Author's response to reviews

Title: Community referral in Home Management of Malaria in Western Uganda: A case series study

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Author's response to reviews: see over
Thank you for the referee comments which were all very relevant and well taken points. We have done our best to try to address them accurately.

Authors’ response to suggested revisions:

1.1. Do the drug distributors use a referral slip, or is the referral done verbally only?
   **Authors’ response:** Referral was only done verbally which has been clarified in the background on pg. 2 and in Box 1.

1.2. Do the health facilities provide any immediate feedback to the DD on the outcome of referral, for example through a “counter-referral” slip?
   **Authors’ response:** The health facilities do not provide any feedback to the DDs and no not use counter-referral slips, although this would have benefited the programme. Details regarding this issue have been added in the discussion on pg. 8 and in Box 1.

   **Authors’ response:** This question has already been addressed under the previous comment.

1.4. Which of the seven models of CHW management of sick children does the DD system in Uganda best approximate, from this same paper by Winch et al.?
   **Authors’ response:** The HBM programme in Uganda fits under Intervention model 3 in the paper mentioned above (as already described in the paper by Winch et al). We have added a reference to that model on pg. 2.

1.5. Once referred children arrive at a health center, are they attended to more quickly because they have been referred?
   **Authors’ response:** Unfortunately no data was collected on the reception of the referred child in the health facility, although this information would have been relevant.

1.6. Do DDs receive regular supervisory visits, and if so, do supervisors provide feedback on their referral success or on the outcome of referral?
   **Authors’ response:** This issue has now been addressed in the discussion on pg. 8.

1.7. Do DD make follow-up visits in the home after children return from a referral facility?
   **Authors’ response:** This has partly been addressed already in Box 1, but a sentence has been added for clarification.

2. Approximately what is the average distance between the home and the health facility for children who were referred? An educated guess would be sufficient. Are there any major physical barriers to reaching the health facilities such as rivers or mountains? No comment was made about the topography of the study site.
   **Authors’ response:** This is indeed an important comment as the study site was very mountainous and health facilities were difficult to reach for the majority of the population. Some more background information on the study district has been added in the methods section on pg 4.

3. It would be interesting to have the authors compare their findings on referral constraining factors to those described in the following papers, including the conceptual framework in Macintyre, K., & Hotchkiss, D.R. (1999). Referral revisited: community financing schemes and emergency transport in rural Africa. Soc Sci Med, 49(11), 1473-1487.
Authors’ response: The main points from the proposed references have been summarised and are discussed on pg. 8.

4.1 What is the range in rates of referral compliance by drug distributor and/or community?

Authors’ response: We have added a sentence on the range of completion rate across parishes on pg. 6.

4.2. Does the variation seem to be related to geography or the skill and motivation of the DD?

Authors’ response: Although this is an interesting query, we do not have this information and the numbers are too small to be able to conclude anything from the data. More in-depth studies on predictors for successful referral should be performed with more information on the individual DD characteristics.