**ROLE OF VILLAGE HEALTH TEAMS TOWARDS MALARIA CONTROL AND PREVENTION IN SELECTED VILLAGES**

**WITHIN BUSIIKA TOWN COUNCIL, UGANDA**

**By**

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| --- | --- |
| **NAME** | **ID** |
| LEILA MUSSA KARUNDE | 20/BNS/BU/R/0002 |

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# CHAPTER ONE

# INTRODUCTION

# Background of the Study

Malaria is a life-threatening disease caused by parasites that are transmitted to people through the bites of infected female Anopheles mosquitoes. It is preventable and curable, whereby in 2020, there were an estimated 241 million cases of malaria worldwide (World Health Organization, 2020). Globally, malaria is still regarded as a great danger to the people and every world country is working hard towards the control and prevention of malaria (World Health Organization, 2020). The World Health Organization has been funding and providing capacity building to different stakeholders to ensure that malaria is controlled, prevented if not eliminated.

According to Root et al., (2013) for effective implementation of village health teams in the United States of America, it was clearly recommended that the right persons are selected as community drug distributors. This informs that in order to meet the above conditions, and to enhance community ownership and participation, the entire village council, comprising adult men and women was expected to be sensitized and guided in the selection of their preferred volunteer as a VHT member to distribute drugs for better benefit of the children under five years.

Malaria remains one of the most dangerous diseases in Sub-Sahara Africa in terms of morbidity, mortality and economic losses alongside other illnesses of the under five years. In light of the third Health Sector Strategic Plan (HSSP III), even after the first Health Sector Strategic Plan (HSSP I) and (HSSP II) which began in 2000 around the time when Village Health Teams (VHTs) were introduced. To stand-up to the challenge of child illnesses, Africa established a disease control strategy, whose goal was “to control and prevent morbidity and mortality, as well as to minimize social effects and economic losses attributable to illnesses in children under five (WHO, 2010).

The use of village health teams towards achieving malaria control and prevention in East Africa has seemed ideal in addressing such challenges warranting their earlier establishments. Such program is reported to have received much attention since the 1978 Declaration of Alma-Ata, which laid a foundation for many community health-related initiatives especially in developing countries including Kenya and Tanzania. Nevertheless, such programmes are said to suffer slow death once the initial enthusiasm of volunteers diminishes and this could be the case with the VHTs (Turinawe, et al., 2015 and Nkurunungi, 2014).

Village Health Teams (VHTs) is one of the community health worker programmes that were introduced into Uganda’s healthcare system in 2000 to help increase the uptake of health services in rural communities. The VHTs strategy was introduced by the Ministry of Health to ensure that every village in Uganda has village health team members who work together to mobilize individuals and households for better health. This strategy has since been replicated in several Sub-Sahara African countries such as Ethiopia, where significant gains have been reported in health service delivery (New Vision, 2014). While the strategy has plausible records in several countries and communities in Uganda, there are reports that claim the opposite. For example, Turinawe, et al., (2015) noted that the VHTs performance has been poor in many communities of Uganda. Basing on reports of success here and failure there, this study seeks to examine how the VHT strategy has faired in Kanala town council. In Uganda, children under the age of 5 years contribute the largest part of malaria related mortality 25%- 30% and 70,000-100,000 annually country-wide (Opolot, 2015). The same could be the case with Busiika Town Council, given the ecological conditions of the area. This study therefore, seeks to establish the role of village health teams towards malaria control and prevention.

# Statement of the Problem

According to Opolot (2015), Uganda’s under five mortality rate is 131 per 1,000 live births, the highest rate in East Africa. Malaria contributing to 25%, pneumonia 10%, diarrhea 9%, malnutrition and HIV/Aids are the major causes of child deaths in the country (UNICEF, 2012). By 2020, statistics showed that only 31% of the Villages in Busiika Town Council had trained VHTs in all the villages, yet the implementation of Maternal and Child Health (MCH) interventions is hampered by inadequate human resource at service delivery outlets and inadequate supervision, while the current public health report indicates that malaria control and prevention in Kalungu, Bunsule and Lukyamu is low with 271 households affected by malaria in 2020, 291 households affected in 2021 and by end of the 2021-2022 financial year in July, the report show that 326 households were affected by malaria (Busiika Town Council Public Health Report, 2022). In the face of the challenge above, cases of malaria and other diseases continue to remain high in the three selected villages of Busiika Town Council. Given the reported high numbers of malaria and other illnesses among household members, more especially children and pregnant women, it is against this background that the researcher has developed the interest to assess the role of village health teams towards malaria control and prevention in selected Villages in Busiika Town Council.

# Research Questions

The study set out to provide answers to the following research questions.

1. What are the malaria control and prevention programs in selected villages within Busiika Town Council?
2. What is the role of village health teams in the control and prevention of malaria in selected villages within Busiika Town Council?
3. What is the relationship between roles of VHTs and malaria prevention control in selected villages within Busiika Town Council?

# General Objective

The general objective of the study is to assess the role of village health teams towards malaria control and prevention in selected Villages in Busiika Town Council.

# Specific Objectives

The study will be guided by the following specific objectives;

1. To identify malaria control and prevention programs in selected villages within Busiika Town Council.
2. To assess the role of village health teams in the control and prevention of malaria in selected villages within Busiika Town Council.
3. To determine the relationship between malaria prevention programs and role of VHTs towards malaria burden control in selected villages within Busiika Town Council.

**Hypothesis of the Study**

There is no significant relationship between roles of VHTs and malaria prevention control in selected villages within Busiika Town Council.

# Scope of the Study

**Geographical Scope**: This study will be carried out in Busiika Town Council condiering three villages namesly Kalungu Village, Bunsule Village and Lukyamu Village. The study is being carried out in this area because the villages are highly affected.

**Content Scope:** The general objective of the study is to assess the role of village health teams towards malaria control and prevention in selected Villages in Busiika Town Council. The independent variable is roles of VHTs and the dependent variable if malaria control and prevention.

**Tome Scope**: This study will be carried out in a period of 7 months which is from May 2022 to December 2022.

# Significance of the Study

**To Other Researchers and scholars**: The findings of this study would contribute to the existing body of knowledge concerning the complex nature of the diseases that mostly affect children under five specifically the household dynamics that affect the utilization of VHT services for treatment of children under five years. Such information will be used by other researchers and scholars.

**To community Members**: May also contributes to the understanding of factors that affect the use of health care services treatment and the challenges by the VHTs in the treatment of malaria which will empower the community with knowledge and ability to control and prevent malaria.

**Policy Makers**: The findings of this study would serve as a source of information to non- Governmental Organizations, government and private enterprises who are involved in the promotion of modern health service seeking behaviors in the fight against diseases such as malaria. The study would be useful to the policy makers in the Ministry of Health. The information obtained could provide useful guide for formulating appropriate policies and programs for the promotion of utilization of health care services in the treatment of malaria by VHT.

**To Nurses and nursing education:** Findings of this study will enable nurses and other students in the nursing education to learn more about contributions of VHT towards malaria control and precention. Such information will create a clear picture of what students should expect if assigned the duty or role of leading VHTs.

# Theoretical Framework

This study will apply the Health Beliefs Model in investigating the role of village health teams in control and prevention of malaria. The health belief model was originally developed to explain preventive health behaviors against a disease that a person did not yet have (Bond, Aiken, & Somerville, 1992). The components of the HBM are derived from a variety of psychological and behavioral theories that hypothesized that behavior depends on two variables: 1) the value placed on a particular goal and 2) the individual’s estimate of the likelihood that an action will achieve that goal. Questions designed to assess this dimension have included things such as one’s belief in the diagnosis, susceptibility to illness, and estimates of receptibility (Becker & Maiman, 1980).

Applying the HBM to different models of disease can provide information about the minimal levels of the model’s elements needed to induce compliance to the disease treatment regimen. Health care providers can tailor interventions to suit the needs of each patient based on components of the HBM. Given et al. (1983) suggests that in order to identify each patient’s needs, an assessment should be used to identify beliefs about abilities to control effects of the disease, the barriers to and the support for carrying out the treatment regimen, and beliefs regarding that treatment. Once this occurs, health professionals can interact with patients to devise strategies that will alter beliefs and subsequent health behaviors. A standardized measurement of the components of the HBM would facilitate evaluation and analysis of the data (Jan, 2006). The theory assumes that if the VHTs were trained and the magnitude of the problem they could actively fulfill their duties in the control and prevention of malaria.

# Conceptual Framework

Figure 1 of the study reflects the study variables in terms of the role of village health teams towards malaria control and prevention in selected Villages in Busiika Town Council. The independent variable is roles of VHTs and the dependent variable is malaria control and prevention.

**Independent Variable Dependent Variable**

**Socio-demographics**

* Gender
* Age
* Education
* Employment status
* Marital status

**Malaria control and prevention Level;**

* High
* Low

**Role of VHTs;**

* Home Care Visit
* Referrals
* First Aid
* Drug Distribution
* Sensitization
* Dispensing Drugs
* Home treatment
* Diseases treated
* Screening

**Control Programs**

* Provision of treated nets
* Clearing of bushes
* Clearing of stagnant water
* Health education

Figure 1: Conceptual Framework

Source: *Adopted and modified from Bashinyora (2010)*

# Operational Definition of Terms

**VHT services:** In this study, this refers to the work that is entitled to the village health workers towards treatment of Malaria. The services considered are; home care visits, referrals, first aid, drug distribution and sensitization of the community about diseases such as malaria.

**Malaria control and prevention**: This refers to the prevalence level of Malaria among household members more especially children and pregnant women in selected Villages in Busiika Town Council.

# CHAPTER TWO

# LITERATURE REVIEW

This section of the study contains reviewed literature on roles of VHTs. Source of the literature is journals, articles and reports. Aim of the literature is to identify the study gaps.

# Role of village health teams in Terms of;

# Home Care Visit

Root *et al*., (2013) shows that with the introduction of HBMF, communities in the selected districts were sensitized on the approach and involved in the implementation and the identification as much as possible of individuals in whom they have confidence to strengthen the management of fever and other diseases in children.

Most studies highlight the need for recruiting Community Health Workers (CHW) from communities they serve, but they also point out the difficulties in implementing this approach. CHWs are from the communities they serve presumably will not only be more accessible and also do multiple home visits but also be able to gain the confidence of community members (Ruebush, Weller, & Klein, 1994). There are cases when the VHTs have not bothered to carryout continues home checks on health issues and how the children health is. Recruited VHTs from local communities have had some impact on utilization, creating health awareness and health outcomes (Bang et al., 2005 Abbatt, 2005; Lewin, Dick, Pond, Zwarenstein, Aja, Wyk et al., 2005).

# Referrals

According to Leku, (2012), community members’ attitude towards malaria as a disease is important in understanding their health seeking behavior and use of preventive methods. Some of the studies reviewed have indicated that communities now regard malaria as a dangerous disease that can kill and affects more children under five years than the adult. Such people always seek the health of the village health team member for primary treatment as they pay close attention to the progress of the disease. Rissa, (2008) informs that when people understand the severity of the disease and the possible prevention, such positive attitudes are essential opportunities for behavior change campaigns.

Health workers at the village level should not hesitate to refer the child for further medication in any case the disease goes out of hand. This ought to be accepted by the care takers without hesitation. The CMS survey (Okello, 2010) revealed that that majority of respondents (98%) believed that malaria was dangerous and could cause death any other disease. This was in line with a study done by Rissa (2008) which indicated that 95.4% of respondents looked at malaria as a severe problem that could kill easily the children under five years of age although other qualitative studies have indicated that malaria in pregnancy is a normal thing (Mangeni, 2013).

# First Aid

The 2003 HBM follow up survey conducted in 9 district of Uganda indicates an increase in knowledge of appropriate health seeking behavior among caretakers for children under five with malaria. Village health teams are obliged to give the fist aid which is a primary treatment of children at the onset of symptoms of diseases but not when the disease is in advanced stages. The same follow up survey (Fapohunda, et al.,2008) noted that on average four of five women in the surveyed households knew that children with malaria should receive care within 24 hours while for other diseases like diarrhea they could wait. The proportion of caretakers of under fives, who took any action in the first 24 hours of the onset of fever, was 39.2% up from7.3% in 2001. The HBM follow up survey (2003) further reports that proper health seeking behaviour for treatment of malaria and other diseases is improving with 60% of surveyed caretakers taking action within 24 hours in VHT areas and 52.7% in the non VHT areas (Fapohunda, et al., 2008). This compares favorably with 47.7% of care takers taking action within 24 hours reported in the 2001 HBM baseline survey (Wanyana, et al., 2011) and 39.2% as reported in the MoH/WHO 2001 Roll Back Malaria (RBM) program monitoring and evaluation survey (Lutalo, et al.,2009).

# Drug Distribution

According to Root et al., (2013) for effective implementation of village health teams, it was clearly recommended that the right persons are selected as community drug distributors. According to the MOH guidelines a suitable distributor should be: Easy to approach; Trustworthy and reliable; permanent resident in that community; basically literate (can read and write) and; willing to work as a volunteer. This informs that in order to meet the above conditions, and to enhance community ownership and participation, the entire village council, comprising adult men and women was expected to be sensitized and guided in the selection of their preferred volunteer as a VHT member to distribute drugs for better benefit of the children under five years. Thus the full village community should be involved not simply the LC1 Committee. They should hold the VHTs accountable to not deliberating on their duties.

# Sensitization

A number of studies have shown that community members’ knowledge about the cause of malaria has increased from figures as low as 40-50% in the early 1990s in most parts of the country to as high as 80-90% by 2001 in several countries. The Net Mark survey (2007) indicates that 92% of the respondents in the five districts knew that mosquitoes cause malaria, although only 21% knew that mosquitoes are the only cause of malaria. The study by CMS (Okello, 2010) indicates that 77.6% of the respondents in the three districts knew that mosquitoes cause malaria but were not sure what the cause of other diseases were. A study done in Kampala by Makanga (2006) shows that 84% of the respondents interviewed knew that mosquitoes transmitted malaria. This indicated that the majority of the population is aware that aware about the cause of malaria and that they can do something to prevent the disease.

The HBM follow up survey by MoH/WHO/BASICS II in nine districts of Uganda indicates that the majority of caretakers (91.1%) knew how malaria is transmitted and little knowledge about other diseases (Fapohunda et al.,2008). They also reported significant improvements in the knowledge of community members about malaria (Njama, et al.,2009 and Kilian, 2010). This was due to the different avenues people get information in the current days although this knowledge acquisition was not particularly based on the work of village health teams to sensitize the community.

In a study done in Moyo District (Leku, 2012) indicated that 50% of the community knew that the mosquito caused malaria, while 42% had misconceptions and 8% did not know of any cause for malaria. The Uganda ITN voucher scheme pilot project survey (Kilian, 2010) also indicates high levels of knowledge among primary school children who were part of the study in Mbale (76- 82%) and Mbarara (83-87.5%) district.

# Dispensing Drugs

A study about urban malaria in Kampala city (Njama et al.,2009) carried out in 2002 also indicated that caretakers’ knowledge regarding anti-malarial therapy is very low, with only 29% of the surveyed respondents knowing the correct dose of CQ and only 19% knew that CQ was best administered orally with knowledge higher among those with high levels of education. In the same survey (Njama, et al., 2009) it is reported that 51% of the caretakers thought that CQ [alone] was the best treatment for malaria and 12% indicated acetaminophen as the best treatment. Mangeni (2013) reports a high tendency for pregnant mothers with fever to always combine herbs with western medicine at the home and health facility level of treatment. The same study reports that the common anti-malarial drugs used to treat malaria in pregnancy were: SP and CQ, though some women also mentioned using septrin and paracetamol as anti-malarial drugs (Mangeni 2013). CQ is no longer used for the treatment of malaria in children.

# Home Treatment

According to Root et al., (2013) there are many mothers especially in the rural setting who would not take their children to the health centers even though they have been recommended by the lower health units to do so. There are many aspects that may cause this situation but most often this is due to the lack of proper awareness of the intensity of the disease that causes reluctance for the care takers to neglect wise advices from the medical team (Kilian, 2010). This seems to imply that mothers who depend solely of primary health care services lack the awareness and ability to take on higher medical services.

Often parents perceive treatment at the hospital negatively with fear for the child’s life to be about to end than to being safe (Njama, et al.,2009 and Kilian, 2010). This makes parents to keep their children home when they are sick with malaria. In many cases children are taken to the health centers after spending many days without treatment. It is however different in situations where the child has received medication from the health facility and hospitalized at home (Root et al., 2013).

# CHAPTER THREE

# METHODOLOGY

This chapter discusses the different methods that the researcher used to collect data from the respondents. This chapter looked at the methodological aspects of the study giving details regarding the procedures that were used in conducting the study. These included the research design, Locale of the study, the population of the study, target population, sampling size, sampling procedures, research instrument, measurement of validity and reliability of the research instrument, data collection procedure, data processing and analysis.

# Research Design

The study will apply both quantitative and qualitative research approaches. Specifically the study will use descriptive, cross-section survey and correlational research design. A descriptive and cross sectional survey will be used since the study seeks to assess level of malaria control and prevention and the roles of VHTs towards malaria control and prevention. Also, a correlational research design will be used to examine the influence of VHT in the control and prevention of malaria.

# Study Settings

### This study will be carried out in Busiika Town Council bordering three villages namely Kalungu Village, Bunsule Village and Lukyamu Village. The study is being carried out in this area because the villages are highly affected by high malaria prevalence.

# Population of the Study

According to UBOS, (2021) Busiika Town Council has a total of 49,025 residents dwelling in 7,102 households. Out of this number, 124 households are located in Kalungu Village, 103 are in Lukyamu Village and 99 are in Bunsule Village. Therefore, the unit of analysis for this study comprises of 326.

# Target Population

This study targets Village health teams from three villages located in Busiika Town Council. The three villages are Bunsule, Kalungu and Lukyamu which have a total of 30 accredited Village Health Team Workers.

# Sample Size

The sample size of the study is 30 village health team members who will not be subjected in any form of sample size calculation. In addition, the study will target 3 community leaders (LC1 of each of the 3 targeted villages. Similarly, the study will target 10 health care providers with health facilities in the 3 villages. The aim of targeting this group of respondents is because they can provide the researcher with the required data. In addition, the study will target household heads in 326 households located in the targeted villages. Out of this number, 124 households are located in Kalungu Village, 103 are in Lukyamu Village and 99 are in Bunsule Village.

The following mathematical formula by Taro Yamane (1970) will be used to determine the sample size of the study participants who will provide data through answering a quesitionnair.

Where; N = total population [326]

n= total sample size.

E= desired margin error [0.05]

Table 1: Target Population and Sample Size

|  |  |  |
| --- | --- | --- |
| Respondents’ Category | Target Population | Sample Size |
| Household Heads | 326 | 180 |
| VHTs | 30 | 30 |
| Community Leaders (LC1) | 3 | 3 |
| Health Care Providers | 10 | 10 |
| Total | 369 | 223 |

# 

# Sampling Procedure

Simple random sampling by the use of lottery method will be used to select the households with under five. The lottery method will be used to get varying number of houses that participated in the study corresponding with the sample size. In this case, the researcher obtained the list of Village health team members operating in the selected villages and then purposively distributed the questionnaires to them.

# Research Instruments

To collect data from respondents, the study will use both a self-administered questionnaire and an interview guide.

# Questionnaire

The researcher will use an administered questionnaire that comprises of semi-structured questions in accordance with the objective of the study. The questionnaire was chosen because it is the most appropriate instrument in collecting quantitative data in cross sectional studies which are easy to quantify and standardize (Spector, 1997). It is also a cheap and convenient method of data collection which ensured greater anonymity and can cover wider geographical area (Amin, 2005). The research instrument has three sections; section A measures the demographic characteristics of respondents. Section B measures the role of village health teams. Section C measures respondents’ suggestions. Closed-ended questions was guided by a two-point Likert scale of; 1. No, 2. Yes.

Figure 2: Showing the operationalized Likert Scale

|  |  |  |  |
| --- | --- | --- | --- |
| **Scale** | **Mean Range** | **Response Mode** | **Interpretation** |
| 2 | 1.50 -2.00 | Yes | High |
| 1 | 1.00-1.49 | No | Low |

# Validity and Reliability of instrument

Ochieng (2009) argues that, for a study to be of real meaning, it has to apply valid and reliable instruments. Before actual research, the researcher will ensured that the instruments are pretested for purpose of achieving validity and reliability.

# Validity

To ensure the validity of the research instrument, the main research advisor and experts like statistics, lecturers will check the questionnaire for the consistency of the items, conciseness, intelligibility and clarity.

Their input will help to make necessary adjustments so that the instrument measures adequately what it is intended to measure. Thereafter, based on the feedback, the researcher will eliminate items that are unclear, irrelevant or redundant and calculate the content validity using the Content Validity Index formula (CVI) by Amin (Amin, 2005).The CVI of above 0.7 is an appropriate validity.

# Reliability

According to Sekaran (2003) and Amin (2005), reliability is an indication of the stability and consistency with which the instrument measures the concept even in repeated observations of the same phenomenon (Babbie 2007). Reliability of the instrument is achieved through validation by brainstorm. Questionnaires will be distributed to a group of four (10) VHTs from Vvumba Village because the village is located same as the targeted villages in Busiika Town Council. Thereafter the question will be adjusted and before being admitted to the respondents.

# Data Collection Procedures

The researcher will obtain a letter from Bugema University introducing her to the authorities of Busiika Town Council to enable her reach the targeted group. The researcher will collect data with the assistance of two (2) research assistants who will well versed in the local language. Before the start of every interview, the researcher promised confidentiality the respondent. The key informants will interviewed at their places of work and their homes. Respondents will be allowed to talk at length on the subject asked. Checks of accuracy, consistency, and comprehensiveness will be done by use of probing questions. The study will consider three research assistants who will help in gathering data from the participants.

# Data Analysis

Data analysis will be both qualitative and quantitative. In a quantitative analysis, information will be organized in a systematic way. Analysis of data will be done using Statistical Package for Social Sciences (SPSS). This package enabled a large number of variables entered simultaneously. The statistical measures and analytical techniques will be used at various levels that involved sorting, editing and generating descriptive statistics. Regression analysis will be used to test the hypotheses.

Objective 1 and 2 will be analyzed by the use of descriptive statistics where frequencies and percentages were used. For objective 3 the researcher will analyze data using inferential statistics. While analyzing qualitative data, summaries will be made on how different themes/variables are related.

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**APPENDICES**

**APPENDIX A: QUESTIONNAIRE**

Dear Student,

I **LEILA MUSSA KARUNDE** am a students of Bugema University pursuing Degree in Nursing and Midwifery. We are carrying out a study on “**ROLE OF VILLAGE HEALTH TEAMS TOWARDS MALARIA CONTROL AND PREVENTION IN SELECTED VILLAGES WITHIN BUSIIKA TOWN COUNCIL, UGANDA**”. The study is purely for academic purpose. The information obtained will be treated with great confidentiality. Therefore, I kindly request you to fill in the questionnaire to the best of your knowledge. Thank you for your cooperation.

**SECTION A: PERSONAL INFORMATION**

Please Tick (**√**) where appropriate in the box provided.

1. Gender: Male ( ), Female ( )
2. Age: 18-28 years ( ), 29-38 years ( ), 39 and above years ( )
3. Education status: Primary ( ), Secondary ( ), Tertiary ( ), None ( )
4. Employment status (occupation): Employed ( ), Self-employed ( ), Not employed ( )
5. Marital Status: Married ( ), Single ( ), Divorced/separated ( ), Widowed ( )

**SECTION B: PREDICTIVE FACTORS FACED**

Please Tick (**√**) where appropriate in the box provided.

The Closed-ended questions was guided by a two-point Likert scale of; 1. No, 2. Yes.

|  |  |  |
| --- | --- | --- |
| **Malaria Control and Prevention Programs** | **Yes** | **No** |
| 1. We are given treated mosquito nets by the government |  |  |
| 1. We clean our environment to ensure that mosquitoes do no breed near the house and this helps in control and prevention of malaria |  |  |
| 1. We sleep with long-sleeved cloths to avoid mosquito bites |  |  |
| 1. We are regularly screened from malaria |  |  |
| 1. We spray nearby bushes to kill mosquitoes which may affect us |  |  |
| **The Role of Village Health Teams in the Control and Prevention of Malaria** | **Yes** | **No** |
| 1. Village health team members come to our homes and educate us about malaria control and prevention |  |  |
| 1. VHT distribute treated mosquito nets to household members |  |  |
| 1. VHT members diagnose us for malaria |  |  |
| 1. Distribution of malaria drugs is always done by Village Health Teams |  |  |
| 1. Village health teams refer malaria patients to other health care facilities |  |  |
| 1. Village health teams carry out environmental cleaning program to eliminate mosquito breading places |  |  |

**MALARIA BURDEN**

1. In the last three months have you or any family member been diagnosed or treated for malaria?

Yes ( ), No ( )

1. If yes, how many family members have been affected of malaria?
2. ( ), 2-3 ( ), 4-5 ( ), more than 5 ( )

3. What do you suggest should be done to promote the control and prevention of malaria in selected villages of Busiika Town Council?

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