6	9	0.140
Free drugs and treatment to my family members	2	2.3	9	7.7	11	0.092
Desire to fight malaria in our community	2	2.3	2	1.7	4	0.764
Having love for the children	0	0	4	3.4	4	0.082

Note: The level of significance is taken at 5% (95% confidence level)

During the FGDs the expectation of allowances and material gains was repeatedly expressed:

"…Some of us expected some allowances because whenever you are given a task to perform you are supposed to be facilitated. Therefore we accepted to work knowing that there would be no salary but at least we would be facilitated in form of allowances". **(FGD Kisozi, Kakira Parish, Kamuli District).**

"…For me I expected to get a bicycle along the way. You can not be expected to be a musaho (doctor)…….. we also expected some umbrellas and gum boots

to help us in the rainy seasons but we have waited for these simple incentives in vain". **(FGD, Mbulamuti village, Bugondha, Kamuli District).**

"…I wanted to get some allowances in form of money for the work as a volunteer". **(FGD, Adyaka, Lira).**

There were some CMDS who said they were driven by a humanitarian call. As shown in Table 9, (85, 53.5% of the female CMDs and (74, 46.5%) of the male CMDs said they had a desire to serve their community with the female CMDs being more willing to work on humanitarian basis than their male counterparts. During the FGDs, the desire to serve their community and need to address the critical problem of malaria in the community was commonly referred to.

"…What motivated me, ok, I saw I had been selected and the fact that am a mother it motivated me to join this club. It made me happy and I started working committed and hoped to hear that the spread of malaria is reducing". **(FGD, Butuntumula, Kyawangabi Parish, Luweero District).**

"…We wanted to assist our village so that our children don't die of malaria and we work on our own will". **(FGD Nyakagyeme, Kahoko Parish, Rukungiri District).**

"…What motivated us is that this is about life and we also have children. So we work for ourselves and our village". **(FGD, Katikamu, Kyarugondo Parish, Luwero District).**

Respect was commonly mentioned as an important incentive for accepting to be become CMDs. There were consistent reports by the CMDs throughout the districts indicating that distribution of drugs was a respectable responsibility. During the discussions, it was obvious that CMDs were definitely excited by being referred

to as '*Basawo*' (doctor or health worker). A collection of quotations from various group discussions explains this more vividly.

"…Some of us developed love straight away from the beginning to serve as CMDs because of other non-monetary benefits like community respect. This is the main reason why some of us have continued to serve as volunteers since 2003 up to date, despite challenges like transport, long distances and competing tasks elsewhere". **(FGD Mbulamuti, Bugandha Parish, Kamuli District).**

"…Me, I was attracted by the need to be called "Musawo" in the community. Because " Basawo" are highly respected in the communities and the health unit level, by virtue of my responsibility as a CMD, the health staff would easily accord me respect in that capacity and i would enjoy some privileges like avoiding lining up for services at the health unit. This kind of special attention minimizes time". **(FGD Kisozi, Magongo parish, Kamuli District).**

*"…Another thing is we have gained popularity. The CMDs homes' have been used as reference homes in terms of giving addresses. Some one will give a direction using a CMDs home as a key landmark say "after musawo's home turn right or left,".***(FGD Kisozi, Magogo parish, Kamuli District).**

Respect was also viewed in terms of clear identification which would be demonstrated by such things as having uniform, badges and certificates that distinguishes them from the rest of the community members.

In addition to other expectations, there were those who speculated that if they started as volunteers, later on they may access employment especially after gaining skills and experience of medicine dispensing. Such CMDs wanted training and related certificates so that in future they could either be employed or can start business of selling medicines on their own.

"…I expected some benefits like a certificate which may allow me to sell drugs to others through opening a drug shop" **(FGD, Apala, Okwangole, Lira District)**

"…Here we have a motto which says things take time (3 Ts). We think things will change in future" (meaning they would get paid) **(FGD, Kyawangabi, Butuntumula, Luwero District**).

3.8 Existing Motivational Arrangements

Existing motivation arrangements were discussed from three perspectives of; CMDs, the communities, and the local governments. CMDs were asked about the kind of motivation/incentives that they were receiving to enable them do their work. By design, the CMDs were to be facilitated by the community and local governments. According to the CMDs, there was nothing much from the community except for a verbal thank you (*weibaale)* as the case of Kamuli. The CMDs were clear that communities were virtually unwilling to part with anything in return for the services the CMDs provided. They believed that this stemmed from the mistaken belief from the communities that CMDs are paid by the government.

Community members on the other hand, were asked about how they facilitate CMDs, and their responses were consistent with those of the CMDs. Overall, although they appreciate the services offered by CMDs, the communities did not feel obliged to facilitate the CMDs for providing services. Communities indicated that they thank CMDs after service. They do not consider it their duty to motivate CMDs believing that in one way or the other they were rewarded. The other reason often given was that CMDs accepted to work as volunteers so they should not complain. Both the CMDs and community members were in agreement and that it was only in few circumstances where on top of *'thank you'* communities exempted CMDs from community development work, e.g. (*Bulungi Bwansi*) and gave them gifts in appreciation for their services. The following are some of the common expressions from community FGDs participants.

"…*As long as she gives drugs to my child. Of course you first say thank you but you don't spend anything"* **(Woman Participant in FGD with Community Members, Katikamu Sub-county, Luweero District).**

"Because we are in the village we don't have money. May be as government we think that may be they are paid salaries" **(FGD Community Members, Buyanja , Nyakina Parish Rukungiri District).**

"…We give them nothing; we have not helped them in any way. Nothing, not even LC, because graduated tax was scraped, so no money at all". **(FGD Community Members Buyanja Nyakina Parish Rukungiri District).**

*"…If you harvest your maize early, you take some for her, not as payment but as a way of appreciating the service she rendered". (***FGD Kisozi, Nankadulo Parish, Kamuli District).**

"…Now for us community members – villages, to be specific we are very difficult people. We need services but we do not want to contribute money towards the cause. It is very difficult for us when you tell somebody to contribute he/she will not accept". **(FGD Kisozi, Nankadulo Parish, Kamuli District).**

Local Governments' contribution towards the motivation for CMDs was found to be ad hoc and limited. These included provision of bags for collection of drugs from health facilities and provision of badges for identification; which were financed by UPHOLD. CMDs are expected to pick the drugs from the health facility to the community. In this case the CMDs receive allowances ranging between Ugandan shillings, 2,000 - 5,000 as transport refund. District and Local Government officials in all the districts were concerned that this amount of money was not sufficient for transport refund but because of resource constraints they could not increase it. Local Government officials were also concerned that the CMDs are not provided

with storage facilities like wooden boxes. They also underscored lack of refresher training especially for those who replaced drop-outs.

The issue of refresher training was also raised by CMDs themselves who argued that it would enhance their skills in doing their work especially in the wake of the changing malaria treatment protocol.

"…*We expect continued sensitization seminars and trainings on malaria by government to capacity build us in terms of skills of managing health conditions so that we can handle some of the conditions we refer to health facilities".* **(FGD, Mbulamuti, Bugondha Parish, Kamuli District).**

"…I expect the government to send more people to train us" **(FGD, Amac, Ayac Parish, Lira District).**

3.9 Stakeholder Perspectives on Motivation for CMDs

Stakeholders in this study as earlier noted included local government officials, the caretakers of under-five children and the CMDs themselves. Under this section, the perspective of each of the stakeholders is presented.

3.9.1 Local Leaders

Local Government leaders were in agreement that the facilitation of the CMDs was inadequate. However, they raised the problem of limited resources especially as a result of the scrapping of the graduated tax. On these grounds, there is nothing much Local Governments can do to increase allowances and facilitation for the CMDs. Local Governments are looking upon the central government and donors to increase the funding for the local governments to fill the gap. At the moment Local Governments are only able to provide technical support supervision and training whenever the necessary logistics are in place in particular reference to vehicles for transport and fuel

"…It should be a shared responsibility to motivate Community Medicine Distributors and this should be between all the development partners that is; NGO`s, Health department at district, Ministry of health and Community" **(Deputy DDHS, Luweero District).**

"…Look for donors to support the Community Development programs that have been of great importance like HBMF". **(In-charge Katikamu, Luweero District)**

"…Can manage to provide technical support and training, then supervision" **(ACAO, Luweero District).**

"…Undertake frequent refresher trainings for them" **(In charge of Apala Health Centre, Lira District).**

3.9.2 CMDs Perspectives

According the CMDs, the motivation expected is seen from two dimensions, motivation by way of facilitation to enable them do their work effectively, and also in form of benefits that accrue by virtue of their improved status in society. The two dimensions sum up the potential motivators for CMDs.

In the course of performing their duties, CMDs require facilitation with regard to transport, stationery, lanterns, gumboots, gloves, and for identification: uniforms, and badges. They also access refresher training, and storage facilities such as wooden boxes, etc... It is mainly male CMDs who feel they should be paid money as a token of appreciation for their work and time sacrificed. Motivation from another dimension covers gains: monetary rewards, community respect (*being addressed as 'omusawo'*), prospect for formal employment/absorption, as a player in the improvement of health in own community. One can also look at that side gaining/enhancing skills for managing human health conditions and the pride of carrying on work where one had experience of doing similar work (for instance those who had volunteered on past community programs).

"…*I expect health staff to continue giving us more training". (***FGD CMDs, Amac Village, Adyaka Parish, Lira District).**

"…As earlier mentioned, we would expect transport in form of bicycles, stationery, lantern, gumboots, gloves, identifications like uniforms, IDs, certificates for each training and others as discussed" **(FGD, Mburamuti, Bugondha Parish, Kamuli Distrct).**

*"…Even when given some allowance is not so bad to enable us to buy soap, to be presentable before community members. If possible a monthly allowance however little, it will be a motivator"**.*** **(FDG,Kisozi, Magogo Parish, Kamuli District).**

"…At least some allowance so that even the people I left home, when I reach there I can show my wife that` you see this` I got this because of doing voluntary work". **(FDG, Butuntumula, Kyawangabi Parish, Luweero District).**

"…Like two motorcycles in each Parish they can help and may be more seminars, some of us can become trained health workers". **(FDG, Nyakakagyeme Kahoko Parish, Rukungiri District).**

"…I think ministry of health should think about us seriously because the work load at health centre III has reduced". **(FDG, Buyanja, Rwakingura Parish, Rukungiri District).**

In relation to the above discussion, Table 9 presents CMDs expectations reported during structured interviews.

Table 9: Support Needed by CMDs (n=204)

Form of Support Needed to Keep Working as a Volunteer	Freq*	%age
Regular allowances	140	21.1
Transport	173	26.1
Certificate	33	5
Storage facilities	91	13.7
Stationery	33	5
Other supplies such as soap, torch, gloves, cotton wool	153	23.1
Candles and paraffin	0	0
Identification: uniforms, t-shirts, identity cards, badges	30	4.5
More training	10	1.5
Total	**663**	**100**

*Multiple responses were allowed

3.9.3 Community Perspectives

It was worthy of note that the general community, in particular the caretakers of children, harbored a hesitant attitude towards the motivation of CMDs. They commended their work and contribution towards child survival but were unwilling to express their appreciation in tangible ways. It became apparent from focus group discussions that community/caretakers did not see any need of raising anything to motivate CMDs. The community indifference towards CMDs motivation tended to derive from the feeling that, they are already paid by the architects of the program (HBMF). The communities believed that they were supposed to enjoy free services. Quotations from FGDs conducted with caretakers give a true picture of their feelings:

"…*As community, the way they have helped us and now that we are different compared to when they were not there, If it was possible we would throw something but the situation is not allowing".* **(FDG Men Butuntumula –Luweero).**

"...For us the community we have our own thinking that those who trained them and put them there have something for them. So we feel the government should buy those bicycles so that they can do their work". **(FDG Men Butuntumula, Luweero).**

We can give gifts like chicken (FDG, Community members Ayach sub county-Lira)

"…If a drug distributor gives a drug to my child though the child gets better, it is not to say that he has provided admission, why should I give him anything?". **(FDG, Community (Women) Katikamu, Luweero).**

"…Someone will know that she can buy an exercise book of 100/= and she takes it to the Health unit and gets treatment so why should she pay anything to the health distributor?". **(FDG,Community (Women) Katikamu, Luweero).**

3.10 Challenges faced by CMDs in their work

During the FGDs and structured interviews, the CMDs were asked to mention the challenges they face in the performance of their work. The challenges mentioned covered a range of problems that are linked to: logistics and supplies, drug distribution and treatment, demanding work schedules, distrust by some caretakers, drug resistance, awkward working hours, drug expiry, under-reporting of children's age by caretakers in order to receive HOMAPAK.

It was documented that insufficient and irregular supplies and lack of transport facilitation hinder CMDs' effective performance. Lack of facilitation with regard to transport leads to CMDs' failure to make timely submissions of monthly reports. The same applies to failure in effecting home visits to follow-up children, and eventual delays in picking up drug replenishments from the health facilities.

CMDs reported some situations effecting referrals when caretakers of critically ill children often refuse to take them to health units. This compromises the aim of the HBMF strategy which emphasizes early care-seeking, compliance to treatment and referral.

*"…Another Challenge I want to add is that some mothers delay to bring their children for treatment and only bring them when the condition is critical, when I can do nothing about it". (***FGD, Amac, Ayal Parish, Lira).**

CMDs also reported that they are blamed if the child's situation does not improve after the administration of Homapak and this worry is growing because of varied reasons:

1. The new drug policy on the first line treatment at facility level which has changed to Artemesinin Combination Therapy, ACT. CMDs have heard that Homapak is no longer effective and is to be replaced with Coartem® (one of the more common ACTs). However, the CMDs are worried that they do not have sufficient information as to when they will receive the new drug and how they are going to administer it.
2. Sometimes they receive the drugs when it is expired or about to, because it overstays in the stores before distribution and they have not been properly guided on managing such a situation.
3. Age limitation for administration of Homapak is a problem because caretakers sometimes understate the age of the child in order to access Homapak.

CMD's participation is sometimes taken for granted. For instance it was reported that they are invited for meeting at the sub-county without facilitation in terms of lunch and transport. This is constraining since some of them borrow money from friends hoping that they would be compensated.

"…Then the other thing is sometimes we are invited for meetings at the Sub-county, we invest our money in transport or even borrow in anticipating transport refund only to be let down. Sometimes the facilitators don't turn up. In that situation you have to look for money to pay back the loan, a situation that could be avoided using own bicycle" **(FGD Kasozi, Kakira Parish, Kamuli District).**

Although it is already indicated that female CMDs constituted the majority and were generally more motivated than males, it is not easy for married women to work effectively because of complaints from their husbands:

"…Sometimes my husband complains that don't you get paraffin? Why are you using the one for the family?" **(FGD, Buyanja, Rwakirungura Parish, Rukungiri District).**

3.11 Attrition of CMDs

According to the district and sub-county level key informant interviews the attrition levels of CMDs were thought to be minimal. It was explained that some CMDs dropped out because they got married, others died and yet others separated from spouses. There were, however no concrete figures on the current number of CMDs in the study districts. Lack of this information on CMDs was attributed to under facilitation for HBMF-related work like support supervision, and fresh training for new CMDs. The act of redistricting in some districts was reported to have further made it hard to rely on available figures since some sub-counties were relocated to be part of the new districts.

"Partly 'yes', some women got married and had to leave" ***(FGD,*** **Okwangole Parish, Apala Sub-County, and Lira District).**

"…There were some community volunteers being paid 9,000/= on weekly basis by CCF and yet the CMDs offer free service and as a result they left. CCF used to avail some materials like rain coats, gum boots, torches and would once in a while pay some allowances ie 2000/=, 3000/=. So when CFF left the area some CMDs left too". **(FGD, Okwangole Parish, Apala Sub-County, and Lira District).**

"…Some have gone to look for money. There is one we used to work and now he is in Apach baking bread" **(FGD Kyawangabi, Parish, Buntuntumula Sub-county, Luwero District).**

The HMBF program implementation in Uganda started in 2002 with 10 pilot districts. Although country wide scale up was declared in 2003, actual training of CMDs in some districts was done as late as 2004. Evidence from the key informant interviews at the districts revealed that the first training for CMDs took place in March 2003 for Kamuli, 2002 for Rukungiri, 2003 for Lira and 2004 for Luwero. The variations across study districts in terms of timing for CMDs training may also explain why CMDs' length of service, varies between districts.

The longest serving CMDs were in Kamuli (82.1%, n=23) reporting 60-80months) followed by those in Rukungiri (48.6, n=35) who served (40-60 months). Additionally, average duration of service by CMDs was 44 months with slight variations between female and male, (40 and 47 months respectively). Females are more likely to remain in service compared to their male counterparts (p value .000). This can be better explained when we consider our cultural values where a man is expected to fend for his family, therefore finding it difficult to stay in one place.

It is remarkable that some CMDs served beyond the maximum period of 60 months since HBMF implementation in the pilot districts. The probable explanation is that some CMDs had worked as volunteers on other community health programs before the HBMF was introduced in their villages. Nonetheless, the general feeling among respondents was that the attrition levels of the CMDs were not disturbing. Indeed, all the villages included in the study had the expected number of CMDs. According to key informant interviews the few CMDs that discontinued had either died, or separated from spouse(s) or even moved on to greener pastures. These were replaced after a short time.

CHAPTER FOUR: EMERGING ISSUES

4.0 CMDs IN THE SURVEY

The CMDs in the survey were peasants who had attained at least secondary education, middle aged and most married, and predominantly females. They are well established in the community and have interests there and like any other member of the community they are equally affected by the day-to-day problems which affect the community. These are people driven by the desire to serve their community which includes their own children.

Their selection by the community out of the many to be CMDs is a big honor but at the same time a big sacrifice in view of what they have to forfeit, roles and responsibilities associated with their status and considering that they are meant to be volunteers. They have to carry this mantle entrusted to them by the community. Whereas they are driven by this desire to serve, there are still basic requirements to be met either by government or community to enable them fulfill their obligations. Failure to obtain these basics as noted earlier, continues to be a major challenge for CMDs. Despite these challenges, CMDs have persisted as attrition levels still remain low. The question is "why they have persisted among these challenges?".

This study has showed that there were both manifest and underlying reasons why CMDs accepted and continue to work as CMDs. Among the manifest include the response to the community call to help in dealing with one of the most pressing health problems and related humanitarian considerations. This study also reveals that there are other underlying motives including monetary gains, respect and acquiring skills that would later help them in life. Studies elsewhere also show that using volunteers without pay may not work where volunteers are expected to work for long term interventions (Kironde and Bajunirwe, 2002). It is important to note that the underlying motives should be considered seriously in case of any community oriented program such as HBMF that may want to use volunteers.

Although the study shows that attrition of CMDs are still low, it is too early celebrate this as they were clear indications of unmet expectations. In Luwero for example, CMDs used the concept of **TTTs** (**things take time**), meaning that although benefits delayed to come, they are still hopeful that one day their dreams would be met. In almost all the districts, CMDs wished was like other programs where good incentives were being provided. As rightly observed by Kironde and Klaasen (2002), they start as volunteers expecting to be remunerated later. They further argued that in resource limited settings, it is important to identify and implement appropriate alternative incentives that could motivate lay persons in order to sustain community participation.

Respect was another important motivator for most of the CMDs. This was more so with female CMDs. They for instance felt elated by the idea of being referred to as '*basawo*' (doctor). This is one of the most fulfilled expectations. In addition to that they expected special consideration especially with community benefits. These would include being introduced to the community during special ceremonies, being treated well at the health facilities. There is evidence elsewhere to the effect that being valued and adding value to the lives of other people is an important motivator (Barlow et al., 2005). Being referred to as (B*asawo*) however motivating for CMDs, program stakeholders should take caution. This title might be abused and they start their own drug selling outlets to provide medical services that they are not qualified to offer.

The issue of training as a motivator was raised a lot in the discussions. Indeed training is crucial for the CMDs to meet the expectations of the HBMF programs. Some CMDs for instance expressed ignorance about the policy regarding malaria management using Coartem®. Some CMDs for instance did not know whether there were plans to use Coartem at community level to replace the Homapak. Several studies have highlighted training of CMDs as essential for the success of HBMF program (Nsabagasani et al., 2007, Kolaczinski et al., 2006). To the CMDs, training was an opening for higher aspirations. They want the training to increase

on their skills so that they treat effectively and become even more popular. Some of them who have some level of education, received the CMD training as a golden opportunity for them to build capacity beyond the basic training they had received. Others looked beyond distribution of Homapak and hoped the training would enable them acquire skills that they could to establish their own clinics. Similarly, Nsabagasani and Birungi (2000) have used the concept of 'pattern of stepping-up ambitions' whereby trainees always want to expand their practices beyond the training they received. Another recent study in Kasese shows how CMDs want drugs for treating other diseases to be included in their package of services (Nsabagasani et al., 2007). This would enable establish simple provision drug shops from which they can earn an income.

This study found that in addition to CMDs performing their established roles under the HBMF program, they are multi-tasked under different programs running in their districts. The assumption of program managers is that there is comparative advantage when voluntary related activities are integrated let us say under the umbrella of the village health teams (VHTs[2]). It is assumed that with this integration, it becomes cheaper, efficient and sustainable to motivate volunteers. Findings from this study indicate that multi-tasking is highly prevalent across the districts. However, there appears to be no formal mechanisms in place for the integration of voluntary activities and the associated motivational packages. Because of this, the HBMF runs a risk of losing its volunteers to other programs that have established mechanisms for motivation. This is partly because there is no initiative on the part of the districts to bring together the volunteers under one umbrella. In this study, CMDs expected payment basing among others on the mere fact that other programs running in their districts reward their volunteers handsomely. These programs not only provide material incentives but also monetary ones. The HBMF program incentives are therefore not considered as rewarding as the other programs.

[2] In this study we did not look specifically into the progress of the VHT. However it came out in some of the discussions in Lira as one of the upcoming community structure where some CMDs were.

The findings from this study are line accord with those of previous studies on the need for motivation by monetary rewards. For instance Kironde and Bajunirwe (2002) found provision of money to volunteers is a key motivator and serves to keep sustained interest particularly in resource limited settings where people expect payment for work done as is the case in Uganda. However, this particular study has extended previous findings by showing that volunteers on the HBMF program have kept working because they have not lost hope for more incentives including money. Clear strategies for motivation are necessary before this hope wanes.

The current drug delivery system is inefficient considering the common concern among CMDs regarding rampant medicine stock outs and expiry problems. This not only demoralizes the medicine distributors but also the caretakers which in turn puts the children at high risk. The need to streamline the drug delivery system to avoid stock outs at health units is therefore crucial.

Whereas the district and community appreciate the work of the CMDs in terms of scaling-up coverage/access of services, their support to Community Medicine Distributors is still minimal. In particular, the local government support is ad hoc and limited to technical support supervision, training and occasional allowances given when they conduct review meetings.

Community support for CMDs' work remains a remote goal. Despite the clear evidence of appreciation of their' work, there is no willingness to support their motivation. It is possible that from the time of selection and training, the communities were made to believe that their only role in the program was to bring children to be treated against malaria related conditions. There is need for clarification as to whether or not the communities know that they are supposed to contribute towards the motivation of CMDs. There was suspicion by the community as reported from both the CMDs and community alluding to the thinking that CMDs receive some form of payment (directly or indirectly) from the

government or NGOs. For communities it does not make sense to pay when someone else is paying. Another concern was that the drugs were supposed to be given free-of-charge according to the promises made by the local politicians. Considering the poverty conditions prevailing in these communities, there is uncertainty as to whether they would be willing and/or able to support the CMDs.

The political situations in the communities can amplify the constraints affecting the performance of the CMDs. In Kamuli, political factions are so intense to the extent that some community members feel insecure if the person serving them belongs to the opposite party. They alleged CMDs who know that a caretaker belongs to a different political party can maliciously give an overdose to children whose parents belong to opposite political parties.

CHAPTER FIVE: CONCLUSIONS & RECOMMENDATIONS

5.1 Conclusions

1. The study established that the communities are adamantly unwilling to facilitate CMDs: They do not feel it is their obligation to support CMDs although they expect them to be efficient in the performance of their services such as ensuring constant medicine stocks, readiness to provide the services anytime and to make child follow-ups.
2. Both CMDs and Local Governments confirm that government recognition of volunteers and their integration into implementation work plans is still lacking, and where efforts are made, they are inadequate. Currently the resources are limited after scrapping the major source of revenue for Local Governments, the graduated tax.
3. CMDs appreciate the fact that they were selected to work as volunteers (not expecting a regular salary) to serve their own people as partners in effort to achieve the HBMF goals. However, they feel the architects of the program should not only appreciate their work but also facilitate them to enable them provide efficient services by way of; provision of transport means (preferably bicycles), ensuring constant drug supplies, provision of storage facilities for medicine and other items as paraffin, stationery and bags and token of appreciation in monetary terms.
4. The seemingly most outstanding motivational issues according to the CMDs include; the new status that they acquire being referred to as '*musawo*', recognition by the Local Government as key players in health service delivery, attainment of refresher training, provision of bicycles to ease transport, certificates, badges, raincoats, gum boots and regular medicine supplies.
5. Quite a number of CMDs under the HBMF program serve more than one master (multi-tasking) in terms of programs implemented in their areas. This potentially divides CMDs commitment towards their work. It was found out for instance that other programs such as AMREF in Luwero and Christian

Children Fund (CCF) in Lira provide more viable rewards (both in–kind and monetary terms) compared to the HBMF program.

6. Record keeping among Local Governments is still a challenge. Due to this challenge, records on current numbers of CMDs, dropouts and replacements were not available for this study. This partly had to do with the weaknesses associated with support supervision from above and the reporting system from below. As a result, there is no conclusive evidence on the attrition rates of CMDs. The general thinking across the studied districts was simply that attrition rates are minimal.
7. There is confusion in the communities as a result of the change of regimen from Homapak to ACTs. The apparent silence from policy makers about how the ACTs will fit into the HBMF program leaves both the community members and the CMDs at loss on the way forward for the management of malaria related conditions among children. To this extent questions about the efficacy of HOMAPAK are being raised: 1) should they continue distributing Homapak? 2) when is ACTs going to replace Homapak? 3) how can they distribute ACTs without guidelines?
8. CMDs are willing to continue working; this evidence is from their reports as well as from key informant interviews. However HBMF being an on-going program, program managers should come up with clear motivational mechanisms that address the CMDs constant expectations to make the program sustainable.

5.2 Programmatic Implications and Recommendations

5.2.1. The Community Ambivalent Attitude towards CMDs in Relation to their Services and Support/Facilitation for them

The communities appreciate the work of CMDs and their contribution towards malaria management among their children. Although CMDs are now confirmed as part of the community, they will not be able to continue working on voluntary basis if the people they serve continue to hold misguided beliefs about their terms of

work. Secondly it demoralizes CMDs for not receiving any support from the community yet they portray them as employees of the government.

There is therefore need for a sensitization strategy to clarify about the working conditions of CMDs and what is expected of the different stakeholders.

5.2.2. Limited Motivational Mechanisms for CMDs and Multi-Tasking

In principle governments are willing to support CMDs but lack the resources. Local Governments should therefore work closely with other programs directly using volunteers so that there is a formal integration to maximize a uniform motivational package. Emphasis in determining the motivational package should go on the aspects identified by the study including refresher training, bicycles to facilitate transport, certificates, badges, gumboots and regular medical supplies plus a token of appreciation in monetary terms.

5.2.3 Medicine Stock-outs and Expiry

Public trust is important in the adoption of development interventions. The `caretakers of children' in this case are not likely to accept new interventions if they come to learn that the medicine supplied to their children has expired. This tendency results into distrust for CMDs and may lead to eventual rejection of the medicine/program by caretakers of children. It is therefore important that the drug delivery system at all levels is streamlined to avoid cases of expiry and stock-outs. This goes hand-in-hand with the need to improve record keeping about the program especially on the CMDs so that in case of drop outs the necessary replacements and training can be made to enable continuity of services in the villages.

5.2.4 Village Health Team concept

The Village Health Team concept seems to be taking root in some districts like Lira. The HBMF program would benefit from this structure if the CMDs were absorbed into the VHT so that all voluntary related activities become part and parcel of it. This is likely to make HBMF cheaper, efficient and sustainable.

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ANNEXES

Attachment A: Tables

Table10: Socio-economic Characteristics of the Respondents

Socio-economic Characteristics		Number	Percent
Gender	Male	87	42.6
	Female	117	57.4
	Total	**204**	**100**
	Less than 20	1	0.5
	20-24	7	3.4
	25-29	36	17.6
	30-34	43	21.1
	35-39	38	18.6
	40 and above	79	38.7
	Total	**204**	**100**
Marital status	Married	178	87.3
	Single	12	5.9
	Divorced/Separated	2	1
	Widow/widower	12	5.9
	Total	**204**	**100**
Ethnicity	Muganda	53	26
	Munyankole/Muhororo/Mukiga	50	24.5
	Luo	55	27
	Iteso	1	0.5
	Musoga	38	18.6
	Mukuku	1	0.5
	Sania	6	2.9
	Total	**204**	**100**
Highest Level of Education	No formal education	1	0.5
	Primary(grade1-7)	80	39.2
	Secondary(S1-S6)	115	56.4
	Tertiary(course after S6)	8	3.9
	Total	**204**	**100**
Occupation	Formal employment	9	4.4
	Self employed	46	22.5
	Unemployed	35	17.2
	Peasant	110	53.9
	Others	4	2
Total		**204**	**100**

Attachment B: Data Collection Instruments/Tools

Table11: Self Awareness of CMDs

Q9: How did you become a community medicine distributor?	Freq	%age
Selected by community	179	88.2
Appointed by parish development committee c/person	14	6.9
Selected by Health worker at the health facility	2	1
Selected by district level health supervisor	1	0.5
Others	7	3.4
Total	203	100
Q10 What are your responsibilities?		
Treating children below five years	199	18.4
Advise on completion of the dose	94	8.7
Filling the forms	66	6.1
Submitting reports	80	7.4
Assessing and monitoring the condition of the child	144	13.3
Refer cases	133	12.3
Collect drugs from health unit	112	10.4
Custodian of drugs	74	6.9
Sensitize people on drug use	142	13.2
Others	35	3.2
Total	**1079**	**100.0**
Q11 Who are you supposed to work with?		
Heath staff at the nearest health unit	187	36.6
Mothers/caretakers of the children under five years	140	27.4
Village health teams	64	12.5
Parish development committee	55	10.8
Local Council (LC1)	58	11.4
Fellow distributors	7	1.4
Total	**511**	**100.0**

Table12: Roles by Different Partners in the Distribution of Drugs

HEALTH STAFF	Freq	%age
Avail & ensure constant supply of drugs	160	48.9
Give advice on complicated matters	13	4
Handle supervision of distribution of drugs	24	7.3
Inform CMDs about meetings & seminars	5	1.5
Handle referred cases	50	15.3
Train CMDs on treatment & drug distribution	47	14.4
Receive and sign the CMDs monthly report	24	7.3
Others	4	1.2
Total	**327**	**100**
MOTHERS/CARETAKER		
Take children for treatment	120	61.9
Monitor if drug has a side effect	18	9.3
Administer drug to children and ensure proper dosage	27	13.9
Describe the type of illness of the child	3	1.5
Ensure good hygiene	11	5.7
Protect children from getting malaria	10	5.2
Others	5	2.6
Total	**194**	**100**
VILLAGE HEALTH TEAM		
Mobilize and sensitize the community on health & sanitation	36	72
Collect drugs from Health Centers to CMDs	9	18
Others	5	10
Total	**50**	**100**
PARISH DEVELOPMENT COMMITTEE		
Sensitize community on the availability of drugs with CMDs	14	15.9
Handle supervision of drug distribution	26	29.5

Mobilize CMDs for workshops	15	17
Network CMDs & sub county health team	11	12.5
Advise people on hygiene	5	5.7
Others	17	19.3
Total	**88**	**100**
OTHERS PARTNERS		
LC1-Sensitize community on the availability of drugs with CMDs	25	26.3
LC1-Mobilize community for treatment	35	36.8
LC1-Mobilize the selection of CMDs	13	13.7
Fellow CMDs provide drugs	1	1.1
Others	11	11.6
Total	**95**	**100**

Motivated by	**Male**		**Female**		
	Freq	**%age**	Freq	%age	**Total**
Anticipated monetary gains	14	63.6	8	36.4	22
Anticipated material gains	16	66.7	8	33.3	24
Respect from community members	29	38.2	47	61.8	76
Anticipated job opportunity	4	50	4	50	8
Humanitarian/desire to serve the community	74	46.5	85	53.5	159
Gain experience and skill	31	46.3	36	53.7	67
Work in line with my profession	4	57.1	3	42.9	7
Others	9	33.3	18	66.7	27
Total	87	42.6	117	57.4	204

Table 13: Departments/Organisations that Trained the CMDs

Who trained you?	Kamuli	Luwero	Rukungiri	Lira	Total
Subcounty health workers	32	41	37	24	134
District health workers	41	29	15	37	122
NGO official	4	26	1	7	38
Fellow CMDs	1	0	0	2	3
Others	0	0	0	2	2
Total	**51**	**50**	**46**	**52**	**199**

Table 14: Challenges faced by CMDs in the Performance of their Work

Challenges faced	Freq	%age
Delays in getting drugs/stock out	96	17.0
Access to households in terms of transport and distance	162	28.6
Delayed care seeking	50	8.8
Drug resurgence/resistance	17	3.0
Mistrust of CMDs by some community members	13	2.3
Competing time demands	46	8.1
Refusal to take referral advise by some community members	21	3.7
Access to nearest health unit to submit reports	67	11.8
Lack of enough facilitation	41	7.2
Others	15	2.7
Total	**566**	**100.0**

Table 15: Ways on how CMDs are Rewarded and who Rewards them

Q18 In what ways is your work rewarded?	Freq	%age
Material gains	64	20.3
Gifts from community members	3	0.9
Certificate	16	5.1
Occasional monetary payment	59	18.7
Respect	113	35.8
None	28	8.9
Free drugs to my family	15	4.7
Training, skills & experience	13	4
Appreciation from the community	5	1.6
Total	**316**	**100**
Q19 Who rewards your work?	**Freq**	**%age**
District/Sub county	85	44.5
Donors	25	13.1
Charitable individuals	1	0.5
Community members	57	29.8
None	10	5.2
NGO	13	6.8
Total	**191**	**100**
Q20 What specific support do you get from communities you serve?	**Freq**	**%age**
Labour	5	2.5
Gifts	3	1.5
None	144	71.3
Lunch & transport	6	3
Respect	11	5.4
Appreciation from the community	30	14.9
Bringing children for treatment	3	1.5
Total	**202**	**100**

Table 16: Support Needed to keep CMD Working in the Capacity as Volunteers

Q21 What more support do you need to keep working in your capacity as a volunteer?	Freq	%age
Regular allowances	140	21.1
Transport	173	26.1
Certificate	33	5
Storage facilities	91	13.7
Stationery	33	5
Other supplies were.soap, torch, gloves, cotton wool, candles and paraffin	153	23.1
Identification like uniform, T-shirts, Identificatioo cards ,etc	30	4.5
More training	10	1.5
Total	**663**	**100**

Table 17: Most Rewarding and Disturbing to the CMDs as Drug Distributors

Q22 What is most rewarding in your work as a drug distributor?	Freq	%age
Being recognized by community members/supervisors/ district leaders	2	2.6
Being able to save lives	26	33.3
Positive community response	21	26.9
Material gains	3	3.8
Experience and skills in managing child related health conditions	21	26.9
Others	5	6.5
Total	**78**	**100**

Q23 What is most disturbing in the work as a drug distributor?	Freq	%age
Drug stock-out	73	24.2
Competing time demands	34	11.3
Unmet expectations	37	12.3
Access to households in terms of distance and transport	109	36.1
Underrating the capacity to treat their children by some community members	13	4.3
Lack of appreciation by some community members/supervisors	18	6
Transport to home and health centers	4	1.3
Working late at night	1	0.3
Poor facilitation	3	1
Expired drugs	4	1.3
Others	1	0.3
Lack of pay	4	1.3
Bad weather	1	0.3
Total	**302**	**100**

Table 18: Other programs for which CMDs are volunteers (n=204)

Q25 For what programs are you a volunteer?	Freq	%age
UNEP related services	45	28.1
Nutrition promotion	34	21.3
TB dots	6	3.8
Family planning	8	5
NAADS	10	6.3
CBDA- Community Based Distribution Agent-FPAU	1	0.6
Bataaka-Barial Association	1	0.6
PLAN International	20	12.5
CM&E- Community Monitoring & Evaluation	1	0.6

AMREF- promote hygiene & control malaria	5	3.1
SEVO ug-Dea;ing with accident patients	1	0.6
AMREF-HIV	6	3.8
AFFORD	2	1.3
VHT- Village Health Team	2	1.3
FAL-Factual Adult Literacy	2	1.3
Member of school management committee	3	1.9
Member of PDC	2	1.3
Vaccination	1	0.6
LC1 committee	2	1.3
Child day5	1	0.6
Immunisation	2	1.3
Church activities	4	2.5
Mobilisation of net distribution	1	0.6
Total	160	100

Table 19: Ways How Community Medicine Distributors are Selected

How did you become community medicine distributors?	Freq	%age
Selected by community	179	88.2
Appointed by parish dev't committee c/man	14	6.9
Selected by health worker at the health facility	2	1
Selected by District level health supervisor	1	0.5
Appointed by LC chairman	3	1.5
Selected by camp leaders	3	1.5
Interviewed by CCF (NGO)	1	0.5
Total	**203**	**100**

Table 20: Motivation to Become a Medicine Distributor (n=204)

Motivated By	Gender				Total
	Male		Female		
	Freq	%age	Freq	%age	
Anticipated monetary gains	14	63.6	8	36.4	22
Anticipated material gains	16	66.7	8	33.3	24
Respect from community members	29	38.2	47	61.8	76
Anticipated job opportunity	4	50.0	4	50.0	8
Humanitarian/desire to serve community	74	46.0	87	54.0	161
Gain experience and skill	31	45.6	37	54.4	68
Work in line with my profession	5	62.5	3	37.5	8
Free drugs and treatment to the family members	2	20.0	8	80.0	10

To fight malaria in the community	4	44.4	5	55.6	9
Having love for children	0	0.0	2	100.0	2
Total	**179**	**46.1**	**209**	**53.9**	**388**

Table 21: Other Programs for which CMDs are Volunteers (n=204)

Q25 For what programs are you a volunteer?	Freq	%age
UNEP related services	45	28.1
Nutrition promotion	34	21.3
TB dots	6	3.8
Family planning	8	5
NAADS	10	6.3
CBDA- Community Based Distribution Agent-FPAU	1	0.6
Bataka-Burial Association	1	0.6
PLAN International	20	12.5
CM&E- Community Monitoring & Evaluation	1	0.6
AMREF- promote hygiene & control malaria	5	3.1
SEVO ug-Dea;ing with accident patients	1	0.6
AMREF-HIV	6	3.8
AFFORD	2	1.3
VHT- Village Health Team	2	1.3
FAL-Factual Adult Literacy	2	1.3
Member of school management committee	3	1.9
Member of PDC	2	1.3
Vaccination	1	0.6
LC1 committee	2	1.3
Child day5	1	0.6
Immunisation	2	1.3
Church activities	4	2.5
Mobilisation of net distribution	1	0.6
Total	160	100

Table 22: Challenges faced in Drug Distribution (n=204)

Challenges that drug distributor faces	Freq	%age
Delays in getting drugs/stock out	96	17.0
Access to households in terms of transport and distance	162	28.6
Delayed care seeking	50	8.8
Drug resurgence/resistance	17	3.0
Mistrust of CMDs by some community members	13	2.3
Competing time demands	46	8.1
Refusal to take referral advise by some community members	21	3.7
Access to nearest health unit to submit reports	67	11.8
Lack of enough facilitation	41	7.2
Others	15	2.7
Total	566	100.0
List of others		
Poor reporting system by community members about children treated	2	0.4
Expired drugs in stock	1	0.2
Working beyond working hours	3	0.5
Lack of identification	2	0.4
Having no pay	7	1.2

Attachment C: Focus Group Discussion Guide for Community Medicine Distributors CMDs

(This guide will specifically be used during discussions with CMDs under the Home Based Management of Fever program (HBMF)

Introductory remarks

Good morning/afternoon ladies and gentlemen. My name is …….. and my colleague's name is……. We are here on behalf of the Uganda Program for Human and Holistic Development (UPHOLD) to learn more about the work you are doing in respect to the distribution of HOMAPAK. You have been selected because we know that you have specialized knowledge and experience. However, you are free to continue with the interview or opt out if you do not feel comfortable. Feel free and respect your friends' views. Everyone will have an opportunity to express their views. Feel free as the views being discussed will not be tagged to your name in the report production. They will be treated with utmost confidentiality.

Main themes for Discussion

1. What are your responsibilities as drug distributors?
2. Who are you supposed to work with? (Probe for health staff, Village Health Teams, Parish Development Committees and how have been helpful?)
3. What attracted you to accept to serve as a drug distributor? (Probe for what they think they have benefited).
4. What were your expectations when you accepted? Have these expectations been met? How has this affected your work?
5. What challenges do you face as medicine distributors? (Probes on transport, monitoring children, complicated conditions, drug stock outs/ expiry, supervision from above) How have you addressed these challenges? What keeps you operating despite the challenges?
6. What kind of support do you get from the community?
7. How does the health staff *support you (pick your data, attending to patients you refer, supplies in store, support visits?)*
8. What forms of support do you get from government?
9. Are you satisfied with the overall support you get?
10. Would you be willing to continue with medicine distribution? (Probe for why and Why not?
11. What would you expect if you are to continue helping with drug distribution?
12. What else would you expect the community to do in return for your services?
13. What else would expect the government to do for you to enable to you to continue volunteering?
14. Are there some of the community medicine distributors who have dropped out of providing services? What are some of the reasons for dropping out?
15. Are there some of you engaged in other voluntary services? How has this affected drug distribution?
16. Any questions/comments related to the issues we have discussed?

Thank you very much for your view and participation in this discussion

Specific discussion questions for NON Home Based Management of Fever program volunteers (These will be identified during district level key informant interviews)

1. What community-oriented programs do you work for as volunteers?
2. What are your responsibilities for each of the programs you work for?
3. Who do you work with under this program?
4. What motivated you to work for this program? What were your expectations?
5. What have you benefited from being a volunteer?
6. What is your service tenure?
7. For how long would you have liked to work as a volunteer? Why?
8. What support do you get from program leaders and the community? Does the community appreciate your work? How do you know?
9. How often do you get the support?
10. What challenges do you face in the performance of your roles? (Probes: community response, motivational issues, competing time demands for other tasks etc)
11. What has kept you working since you were selected? What causes others to leave if any?
12. How can the challenges you mentioned be addressed?
13. Any questions/comments related to the issues we have discussed?

Thank you very much for your view and participation in this discussion

Focus Group Discussion guide for Community members

Introductory remarks

Good morning/afternoon Ladies and Gentlemen. My name is…… and my colleague's name is……We are here on behalf of the Uganda program for Human and Holistic Development (UPHOLD) to learn more about community medicine distributors in your villages in terms of their work they do. You have been invited to this meeting because we know that you have had occasion to interact with them and or directly or indirectly benefited from their services. Please feel free to air your views and also allow others to tell us what they think about the issues under discussion. Your participation in this discussion is voluntary and you are free to opt out if you feel uncomfortable in the course of the discussions. The information/views you give will be treated with utmost confidentiality and your views will not be tagged to your name in the analysis and presentation of the study report.

Discussion questions

1. Who are the community medicine distributors
2. What they do?
3. How were they selected
4. What are your expectations of the community medicine distributors?
5. How do you rate the performance of community medicine distributors? (Probe for drug stocks, drug efficacy)
6. Why do some community medicine distributors drop out?
7. How are the community medicine distributors rewarded?
8. Who rewards them?
9. How has the community contributed to the facilitation of community medicine distributors?
10. What is the community willing to do to support community medicine distributors?
11. In what ways can the community support community medicine distributors?

Thank you very much for your time and views

Guide for District Health Managers (District Health Team, Secretary for Health, community development officers and the Chief Administrative Officer (CAO) in charge of health).

Introductory remarks

Good morning/afternoon sir/madam. My name is ……I am here on behalf UPHOLD conducting an action research-oriented study on motivational issues for community medicine distributors and other community-based volunteers. The purpose is to come up with evidence-based data for contributing to the efforts geared towards sustainable service delivery through volunteers viewed as important partners in service delivery. You have been identified as a useful source of information about issues of volunteers and their motivation. Your views will be kept confidential and will only be used for purposes of analyzing and producing the study report.

Guide Questions

1. What are the community development programs implemented by the district that include working with volunteers? (Probe for the community medicine distributors)
2. What is your estimate of those volunteers?
3. Are there established mechanisms for motivating community-based volunteers? (probe for *allowances, forms of appreciation, recognition and frequency of support supervision*) Who determines this? (probe for their: sustainability, uniformity, sources)
4. What are some of the benefits of working with volunteers? What is going on well with volunteers in the district?

5. What are the challenges of working with volunteers? How have you tried to minimize the challenges?
6. Are the community medicine distributors well integrated into other community based volunteers? What makes community medicine distributors different from others? Are there challenges that are specific to community medicine distributors?
7. What kind of support are community medicine distributors receiving?
8. What kind of incentives would you recommend for community medicine distributors
9. Who should be responsible for facilitating the community medicine distributors to enable them to do their work effectively?
10. What kind of support/facilitation do they need?
11. What role are communities playing to support CMDs?
12. What role should the communities play?
13. What is the sub county/Local government doing to support CMD?
14. What role should the local governments at sub county play?
15. Are there any specific ways in which you local leaders can assist community medicine distributors?
16. Are there any specific ways in which the District health workers can assist the community medicine distributors?
17. Are there any specific ways in which donors such as UPHOLD can assist the community medicine distributors?

Thank you very much for your time and views

Attachment D: Community Medicine Distributors' Questionnaire

Action Research on Motivation of Community Medicine Distributors in Uganda

Questionnaire No.

Name of interviewer……..…

Date of interview……..

Interview location particulars

District	
Sub county	
Parish	
Village/Local council (LC)	

Instructions to the Interviewer

I am ……..…… doing a study on behalf of the Uganda program for Human and Holistic Development (UPHOLD) to understand more about the work of community medicine distributors and other community volunteers. I would like to ask you some questions about the work you as a community volunteer. Please do not hesitate to seek clarification on any of the questions. The information you give will be handled confidentially and will not be used for any other purpose other than the production of the study report

I therefore request your permission to proceed with this interview. You are free to choose top participate in the study or with draw from the interview anytime you wish

IF CONSENT IS GRANTED PROCEED WITH THE INTERVIEW
NB: Circle appropriate response or fill in the respondents' answer in the space
Provided.

1. Name of respondent……

2. Age
    1. Less than 20
    2. 20 – 24
    3. 25 – 29
    4. 30 – 34

5. 35-39
6. 40 and above

3. Sex:
    1. Male
    2. Female

4. Marital Status

    1. Married
    2. Single
    3. Divorced/Separated

5. Ethnicity

    1. Muganda
    2. Munyankole/Muhororo/Mukiga
    3. Luo
    4. Itesot
    5. others (specify)

6. Highest level of education attained:

    1. No formal education
    2. Primary (grade1-7)
    3. Secondary Senior 1- S6
    4. Tertiary (Course after S6)
    5. Other (specify)……..

7. Occupation

    1. Formal employment
    2. Self employed
    3. Unemployed
    4. Retired
    5. Student

8. For how long have you been a community medicine distributor……. (in months)

9. How did you become a community medicine distributor?

    1. Selected by community
    2. Appointed by parish development committee chairperson
    3. Health facility
    4. District supervisor
    5. Others (specify

10. What are your responsibilities?

1. Treating children below five years
2. Advise on the completion of the dose
3. Filling the forms
4. Submitting reports
5. Assessing and monitoring the condition of the child
6. Refer cases
7. Collect drugs from the health unit
8. Custodian of the drugs
9. Sensitize people on drug use
10. Others (specify)

11. Who are you supposed to work with?

1. Health staff at the nearest health unit
2. Mothers/caretakers of the children under five years
3. Village health teams
4. Parish development Committee
5. Others (specify)

12. What are the roles of each of the partners mentioned?

Health staff

Mothers/ caretakers

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Village health team

Parish development committee

Others (specify)

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13. What motivated you to become a medicine distributor?

    1. Anticipated monetary gains
    2. Anticipated material gains
    3. Respect from community members
    4. Anticipated job opportunity
    5. Humanitarian/desire to serve community
    6. Gain experience and skill
    7. Work in line with my profession
    8. Others (specify)

14. Did you receive any formal training related to your work as a volunteer?

    1. Yes
    2. No

15. If yes who trained you

    1. Sub county health workers
    2. District health workers
    3. Parish development committee
    4. NGO official (specify)
    5. Fellow CMDs
    6. Others (Specify)

16. How many families/households are you responsible for……..

17. What challenges do you face in the performance of your work?

    1. Delays in getting drugs/stock outs
    2. Access to households in terms of transport and distance
    3. Delayed care seeking
    4. Drug resurgence/resistance
    5. Mistrust of CMDs by some community members
    6. Competing time demands
    7. Refusal to take referral advise by some community members

8. Access to nearest health unit to submit reports
9. Others (specify)

18. In what ways is your work rewarded?

1. Material gains
2. Gifts from community members
3. Certificate
4. Occasional monetary payment
5. Respect
6. None
7. Others (specify)

19. Who rewards your work?
1. District/sub county
2. Donors
3. Charitable individuals
4. Others (specify)

20. What specific support do you get from the communities you serve?
1. Labour
2. Gifts
3. None
4. Others (specify)

21. What more support do you need to keep working in your capacity as a volunteer?
1. Regular allowances
2. Transport
3. Certificate
4. Storage facilities
5. Stationery
6. Other supplies (such as soap, paraffin, torch, candles, gloves, cotton wool)

22. What is most rewarding in your work as a drug distributor?
1. Being recognized by community members/supervisors/district leaders
2. Being able to save lives
3. Positive community response
4. Material gains
5. Experience and skills in managing child related health conditions
6. Others (specify)

23. What is most disturbing in the work as a drug distributor?
    1. Drug stock-out
    2. Competing time demands
    3. Unmet expectations
    4. Access to households in terms of distance and transport
    5. Underrating the capacity to treat their children by some community members
    6. Lack of appreciation by some community members/supervisors

24. Are you involved in any other voluntary activity apart from distribution of drugs?
    1. Yes
    2. No

25. For what programs are you a volunteer
    1. UNEP related services
    2. Nutrition promotion
    3. TB dots
    4. others (specify)

26. **Questions /Comments**

Thank you very much for your time and views