

Performance of Village Health Teams,
A case Study of Soroti District VHTs.

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DEDICATION.

I would like to dedicate the success of this study to my dear wife Tino Mary and all the entire family members for their continued support in the process of carrying out the study and subsequently giving encouragement during the development of this dissertation. Their ideas and moral support gave me strength and energy to accomplish this study.

DECLARATION.

I the undersigned would like to declare that this dissertation is my original work and has not been presented for Masters Degree in this or any other University. I also want to declare that all the resources and materials used in this study have been duly acknowledged.

Name Adoa John Steven.

Signature

I have approved this dissertation for submission and examination as University research supervisor for the student.

Name John Charles Okiria,

Signature.....

Abstract.

This study was about establishing the factors that influence the performance of Village Health Teams in Soroti District. The main objective of the study was to establish factors that influence the performance of the Village Health Teams in Soroti and to suggest measures that can be used to address these factors.

The specific objectives of the study were: To examine the current motivational factors for the VHTs in Soroti District, to assess the current educational levels of VHTs in the District, to assess the current levels of skills and knowledge among VHTs in the District, to assess the level of training of VHTs and to assess the level of support supervision and mentoring of VHTs by the District and sub county health officials and also assess the level of performance of VHTs in Soroti District.

Methodology: This was a cross sectional survey carried out in the District of Soroti covering the seven sub counties and the study sample population size was 175.

Results: The study findings revealed that lack of motivation (provision of incentives), inadequate support supervision and lack of transport were identified as the key factors influencing the performance of VHTs in Soroti District.

Conclusion: The study concluded that lack of motivation; support supervision and mentoring and inadequate transport have a significant influence on the performance of the VHTs in Soroti District.

Recommendation: The study recommends implementation of a sustainable motivation mechanism, provision of regular support supervision and mentoring and provision of transport to VHTs as among the important measures that should be put in place to improve on their performance and consequently contribute to improvement of the health services delivery in Soroti District by the VHTs. And also further studies should be conducted on community's attitudes and perceptions.

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ACRONYMS.

ADHO	Assistant District Health Officer.
AIDS	Acquired Immune deficiency Syndrome.
AMREF	African Medical Research Foundation.
CB-DOTS	Community Based Directly Observed Treatment Short course.
CEMP	Community Empowerment and Mobilization for Health.
CORPS	Community Resource Persons.
DHE	District Health Educator.
DHO	District Health Office.
FGD	Focus Group Discussion.
HBMF	Home Based Management of Fever.
HIV	Human Immune deficiency Virus.
HSSP.	Health Sector Strategic Plan.
IEC	Information Education and Communication.
ITNS	Insecticide Treated Nets.
KIs	Key Informants.
LC1	Local Council One.
LC11	Local Council Two.
LC111	Local Council Three.
MDGs	Millennium Development Goals.
MOFPED	Ministry of Finance Planning and Economic Development.
MOH	Ministry of Health.
NGO	Non-Governmental Organization.
NHP	National Health Policy.
PAG	Pentecostal Assemblies of God.
PEAP	Poverty Eradication Action Plan.
PHC	Primary Health Care.
TBAs	Traditional Birth Attendants.
UNMHCP	Uganda National Minimum Health Care Package.
VHTs	Village Health Teams.
VHV	Village Health Volunteer

OPERATIONAL DEFINITIONS.

For purposes of this study the following concepts / terms have been defined as:

Village Health Teams is the community based village structure whose members are selected by the people themselves to promote health and wellbeing of people in their areas.

Village Health Centre one shall mean the Village health Team.

Married means marriage which is either customary or church marriage.

Tertiary education shall mean any level of education above primary, secondary and advanced level.

Quarterly shall mean a period of three calendar months.

Annually shall be taken to mean 12 calendar months

CHAPTER ONE.

INTRODUCTION.

Background to the study.

This study focused on establishing the factors that influence the performance of VHTs in Soroti District. It has been observed that despite the establishment of VHTs in all the villages in the District with the prime objective of mobilizing and empowering communities to take decisions that affect their health and to strengthen delivery of health services at the household level, service delivery has remained poor as evidenced by the District Health Office (DHO) reports. Key issues like the existing motivational factors, level of knowledge and skills of the VHTs to do their work, educational levels of VHTs, level of supervision by the District and sub county health officials, and their level of training were investigated. Chapter one of this report covers the introduction to the research issues which includes background, statement of the research, objectives, purpose, significance and the conceptual framework. In chapter two related literature is reviewed. Chapter three discusses issues of study design, study population, sample size determination, sampling procedures, sources of data, study variables, data collection methods/tools, data analysis procedures, quality control and ethical issues. In chapter four, research findings/data are analyzed and interpreted. Chapter five discusses the findings of the research and the conclusion and recommendations are made in chapter six.

Health is recognized as one of the fundamental pillars of human and national development and this is not only consistent with Uganda's development priorities but also a commitment to achieving health related Millennium Development Goals (MOH 2005). There is a direct link between development and health outcomes at individual, community, and National levels (MOFPED 2001). It has generally been recognized that it is critical to foster an integrated

approach to development by tackling health from a development perspective. It is envisaged that engendering community participation and ownership through community based structures such as Village Health Teams will increase individual and community control over the determinants of health and thereby contributing significantly to socio- economic development of a country.

In Uganda as in other African countries, where there is an acute shortage of health workers especially in rural and peripheral areas due to attrition, HIV/AIDS, migration or search for greener pastures (Lehmann and Sanders, 2007), it was realized that in order to fight poverty and enhance development, and if PEAP targets and MDGS were to be met, there was need to harmonize and universalize efforts towards community empowerment and mobilization for health (CEMP). To this end the Uganda National Health Policy (NHP) of 1999 and the Health Sector Strategic Plan (HSSP) 1 (2000/2005) and HSSPII (2005/2010) included (CEMH) as one of the elements of the Uganda National Minimum Health Care Package (UNMHCP). Initially, the Home Based Management of Fevers (HBMF) programme that was rolled out after the Abuja Declaration, demonstrated the practicality and massive benefit of a sustained Universal Community Empowerment and Mobilization intervention in Uganda. When this was added to the successes of more focal community efforts such as Guinea Worm Eradication Programme, CB-DOTS and Ivermectin Distribution, it became clear that an all-embracing integrated community empowerment and mobilization strategy, the Village Health Team (VHT) strategy could indeed be practicable and synergistically more beneficial. The VHT strategy was then rolled out in Uganda in 2003.

Besides in Uganda, more than 75% of the diseases are preventable (MOH 2000) which can only be achieved through increase of awareness, positive behavioral change and adaptation of positive health practices.

This realization therefore makes initiation and widespread implementation of the VHT strategy even more critical in order to reduce the workload on the few health workers and as a stop-gap measure in places where there is none.

The Village Health Team is non-political implementing structure, an equivalent of Health Centre 1, responsible for the health of community members at household level. The functionality of VHTs strengthens and coordinates the delivery of health services in the community. They are answerable to the lcl executive and are expected to create a sense of ownership and sustainability of health activities at household level. The VHTs concept in Uganda is prescribed by the National Health Policy (NHP) of 1999 as a strategy of community mobilization and empowerment. The strategy brings health services nearer to the people and as a result yields positive outcomes. VHT members are selected through a popular vote after sensitization and consensus building of all village members from all households. Each VHT member is in charge of 20-30 households. Priority in selection is given to already existing Community Resource Persons (CORPS) such as Community Health Workers, Community Drug Distributors, Traditional Birth Attendants, Traditional Healers, Counseling Aides, Condom Distributors, and Community Vaccinators etc.

Background to the study area

In Soroti District there are 240 villages, with a total of 309 VHTs selected and trained (District Health Report, 2008). Though the selection and training of VHTs went well, measures to ensure their functionality and sustainability however, seem not to have been addressed. Review meetings, for example, between the VHTs and District officials were planned quarterly but one was conducted in the period of one year. The village health registers that were `given to the VHTs were not well utilized. Many VHTs are reportedly not attending meetings organized by

parish coordinators. After training some VHT members have dropped off. The reports that were made by some VHTs were not up to standard and lacked many details. In some sub counties however, like Katine bicycles were given to the VHTs to facilitate their work and yet this is the sub county where the VHTs had a strike and laid down their tools (District Health Office Report, 2009). This provides evidence that there is poor performance of VHTs and there may be factors besetting their performance and functionality that need to be investigated.

Geographical location and social demographic profile.

Soroti district is located in Eastern Uganda bordered by the Districts of Kaberemaido in the West Amuria and Katakwi in the North East and Kumi in the South. Formerly it included the new District of Serere which was carved out in 2010. The Districts population is approximately 151,599 with about 73,498 males and 78,101 females (Source, Population and Housing Census, Final results).

Administratively Soroti District has one rural county, seven sub counties, 26 parishes and 240 villages. It has 27,700 households with the average household size of 5.4 and the approximate population density of 150 people per km². The population growth rate of Soroti is 5.12 (compared with the National average of 3.3) (Population and Housing Census 2002). The District has established administrative and political structures up to village level based on a decentralized structure. The local councils make up the political structure i.e. LCV at the District level to the LC1 at the village level. The RDC is the central government representative. The District administrative structure in the District is set up right from the District to the parish level. The Chief Administrative Officer is the head of the civil service in the District.

The ethnicity of Soroti District is mainly composed of three tribes i.e. Iteso, Kumams and Bakenye, however other tribes also exist like the Bagishu and Baganda who mainly do business in the District. The Iteso are the dominant tribe followed by Kumams.

The total fertility rate is 7.4, infant mortality rate is 85.3 per 1000 and the life expectancy at birth is 46 (Population and Housing census 2002).

The District has one government hospital which is also a regional hospital, two health centre 1Vs, seven health centre 111s and 309 VHTs who represent health centre ones at the village level.

Statement of the Problem:

Despite the adoption and use of the VHTs strategy by the District Health Department and many Health Development Partners as a more effective approach to improving health services delivery, through improving access and effective utilization of health services , the performance of VHTs has been found to be below standard. Reports available at the District Health Office indicated that many VHTs were not carrying out their functions as expected. They were expected to carry out home visiting, mobilization of communities for health promotion, carry out health education of the community members and to carry out data collection and management of health information at the village level among others. However they were found to not be carrying out these activities effectively. They were also not attending meetings organized by parish coordinators neither making monthly reports. This therefore indicates a poor level of performance subsequently contributing to poor service delivery at the grass root, especially where the VHTs were expected to close the gaps. A study therefore to assesses level of motivation, the level of knowledge/skills, level of education, level of support supervision and

mentoring and the level of training as the possible factors that can influence the performance of VHTs was carried out.

Scope of the Study:

This study was carried out in all the seven rural sub counties of Soroti District and in the seven selected parishes. The study period of this research was from 2006 when most of the VHTs had been selected and trained in the district up to November 2011. The study kicked off in the month of July 2011. The major focus of the study was to establish the factors that influence the performance of VHTs in Soroti District and specifically the study examined the current incentives or motivational factors available for VHTs, assessed the current educational levels of the VHTs and the current levels of knowledge and skills of VHTs and the level of support supervision and mentoring . Besides the attitudes, performance of VHTs was also assessed.

Research question.

What are the key factors influencing the performance of Village Health Teams in Soroti District?

The purpose of the study.

Thy purpose of the study was to determine the factors that influence the performance of the VHTs and the findings may be used for the improvement of the performance of VHTs in the District and the country as a whole.

Major objective of the study.

The major objective of the study was to determine the factors that influence the performance of Village Health Teams in Soroti District and recommend measures through which their performance can be improved for the better delivery of health services in the District.

Specific objectives of the study:

- To examine the current motivational factors for the VHTs in Soroti District
- To assess the current educational levels of VHTs in the District.
- To assess the current level of performance of VHTs in the District.
- To assess the level of training and the current levels of skills and knowledge among VHTs in the District
- To assess the level of supervision of VHTs by the District and sub county health officials.

Research questions of the study:

- What are the current motivational factors for the VHTs in the District?
- What are the current educational levels of VHTs in the District?
- What is the current level of performance of VHTs in Soroti District?
- What is the level of training and the current levels of skills and knowledge of VHTs in the District?
- What is the current level of supervision of VHTs by the District officials?

Significance of the study.

This study hopes to generate information that will guide the District in the identification and planning for practical and feasible measures that will be used to make the VHTs in the District more functional and productive and subsequently improving health services delivery especially at the rural peripheral areas. With improved functionality of VHTs in the District the most vulnerable sections of the populations will be mobilized and empowered to benefit from the

basic health care services provided thus improving the health and the general quality of life of the people.

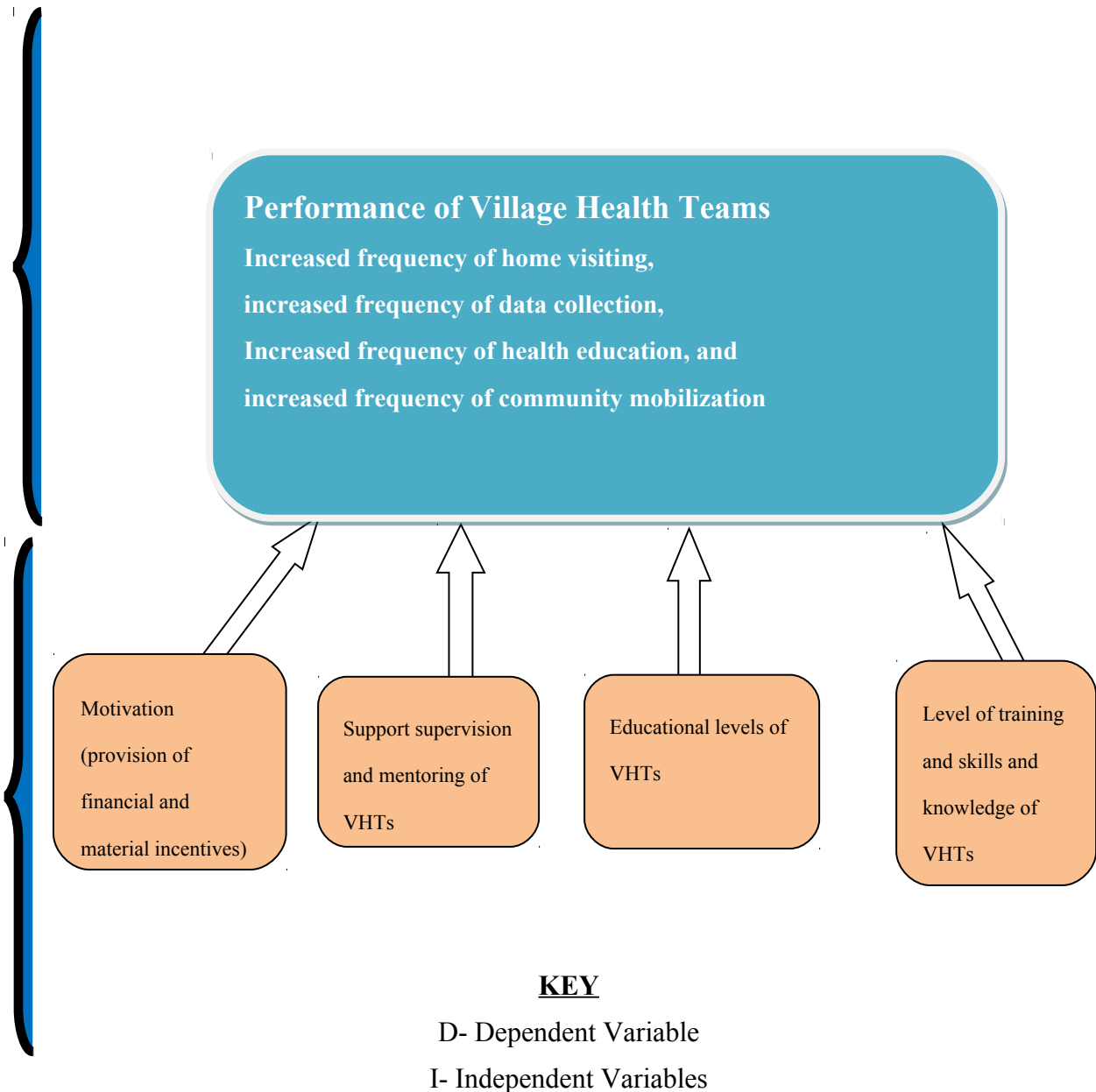
The study will also generate issues that can be used to inform policy making at the national level that will not only enhance the performance of VHTs but also lead to the improvement of health care delivery at the village level. This study will also make an addition to the general body of knowledge that may be useful to other researchers in future and may also lead to other related researches to be conducted. The primary beneficiaries of this study will be the people of Soroti District as the study will generate clear recommendations that may help to improve on the performance of VHTs and subsequently be able to render quality services to the population ultimately improving on health of the people.

Some of the key factors that contributed to the research problem.

The following are some of the key factors that contributed to the research problem and were investigated upon by the study:

- Levels of education of the VHTs.
- Level of training and skills and knowledge of the VHTs.
- Levels of motivation for the VHTs.
- Supervision and mentoring of VHTs by the District and sub county officials.
- Level of performance by VHTs.

Figure 1. Conceptual frame work (problem analysis diagram) showing relationship between the core problem and influencing factors.



Discussion of the conceptual Framework diagram.

The above conceptual framework diagram represents the conceptualization of the factors that may influence the performance of VHTs in the District. The desirable outcome of this conceptual framework diagram is the improvement of the performance of the VHTs in the District. This can be achieved if the factors in the boxes below (**representing the Independent variables**) are fulfilled or put in place.

Improvement in the level of training of VHTs leads to acquisition of better skills and knowledge among the VHTs and subsequently improving their level of performance.

Selection and recruitment of VHTs with higher educational levels/ standards enhances the abilities of VHTs to perform.

Adequate level of support supervision and mentoring by the District and sub county health officials will lead to improved skills and knowledge of the VHTs and their enhanced performance.

Fulfillment of the above factors is likely to lead to the improvement of performance of VHTs in the district.

Analysis of the independent and dependent variables in the study.

Independent Variables.

The following are the key independent variables in the study

- Motivation by provision of financial and material incentives to VHTs.
- Support supervision and mentoring of VHTs.
- Educational levels of VHTs.
- Level of training and skills and knowledge acquired by the VHTs.

Dependent Variables. Performance of VHTs

Performance is the key important dependent variable and the indicators that the study considered to assess as performance indicators include the following:

- Frequency of Home Visiting by the VHTs, which can be influenced by the factors like motivation with financial and material incentives as seen above
- Frequency in community mobilization by the VHTs is another important measure for the performance of the VHTs which can be influenced by factors of motivation like provision of transport to the VHTs and also effective support supervision and mentoring by the District and sub county health officials.
- Frequency of data collection and reporting by the VHTs can also be used to measure performance of the VHTs and this can be influenced by the factor of relevant skills and knowledge acquired by the VHTs.
- Frequency of carrying out health education to community members.
- Frequency of carrying out distribution of health commodities

In this study both the independent and the dependent variables have been measured and the findings for both variables are presented in tables as below.

CHAPTER TWO.

LITERATURE REVIEW.

This study focuses on the establishment of factors that influence the performance of the Village Health Teams in the District of Soroti. The review of the literature of this study is divided into two parts as follows:

The overview of VHT concept in the Uganda National Health System.

The VHT strategy was established in Uganda as early as 2001 by the Ministry of Health with the main objective of empowering communities to take part in the decisions that affect their health, mobilizing communities for health programs and to strengthen the delivery of health services at household level. The Primary Health Care (PHC) principle recognizes that health services should be accessible, cost effective, tailored to the local health needs, characterized by inter-sectoral co-operation and delivered with the participation of the people. The VHT strategy was therefore identified and developed as the most appropriate and would enable the realization of Alma Ata Declaration and also the recent 2008 Ouagadougou Declaration on Primary Health Care and Health systems in Africa to which Uganda subscribes, (MoH Uganda, VHT Strategy and Operational Guidelines, Health Education and Promotion Division, March 2010)

According to the HSSP 2000/01-2005/06 there was a realization that a challenge existed in the Health Care system in extending basic health care services to the entire population especially in rural areas where access to health care is so limited. In this regard HSSP 1 recommended the

establishment of the VHTs strategy, HSSP 11 and HSSP 111 called for a roll out and the consolidation of the strategy.

With this view, one of the fundamental missions of government which is the improvement of health care for all in terms of provision, accessibility and utilization may be realized. Many studies indicate that unacceptably high morbidity and mortality rates in Uganda are from preventable diseases. Other studies further indicate that only about 49% of the population in Uganda lives within five kilometers to a health facility. In Uganda, over 75% of the diseases are preventable if only people changed and adopted appropriate and well known behaviors geared towards better health (MoH, 2005). The implementation of the VHT strategy can help turn the situation round so that the country can make big strides towards achieving the Millennium Development Goals (MDGs) and to achieve better health and development for the people.

Roles and functions of VHTs.

The major functions performed by VHTs include the following, (MoH Uganda, VHT Strategy and Operational Guidelines, Health Education and Promotion Division, March 2010)

- Carrying out home visiting so that people are encouraged to adopt good health behaviors and practices. Health is made from home and is broken from home.
- Mobilization of communities for the utilization of existing health services.
- Health promotion and education.
- Community based case management of common ill health conditions.
- Following up of mothers during pregnancy and after birth and the new born for provision of advice, recognition of danger signs and referral.
- Following up of people who have been discharged from health facilities and those on long term treatment.

- Distribution of health commodities.
- Community information management and record keeping
- Disease surveillance.

Criteria for the selection of VHTs.

The selection of the VHT members is done after a village sensitization meeting. The Village members /Local council 1 with the help of a facilitator from the District or sub county maps all the households in the village and from every 25 households one member is selected as VHT using a popular vote and a village may have 5 members or more to constitute the VHT team depending on the number of households in that village. Selection should be gender sensitive and political leaders such as the lc1 chairperson, or vice or secretary are not eligible for selection. Potential VHT members may already be community health workers such as Traditional Birth Attendants and Drug Distributors if acceptable to the community. If a VHT member drops out a new member will be identified in the community during the quarterly review meetings. The new member will acquire knowledge and skills from on the job training.(MoH Uganda,VHT Strategy and Operational Guidelines, Health Education and Promotion Division , March 2010). The size of the team depends on the number of the households in the village, but on average it should be one team member per 25-30 households. The more sparsely populated the area is the less the number of households per member. However in areas where people live in close proximity, the number of households per VHT can be more than 30.

Motivation and Sustainability of VHTs.

VHTs are expected to perform their roles and responsibilities on voluntary basis, and yet they are expected to achieve the set objectives for the VHT strategy. The Ministry of Health proposes

some incentive mechanisms that may be used to reward and motivate VHT members and thereby sustain the programme.

Initial incentives shall be provided to VHTs to accept the assignment and begin work; this should include the following among others:

- Good quality training, award of certificates, commissioning ceremony, badges, T-shirts, bags, job aides, IEC materials and registers.
- Continuous/ consistent engagement of the VHTs. This is very vital in sustaining the services of the VHTs and minimize attrition.
- Also budgetary provision should be made at all levels from national to the village. There should be put in place innovative financing mechanisms to support VHTs.
- Task specific allowances and refresher trainings should be provided.
- Logistics and supplies should be provided on regular basis so that VHTs can provide services to their clients on continuous basis.
- Follow up, support supervision and mentoring should be provided to the VHTs on a regular basis.
- Recognition and appreciation by health workers, leaders and the community is important as a marketing strategy for the services of the VHTs and also make s them feel important and that their services are valued.

Previous researches related to the study.

The following studies carried out by some researchers were reviewed. On the international literature review there was some related literature of Village Health Volunteers (VHV) carried out in Thailand and has been reviewed and presented here as follows:

Age:

Bayliab Ketsophaphone when carrying out a study on Village Health Volunteers in Thailand quoted a number of studies carried out by various researchers some of them I was able to access and read about Village Health Volunteers. One such a study was carried out by Tiewsuwan suggesting that there was a significant association between the performances of Village Health Volunteers and the age group. Those in higher age group performed better than those in younger age group. Another study by Francis Wade Z.Gomez suggested that VHV aged between 45-70 years were more active than those who were under 30 years old. Other studies by Sulaiman Ratman 1991 and Khin-Myyitzu Han suggested contrary to the above that there was no significant association between age and performance of VHVs.

The current study also aimed to describe the different age groups distribution among the VHTs in Soroti and suggesting if this could be the problem affecting their performance.

Gender:

Studies by Havaree V. and ChaoniyonV. suggested that there was no significant relationship between gender and performance of the VHVs.

Another study by Yindeechan P. suggested a different view that there was significant relationship between gender and performance of VHVs. Another study by Phonthongsyk found out that both sexes of VHVs had poor performances.

Again the current study did not aim at establishing whether there was a significant relationship between gender and the performance of VHTs but rather focused on describing the gender disaggregation of the VHTs in the District and finding out whether the selection was done as per

the guidelines provided by Ministry of Health. MoH recommends that there shall be at least one third of the members as women.

Educational levels of VHTs:

A study conducted by Surendra Kumarshetha showed that there was significant association between education and job satisfaction and recommended that educational background should be considered in selecting the Village Health Volunteers .

Another study conducted by KhinMyyitzu Han also showed that there was significant association between education and performance of the VHV.

However another study by Tiewsuwan B. showed that there was no significant association between education and performance of the VHV.

Marital Status:

A study by Tiewsuwan B. reported that there was no significant association between marital status of the VHVs and their performance. However another study carried out by Ratoran S. found out that marital status had an effect on participation of VHV in their work.

Another study by Haryandi which revealed that married people were more stable than the unmarried and are better able to perform their tasks and responsibilities as VHV.

The current study also investigated the marital status of VHTs in the District of Soroti and tried to link marital status with performance of the VHTs.

Duration of Work as VHV/VHT:

A study by Ratorans, revealed that 66% of the VHVs served for about six and half years and spending 0.5-3hours per day for VHV work. This study showed that there was an effect of duration of work as VHT on performance.

Another study by Soongkhang I. and Admodjo BSK. indicated that there was no significant association between duration of work as VHV and their performances. This was contrary to the above views.

Knowledge and skills

A study by Tanapiwatanakul N. revealed that knowledge of VHT in regard to their roles was not associated with their performances.

While the studies carried out by Kummerdmarn K. Rahman M and Soongkhang I. indicated that knowledge of VHVs had a significant association on their performance.

Also according to the study by Nguyen Thu Huong, found a positive correlation between knowledge and performances of VHVs. This study showed that VHVs with good knowledge have a tendency to produce good performance.

Training Experience

A study by Tiewsuwan B. showed that the training experience in terms of monthly meetings was significantly associated with VHVs performances. The proportion of satisfactory performances was higher among VHVs who had high monthly meetings as compared to those with moderate and low monthly meetings.

Another study by Uthonthavikam Na Ayuthaya S. Showed that continuing knowledge provision from health officers had an effect on VHVs practice at a satisfactory level.

Support supervision

A study by Ratoran S, found out that most sources of emotional support and instrumental support to VHVs was from health officers during supervision. The study found out that the first priority of the support to VHVs was from health officers. It showed that the emotional support from health officers to VHVs had effects on the participation and performance of VHVs.

A study by Nguyen Thu Huong showed that the sources of motivational support for VHVs came from family and local leaders besides health officers.

On family support the study found out that VHVs with good performances were found to be higher among those VHVs who received more support from their families and communities.

On support from local leaders, the study found out that those VHVs who received more support from local leaders were more likely to have good performances than those who received less support.

On support from health officers, the study found out that there was association between type of support from Health officers and performances. Those VHVs who received more frequency of supervisions and were provided with IEC materials were performing better.

In conclusion supervision and social support is a basic human need. It is a personal-environmental interaction that decreases stress; provides comfort, assistance, encouragement and information for better performance. These studies are in line with the prepositions of the current study except they did not establish the level of association between support supervision and performance the position which the current study has established as seen in its findings

Motivation:

A study on Community Health workers in Uganda with focus on VHTs strategy conducted in 2007 by Dr. D.K Sekimpi, Uganda National Association of Occupational Health (UNACOH)

advanced that motivation and recognition of VHT members could address some of the critical challenges faced by the VHTs and would enhance their performance but did not go ahead to investigate whether these were the real factors affecting their performance or there were other factors besides .The current study therefore covered these gaps in knowledge by specifically investigating on key factors presumed to be influencing performance

CHAPTER THREE.

METHODOLOGY.

Introduction

This part of the dissertation outlines study design or the plan to be followed in the study and also includes study population, sample size determination, sampling procedures, sources of data, data collection methods/tools, data analysis procedures, quality control issues and ethical issues.

Study design.

The descriptive cross sectional survey research design was used for this study. This design was beneficial for collection of both qualitative and quantitative data. This research design specifically describes the important variables that influence the performance of VHTs

Study population

The study population was the Village Health Teams of Soroti District. However, some local leaders of Sub County and District and sub county health officials were also targeted in the FGD and key informant interviews especially. Some members of the community were also included in the FGDs.

Sample size determination

A sample table was used to determine the sample size of the respondents for the structured questionnaire. Tables have been developed that the researcher can use for selecting the appropriate sample size. These tables however require prior information about the number of individuals in the target population.

One such a table is from R.V. Krejcie D.W. Morgan (1970), determining sample size for research activities, educational and psychological measurements. For this study, the number of individuals (total number of VHTs) in the district is 309; therefore using the table the most appropriate sample size is 175. This means the total number of Village Health Teams that qualify for the study is 175. However, one member was selected from each of the 175 VHTs giving a total of 175 respondents for the structured questionnaire.

Sampling techniques/design/procedure.

Selection of the 175 respondents for structured questionnaire.

A two stage cluster sampling was used for this study, whereby the seven sub counties formed the first cluster. The second cluster was the seven parishes from which the 25 VHTs were selected by simple random sampling.

In each of the 7 sub counties one parish was selected by random sampling. This involved listing all the parishes in each sub county and randomly picking one at a time.

From each of the seven selected parishes 25 village health team members were randomly selected. This involved listing all the names of all the village health team members in each parish and randomly

picking one at a time until 25 respondents have been registered in each respective parish making a total of 175 respondents altogether.

For the Focus Group Discussion, seven groups of respondents were purposively selected from each of the seven parishes forming seven discussion groups. The selection was purposive because it involved picking those members who have been active in VHT activities. At any one discussion eight members were met and in total seven FGDs were held with a total of 56 respondents. Also selected for the FGDs were some of the sub county leaders.

There were altogether seven FGDs selected and they were categorized into two, 4 FGD groups composed of purposively selected members from each of the 4 sub counties (each composed of one LC111 chairperson or Sub County chief, LC1 chairperson, one health assistant, four members of the community, and one parish VHT coordinator) making 8 respondents per each FGDs.

The second category of 3 FGDs was selected from the remaining 3 sub counties and this was purely composed of 8 VHT members all purposively selected.

Selection of the respondents for the Key Informants (KIs).

Three key informants were purposively selected and they included the District Health Officer, the District Health Educator and the Assistant District Health Officer in charge maternal and child health. These were the officials who played a central role in the selection and training of the VHTs in the District, hence it was important to get their opinions and views about the VHT strategy.

Sources of data.

Both primary and secondary data was used for this study. The primary data sources included responses from the VHTs (quantitative data) which were derived from the structured questionnaires and also responses from the FGDs and the key informants (qualitative data).

Reports and records in the District Health Office provided another useful source of data (secondary data) which was used to augment the primary sources.

Internet sources and reports from other stakeholders like AMREF (African Medical Research Foundation) and PAG (Pentecostal Assemblies of God) provided useful data during the literature review

Study unit(s).

This study principally consists of three study units, namely the Village Health Teams, community members and local leaders who will be in the FGDs and the District health officials who will form the key informants

Table1. Specific objectives and corresponding variables and their indicators

Specific objectives	Independent Variables	Indicators
To examine the current motivational factors for the VHTs in the district	Motivation factors for the VHTs	Number of refresher trainings, number of support supervisions, number of meetings with supervisors Amount of allowances
To assess the current educational levels of VHTs in Soroti	Educational levels of VHTs in Soroti	Number of VHTs who can read and write in local language, number of VHTs who can read and write in English, number of VHTs in primary level, ordinary level, advanced level, tertiary level.
To assess the current levels of skills and knowledge among VHTs in Soroti	Levels of skills among VHTs in Soroti	Number of VHTs with sound knowledge of what they are expected to do.
To assess the level of supervision of VHTs by the District and sub county health officials.	Level of supervision	Number of supervisory visits by the district and sub county health officials to the VHTs.
To assess the level of training of VHTS	Level of training of VHTs	Number of days of training. Number of refresher trainings
	Dependent Variable	
To establish the level of performance of VHTs	Level of performance Frequency of home visiting. Frequency of community mobilization. Frequency of health education sessions. Frequency of data collection. Frequency of distribution of health commodities	Number of home visits Number of community mobilization meetings. Number of health education sessions. Number of data collection exercises. Number of times of distribution of health commodities

Data collection techniques /methods/tools

The researcher used both quantitative and qualitative methodologies for data collection in the field.

Quantitative methods.

The quantitative methods involved use of structured questionnaires highlighting key variables about the factors presumed to be influencing the work of VHTs. A questionnaire was designed in English and the research assistants translated it in the local language in case the respondent did not know English. It included the following sections; socio-demographic information, motivational factors for VHTs, level of knowledge and skills of VHTs to carry out their roles and responsibilities effectively, education levels of VHTs, Level of training of VHTs, level of supervision by the District and sub county health officials.

Questions that targeted performance assessment were distributed and integrated in the various parts of the questionnaire. Each of the 175 respondents gave responses to the questions in the different sections of the questionnaire.

Qualitative methods.

Under qualitative methods, Focus Group Discussions (FGDs), key informants interviews (KI) and review of documents were applied.

The Focus Group Discussions were used to gather data relating to the feelings, experiences, opinions and views of the people who are involved in VHT strategy. Under the guidance of the researcher, selected participants of eight members were stimulated to discuss their opinions, reactions, and feelings about the situation of VHTs by use of questions in the FGDs guide. The local councilors of the area helped in the mobilization of the respondents.

The discussions focused on participation of VHTs in the health care programs, satisfaction with the work of VHTs and functionality of VHTs among other issues.

Key informant interviews

Direct interviews were held with selected District Health officials who were involved in the VHT formation and training. Three key informants interviewed were the District Health officer, District Health Educator (DHE) and the Assistant District Health Officer (ADHO) in charge maternal and child health. An interview guide was used to generate responses from the informants.

Review of Reports and relevant documents.

Whereas the above research methods required responses from the respondents, in this case reports and relevant documentation from the district health office were reviewed to provide additional information to the findings from the other methods. Among the important documents reviewed were; work plans and reports by VHTs, minutes of meetings conducted with VHTs, reports about training of VHTs and reports about supervisory visits by the district health officials.

Plan for Data analysis/ techniques and presentations.

After collection of data, quantitative data generated through questionnaires was checked for completeness, accuracy and consistency immediately it was collected. Data and information collected using questionnaire responses from the numerous respondents were statistically analyzed. The questionnaire based data was entered in SPSS statistical package and analyzed using the same package.

Data was entered into prepared computer sheets using the SPSS statistical package.

This information was then summarized into tables for ease of analysis and interpretation.

Qualitative data was analyzed using a matrix format whereby responses were ranked according to categories and then summaries written out.

The researcher interpreted the data in view of objectives of the study.

A summary of the results was then used to formulate conclusions and recommendations.

A draft report for the study was then produced and presented to the university supervisor for comments after which the final report was produced.

Data quality control techniques (validity and reliability of the instruments)

All the instruments used for the study were discussed and agreed with the supervisor before actual data collection was conducted. This helped to check for the flow and completeness of the questions. The questions were thoroughly edited on an analysis basis to check for the completeness of the answers and were pre-tested in Soroti Sub County before the actual study began. The research assistants were trained on the data collection tools and given the necessary ethical guidelines regarding the research. The research assistants were cautioned against filling the questionnaires under trees or failing to visit the villages selected and avoidance of personal bias as much as possible. The third year students of Soroti Comprehensive Nursing were picked as research assistants. The choice of nursing students was purposeful since they have the knowledge about VHTs. They can therefore understand quickly and correctly and ensure the correctness and reliability of data collected. The supervisor ensured that the data was correctly collected by crosschecking on sample questionnaire and validating information collected.

Pre-testing questionnaire.

10 % of the sample size which is about 17 respondents were used for Pre testing the questionnaire in Amen parish, Soroti Sub County and the results showed 94 % validity. This represented a good level of accuracy of the findings of the study. This means that out of the 17 questionnaires pre -tested 16 of them were answered correctly as expected. The researcher further reviewed the questionnaires to ensure completeness and accuracy before the final data collection.

Data and results management.

Data collection Tools

Data was collected using 3 different data collection tools namely

Focus Group Discussion guide, interviewer administered structured questionnaire and the key informant interview guide.

Data management.

The questionnaire were structured and interviewer administered and each had questions covering specific variables like socio-demographic data, motivational factors ,educational levels, skills and knowledge, supervision and level of training. Every questionnaire was checked for completeness, data consistency and accuracy at end of each day. The supervisor would make an impromptu visit and check on the research assistants in the field to ensure that data was being collected as per the plan. In this study the response rate was 100%, this could be due to the fact that the respondents were anxious to reveal the challenges they face in their work and also the fact that the research assistants used were more knowledgeable.

Data Analysis.

Data from the questionnaires were entered on the prepared data sheet in the SPSS computer data analysis application. Later frequency tables were developed, this formed the basis of the analysis. Qualitative Data from the key informants and FGDs guides were analyzed by recording on a paper and summarized according to particular themes or categories.

Ethical considerations:

Some of the most critical ethical issues considered during the study included:

All data/ information collected from the respondents was treated with confidentiality and only used for academic work as well as institutional improvements

The investigator first sought for prior consent of the authorities concerned and the participants of the study before the research was conducted.

Limitations of the study.

The major limitation to this study is that the finding of the study cannot be generalized to apply to other areas outside Soroti District. This is because this is simple sample taken from Soroti district only.

Anticipated challenges and how they were overcome

During the design stage of the study some challenges were anticipated. These included the problems that were likely to be encountered during the actual study; they could not be resolved at the design stage of study.

Getting the co-operation of the respondents was one expected challenge to the study, however, the existing local council structures were used for mobilization of the participants of the study and the district health officials provided the researcher with introductory letters to the area of

study and to the participants of the study. Prior informed consent of the respondents was also sought before the questionnaire was administered.

Getting access to the research site was also another anticipated challenge. To overcome this, the researcher made a familiarization pre-visit to the area to acquaint him with leadership and held discussions with them about the benefits of the study to the community.

The incompleteness of the questionnaire was also an anticipated challenge to the study, the researcher overcame this by having prior discussions with the supervisor, and also carried out pre-testing of the questionnaires so that they are complete and will gather all the important issues about the study with ease.

A financial constraint was another anticipated challenge during the study. The researcher made the sample size of the study that was proportionate enough for the available resources to complete the study.

CHAPTER FOUR

PRESENTATION OF FINDINGS.

This chapter of the report is presenting the findings of the study looking at both the independent and dependent variables that were investigated and the frequencies and percentages. The findings have been presented in table formats as below. Tables 2-7 present Univariate analysis of the findings, Tables 8-10 presents bivariate analysis while Table 11 presents a multivariate analysis. After the tables descriptive notes have been provided highlighting the characteristics of the various variables being investigated. After presentation of all tables detailed interpretation of the findings is presented.

Presentation of Findings Of The Various Variables / Parameters That Were Investigated.

Table 2. Socio- Demographic factors

	VARIABLE	FREQUENCY	PERCENTAGE
	SOCIO-DEMOGRAPHIC FACTORS		
1.	Ages of respondents (VHTs) in years		
	20-30	36	20.6
	31-40	104	59.4
	41-50	27	15.4
	Total	175	100.0
2.	Years of work as VHT member.		
	1-3	18	10.3
	4-6	22	12.6
	7-9	135	77.1
	Total	175	100.0
3.	Marital status of VHTs		
	Married / cohabiting	150	85.7
	Single	22	12.6
	Divorced	3	1.7
	Total	175	100.0
4	Level of education of VHTs		
	None	5	2.9
	Primary	32	18.3
	Secondary	116	66.3
	A level	16	9.1
	Tertiary	6	3.4
	Total	175	100.0

Source : Primary Data

From the table 2 above the majority of the respondents (59.4 %) were between 31-40 years of age. The majority of them (77.1 %) worked for the longest period of 7-9 years, while the majority of the respondents (85.7 %) were married / cohabiting. On the level of education the majority of them (66.3 %) had secondary education and at least (97.1 %) of all the VHTs interviewed had at least some basic education.

From these findings we can conclude that most of the VHTs had long working experience, the high proportion of married VHTs is a good promoter of stability in tenure of the VHTs and a bigger proportion of them had had some basic education. All these attributes are good for the better performance of VHTs.

Table 3. Motivational factors

	VARIABLE	FREQUENCY	PERCENTAGE
5	Whether VHTs received incentives or not		
	Yes	172	98.3
	No	3	1.7
	Total	175	100.0
6	Type of incentives received by the VHTs		
	Money	169	96.6
	Bicycle	4	2.3
	Protective wear	2	1.1
	Total	175	100.0
7	Frequency of receiving money by VHTS		
	Monthly	8	4.6
	Once in Six months	153	87.4
	Once in a year	14	8.0
	Total	175	100.0
8.	Amount of money received by VHTs within 6 months (Ug.shs)		
	1000-3000	135	77.1
	4000-6000	39	22.3
	7000-9000	1	0.6
	Total	175	100.0
9	Source of incentive (money) received by VHTs		
	Government/MOH	10	5.7
	NGO	157	89.7
	Government/District	8	4.6
	Total	175	100.0
10	Level of satisfaction about money received		
	Strongly disagree	151	86.3
	Disagree	23	13.1
	Strongly agree	1	0.6
	Total	175	100.0
11.	Availability of transport for VHTs		
	Bicycle	41	23.3
	None at all	129	73.7
	Motor cycle	5	2.9
	Total	175	100.0

Source: Primary Data

The findings of the univariate analysis as seen the Table 3 above reveal that 98.3 % of the respondents reported receiving incentives of money at least once in a period of six months as reported by 87.4 % of the respondents. Also the findings of the investigation still on motivation reveal that 23.4 % of the respondents reported that they received bicycles and others 1.1% received protective wear as incentives.96% of the respondents reported that the commonest incentive they received was money which was received in six months interval as reported by the majority of the respondents(87.4 %.) On the amount received majority of respondents 77.1% said they received between Ug.Shs.1000-3000. The majority of the respondents (89.7 %) reported that NGOs was the most common source of this money. On the level of satisfaction, the majority of respondents 86.3% were strongly dissatisfied with the amount of incentives (money) given. On transport availability a majority of respondents73.7 % had no means of transport while only 23.3 % had bicycles.

Though these incentives were by far very meager and irregular they are able to influence some level of performance among the VHTs as proved in bivariate analysis of motivation versus performance. However, the level of performance could have been proportionate if the incentives were adequate enough to motivate VHTs in their work.

Table 4. Level of knowledge of VHTs

	VARIABLE	FREQUENCY	PERCENTAGE
12	Level of knowledge about home visiting		
	Strongly disagree	1	0.6
	Disagree	1	0.6
	Neutral	9	5.1
	Agree	4	2.3
	Strongly agree	160	91.4
	Total	175	100.0
13	Level of knowledge about health education		
	Strongly disagree	2	1.1
	Neutral	5	2.9
	Agree	11	6.3
	Strongly agree	157	89.7
	Total	175	100.0
14	Level of knowledge of VHTs about following up of cases		
	Strongly disagree	5	2.9
	Neutral	3	1.7
	Agree	35	20
	Strongly agree	132	75.4
	Total	175	100.0
15	Level of knowledge of VHTS about data collection		
	Strongly disagree	3	1.7
	Disagree	1	0.6
	Neutral	3	1.7
	Agree	20	11.4
	Strongly agree	148	84.6
	Total	175	100.0
16	Level of knowledge of VHTs about distribution of health commodities		
	Strongly disagree	1	0.6
	Disagree	4	2.3
	Neutral	2	1.1
	Agree	16	9.1
	Strongly agree	152	86.9
	Total	175	100.0

Source: Primary Data

The findings of the study as per the table 4 above reveal that the level of knowledge of VHTs about home visiting was found to be 91.4 %.The level of knowledge of VHTs about health

education was 89.4% while the knowledge about follow up of cases/patients was 75%. On data collection it was found out that the VHTs knowledge was 84.6% while the knowledge about distribution of health commodities was 86.9%. Looking at all the measurements for we can draw conclusions from these findings that the level of knowledge of VHTs about the key roles was generally found to be quite high, almost 80% of the VHTs knew their roles and responsibilities and this is good for their work of health promotion, however because of some reasons the performance of VHTs is not good.

Table 5. Level of supervision.

	VARIABLE	FREQUENCY	PERCENTAGE
17.	Level of supervision of VHTs by district health officials		
	Strongly disagree	108	61.7
	Disagree	34	19.4
	Agree	22	12.6
	Strongly agree	11	6.3
	Total	175	100.0
18.	Level of supervision by sub county health officials		
	Disagree	5	2.9
	Neutral	2	1.1
	Agree	117	66.9
	Strongly agree	51	29.1
	Total	175	100.0
19.	Maximum average time spent on supervision of VHTs		
	One hour	22	12.6
	Two hours	94	53.7
	Six hours	34	19.4
	Total	175	100.0
	One day	24	13.7

Source: Primary Data

The study findings from the table 5 above reveal that the majority of VHTs 61.7% reported that district health professionals do not supervise them, while the majority 66.9

% reported that the sub county health professionals supervised them but at quarterly intervals and the majority of VHTs 53.7% reported that both the district and sub county health officials spent on average 2 hours while supervising them.

From these findings we can conclude that the level of supervision by both district health and sub county health professionals is inadequate and because of this we can probably say it contributes to poor performance by VHTs.

Table 6. Level of training

	VARIABLE	FREQUENCY	PERCENTAGE
20..	Level of training		
	Had initial training	167	95.4
	Had no initial training	6	3.4
	Neutral	1	0.6
	Total	175	100.0
21	Duration of initial training		
	1 day	6	3.4
	2 days	21	12
	1 week	147	84.0
	2 weeks	1	0.6
	Total	175	100.0
22.	Level of refresher training		
	Yes	164	93.7
	No	10	5.7
	Neutral	1	0.6
	Total	175	100.0

Source: Primary data.

From the table 6 above 95.4% of the VHTs (the majority) reported that they had initial training, while the majority of VHTs 84% reported that the training lasted at least one week and the majority (93.7%) reported that they at least had refresher training.

From these findings we can say that the level of training of VHTs was generally satisfactory and without other inhibiting factors the performance of VHTs would be proportionately be good

Table 7. Level of performance

	VARIABLE	FREQUENCY	PERCENTAGE
	Level of performance		
23	Frequency of home visiting		
	Every day	1	0.6
	Weekly	8	4.5
	Monthly	21	12.0
	Quarterly	145	82.9
	Total	175	100
24	Frequency of carrying out health education		
	Once a week	21	12.0
	Monthly	5	2.9
	Quarterly	144	82.3
	Annually	5	2.9
	Total	175	100.0
25	Frequency of carrying out community mobilization		
	Weekly	19	11.0
	Monthly	24	14.0
	Quarterly	120	69.0
	Not all	12	6.0
	Total	175	100.0
26	Frequency of carrying out data collection		
	Monthly	69	39.4
	Quarterly	91	52.0
	Annually	8	4.6
	Not at all	7	4.0
	Total	175	100.0

Source: Primary Data.

According to the table 7 above the performance of VHTs has been measured by the frequency by which they carry out certain functions and roles that have been assigned to them.

The findings reveal that the majority of VHTs (82.9 %) reported that they carried out home visiting at least once in three months.

82.3 % of the respondents (the majority) reported that they carried out health education to the communities at least once in three months; while 69 % of the VHTs said they carried out community mobilization at least once in three months and 53 % said they carried out data collection at least once in three months. As per the MoH guidelines VHTs are expected to at least visit their areas regularly, at least once every month and perform other functions also on monthly basis. However these findings reveal that VHTs take three months before they visit their areas and perform other roles.

From these finding we can conclude that whereas there was an attempt by most VHTs to carry out these key functions, the interval of time of carrying them out was so wide and irregular and for this matter we can conclude that the level of performance of the VHTs was generally poor

Table 8- Bivariate analysis of Motivation and Performance of VHTs

Correlations

		MOTIVATION	PERFORMANCE
MOTIVATION	Pearson Correlation	1	.170*
	Sig. (2-tailed)		.025
	N	175	175
PERFORMANCE	Pearson Correlation	.170*	1
	Sig. (2-tailed)	.025	
	N	175	175

. Correlation is significant at the 0.05 level (2-tailed).(Source: Primary data)*

From the correlation table 8 above, there is positive relationship between motivation and performance at a 0.05 significance level.

The value of the correlation coefficient r is 0.170*.

The coefficient of determination which equals to $r^2 \times 100$,

Where $r = 0.170$, thus $r^2 = (0.170 \times 0.170) \times 100 \%$

$$= 2.89 \%$$

This implies that the performance of VHTs of 2.89 % is explained by motivation.

The remaining 97.11 % of the performance of VHTs is explained by other factors other than motivation.

Table 9- Bivariate analysis of knowledge/ skills and performance of VHTs

		KNOWLEDGE	PERFORMANCE
KNOWLEDGE	Pearson Correlation	1	.620**
	Sig. (2-tailed)		.000
	N	175	175
PERFORMANCE	Pearson Correlation	.620**	1
	Sig. (2-tailed)	.000	
	N	175	175

** . Correlation is significant at the 0.01 level (2-tailed). *(source: Primary Data)*

From the correlation Table 9 above, there is a significant relationship between knowledge/ skills and the performance of VHTs at 99% significance level (100-0.01) %.

The relationship has a correlation coefficient of 0.620**

The coefficient of determination which is equals to $r^2 \times 100$ %.

Where $r = 0.620$ as seen above

Thus $r^2 = (0.620 \times 0.620) \times 100$ %

$$= 0.38 \times 100 \%$$

$$= 38 \%$$

This implies that Knowledge and Skills of the VHTs explains up to 38 % of the performance of the VHTs.

The remaining (100 -38) % which is equal to 62 % of the VHTs performance is explained by other factors other than Knowledge and Skills.

Table 10 Bivariate analysis of level of training and performance

Correlations

		TRAINING	PERFORMANCE
TRAINING	Pearson Correlation	1	.124
	Sig. (2-tailed)		.102
	N	175	175
PERFORMANCE	Pearson Correlation	.124	1
	Sig. (2-tailed)	.102	
	N	175	175

(Source: Primary data)

From the Table 10 above it shows that there is positive relationship between training of the VHTs and performance.

The coefficient of determination which equals to $r^2 \times 100$, where r for this case is 0.124.

Thus $r^2 \times 100 \% = (0.124 \times 0.124) \times 100 \%$.

$$= 1.53 \%$$

This implies that the level of training of VHTs only explains up to 1.53 % of the performance of VHTs.

The remaining (100-1.53) % which is equal to 98.4 % of the VHTS performance is explained by other factors other than the level of training.

Table 11 Multivariate analysis of motivation, knowledge and skills, level of training and Performance

Correlations

		MOTIVATION	KNOWLEDGE/SKILLS.	TRAINING.	PERFORMANCE.
MOTIVATION	Pearson Correlation	1	.148	.131	.170*
	Sig. (2-tailed)		.051	.085	.025
	N	175	175	175	175
KNOWLEDGE/ SKILLS	Pearson Correlation	.148	1	.001	.620**
	Sig. (2-tailed)	.051		.987	.000
	N	175	175	175	175
TRAINING	Pearson Correlation	.131	.001	1	.124
	Sig. (2-tailed)	.085	.987		.102
	N	175	175	175	175
PERFORMANCE	Pearson Correlation	.170*	.620**	.124	1
	Sig. (2-tailed)	.025	.000	.102	
	N	175	175	175	175

*. Correlation is significant at the 0.05 level (2-tailed). (Source: Primary Data)

** . Correlation is significant at the 0.01 level (2-tailed).

Table 6 above relates all the three variables (motivation, knowledge and skills, and training) with performance.

The coefficient of determination for motivation and performance of VHTs is 2.89 %.

The coefficient of determination for knowledge, skills and performance of VHTs is 38%.

The coefficient of determination for level of training and performance of VHTs is 1.53 %.

Over all the coefficients of determination for **levels of training, skills and knowledge and motivation** Versus **performance** is equal to (1.53 % +38.0 % 2.89 %).

Which equals to 42.42% , approximately 42 %.

This implies that the factors that have been investigated in this study i.e. motivation, level of training and the levels of knowledge and skills have only explained up to 42 % of the performance of VHTs.

Therefore the remaining (100-42) % which is equal to 58 % of the VHTs performance is yet unknown.

I am suspecting the following areas that have not been investigated by this study could be able to explain or account for remaining proportion of the performance of VHTs. political involvement or interference could be one factor that be used to explain the performance of VHTs and community's attitudes and perceptions.

Interpretation of Findings.

Motivation.

The findings of the univariate analysis as seen from Table 3 reveal that 98.3% of the respondents reported receiving incentives of money at least once in a period of six months . Also the findings of the investigation on motivation reveal that 23.4% of the respondents reported that they received bicycles and others 1.1% received protective wear as incentives.

Though these incentives were infact very meager and irregular it is able to influence some level of performance among the VHTs as proved in bivariate analysis of motivation versus performance.

Also the findings of bivariate analysis for motivation in correlation with performance as seen in Table 3 above reveals that there is positive association between motivation and performance which was found to be up to 0.05 significance level .

Further the findings of the bivariate analysis of motivation versus performance as seen in Table 8 above indicate that the coefficient of determination is equal to $r^2 \times 100\%$, where r is equal to 0.170 as seen from the table 3 above.

Thus the coefficient of determination is $(0.170 \times 0.170) \times 100\%$ which is equal to 2.89 %.

This implies that 2.89 % of the performance of VHTs is influenced by motivation and the remaining 97.11 % of the performance of the VHTs is influenced or explained by other factors other than motivation

Looking at both the univariate and bivariate analyses, we can conclude that motivation has positive influence on performance of VHTs however, there are also other factors other than motivation and basing on this we can generally say that motivation is to some extent one the factors that influences performance of the VHTs in addition to other factors that this study cannot establish but recommends for another study.

Knowledge and Skills.

This study also carried out an investigation on knowledge and skills of the VHTs in order to find out the levels as these can have influence on performance.

The findings from the univariate analysis as seen from table 4, section for knowledge and skills show some of the key findings about knowledge and skills.

This part of the study investigated the knowledge of the VHTs on key roles and functions of the VHTs as prescribed by Ministry of Health Uganda guide lines for operation of VHTs to find out whether VHTs had knowledge about them and the following were the findings.

The study found out that 91.4 % of the VHTs had knowledge about home visiting and this was quite commendable.

89.7 % of the VHTs interviewed were found to be knowledgeable about health education, while 75.4 % of VHTs were found to be knowledgeable about follow up of cases. On data collection 84.6 % of VHTs were found to have knowledge and 86.9 % were knowledgeable about distribution of health commodities.

From this analysis it is evidently clear that the level of knowledge of the VHTs about the key important roles and responsibilities is quite high.

On finding out association between levels of knowledge/ skills and performance this study carried out a bivariate analysis.

The findings of the bivariate analysis indicate that the correlation between knowledge/ skills and performance is significant at the 0.01 level as seen in Table 9 above. This shows that there is a significant relationship between knowledge/skills and performance of VHTs at 99 % significance level (100-0.01) %.

The coefficient of determination here is equal to $r^2 \times 100\%$, where r is equal to 0.620 as seen from table 4 above.

$$\begin{aligned}\text{Thus } r^2 &= (0.620 \times 0.620) \times 100\% \\ &= 38\%.\end{aligned}$$

This means that knowledge and skills explains up to 38 % of the performance of the VHTs and the remaining 62 % is explained by other factors other than knowledge and skills.

In conclusion we can say that the findings of both the univariate and bivariate analysis of knowledge and skills indicate that knowledge and skills has a strong influence on performance.

We can also conclude that whereas the level of knowledge and skills is very high among VHTs as revealed by the univariate analysis there would be a proportionately a high level of performance among VHTs, however this is not true as seen from the bivariate analysis, whereby knowledge and skills explains only up to 38% performance of VHTs. This means that there other factors other than knowledge and skills that influence performance of the VHTs.

Basing on these findings we can conclude that whereas knowledge and skills has a significant influence on performance, there are also other factors which this study has not established that have influence on performance of VHTs.

Levels of Training.

Table 6 above, section for levels of training of VHTs shows findings of the univariate analysis of the levels of training of the VHTs. From this analysis 95.% of the respondents reported that they had initial training before being given assignments as VHTs.84% of the respondents reported that the training lasted one week. Also 93.7% of the respondents reported that they received refresher training.

From this analysis it is clear that most VHTs received an adequate level of training which conforms to the recommended one week training as per MOH guidelines. This finding is also supported by the documentary review which was carried out by the researcher. From the review of the reports on training of the VHTs both the content and the duration of the training was found satisfactory.

On a correlation of training and performance as seen in Table 10 above the study found that there was positive relationship between training and performance of the VHTs.

From the bivariate analysis, the study found out that the coefficient of determination given by $r^2 \times 100\%$ where r is equal to 0.124 as seen in table 10 above.

$$\begin{aligned} \text{Thus } r^2 \times 100\% &= (0.124 \times 0.124) \times 100\% \\ &= 1.53\% \end{aligned}$$

This means that the coefficient of determination of training and performance is only 1.53%.implying that though there is association between training and performance but only 1.53% of the performance of the VHTs is explained by the level of training and the remaining 98.47% is explained by other factors which this study cannot establish at the moment and therefore recommends another study of the related nature.

From these findings we can conclude that though the level of training of VHTs is satisfactory as was discussed above, there is a weaker association between training and performance of VHTs.

This implies that there are other factors that influence performance of VHTs that we cannot establish in this study.

Levels of Education.

This study carried out a Univariate analysis of the levels of education among the VHTs in the District and found out that 66.3% of the respondents had completed secondary education. 18.3% completed primary level of education, while 9.1% had reached advanced certificate of education and only 2.3% had no level of education as seen in the above table 2, section for level of education.

These findings indicate that at least 97.7 % of the VHTs interviewed had some level of education ranging from primary level to tertiary level which could enable them do their work with enhanced performance levels. These findings are in line with the MOH guidelines and therefore the district of Soroti is commended for this achievement of recruiting the right teams of VHTs in the District. Though this study did not attempt to show association between levels of education and performance of VHTs and basing on the findings above it can concluded that the education levels of VHTs in the District of Soroti are adequate enough to influence performance.

Levels of supervision by the District and sub county health officials.

Findings from the study as seen in table 5 reveal that 81.1% of the respondents reported that district officials never supervised them, while 18.9% of the respondents said they were supervised by the district. About sub county health officials supervising them, 96% of the respondents said they were supervised by the sub county health officials while 2.9 % said they did not and 1.1 % was non-committal.

On the amount of time spent by both the district and sub county health officials on supervision of VHTs 53.7 % said they spent 2 hours, 12.6 % said they spent 1 hour while 19.4 % said they took six hours and 13.7% said they took one day.

From the above findings it is observed that the district health professionals rarely carried out support supervision to the VHTs on a regular basis and whereas the sub county health officials did some support supervision to the VHTs the intervals of supervision were not frequent. It is also observed that the maximum time the district and sub county health officials spent on

supervision per day was commonly two hours only. This therefore means that VHTs don't receive adequate guidance and support which would enhance their performance.

In conclusion we can say that probably the low level of support supervision and mentoring has some contribution to the poor performance of VHTs in the district of Soroti.

This study also went ahead to analyze some issues related to VHTs work that may influence their performance as the following.

Duration of time as VHT.

On the investigation on the duration of time of work as VHT the study revealed that the majority of the VHTs had a long serving time falling within 7-9 years representing 77%. However, some of the VHTs worked for a period of three years representing 10% and others worked for of time between 4-6 years representing 12%. The Duration of time of work by VHTs has also implications that will be discussed later. (Refer to the Table 2 above).

Marital status.

Regarding marital status about VHTs these study findings revealed that most VHTs were married or cohabiting representing 85%. Those VHTs who reported being single were 22%. However, those VHTs who admitted having divorced were few representing 1%. (as per table 2 above)

Availability of transport for VHTs.

This study also investigated the availability of the means of transport for the VHTs as this would enhance their work and motivation to do work. The above table 3 shows that the majority of VHTs have no means of transport, represented by 73% of the respondents. Only 23% of the VHTs had bicycles which also lacked maintenance. 2% of the respondents reported that they relied on borrowing motorcycles of other health staff representing 2%. (Refer to table 3 above)

Analysis of Performance of the VHTs as per the findings.

Five variables were used to measure the performance of VHTs and the study was able to come up with the following findings as per table 7 above and below are the findings

Frequency of carrying out Home Visiting.

The study found out that 82.9% of the VHTs carried out home visiting at least once in three months, 12% of the VHTs interviewed carried out home visiting at least once in a month, while 4.5% carried out home visiting on a weekly basis. Only 0.6 % of the respondents said they did it on a daily basis.

Frequency of carrying out health education to the community members.

This study found out that 82.3% of the VHTs carried out health education to the community at least once in three months, 12 % did it at least once in a week ,while 2.9% carried out health education to the community once every month and 2.9 % did it once a year.

Frequency of carrying out community mobilization for health promotion.

This study found out that 69 % of the VHTs interviewed carried out community mobilization once in three months, while 14 % did it on a monthly basis and 11 % on a weekly basis .2 5 said they never did it in the last one year.

Frequency of data collection for Health.

Here the study found out that 52 % of the VHTs interviewed carried out data collection once in three months, 39.4 % did it on a monthly basis, and 4.6 % said they did it at least once in a year while 4 % said they have never done it.

Frequency of distribution of health commodities.

The study found out that 68% of the VHTs interviewed said the last time they did distribution was a year ago, 20% said they did it a month ago, while 8% said they did it three months ago and 2% said they did it a week ago.

Looking at these findings and specifically on the regularity of carrying out the important roles and responsibilities like home visiting, community mobilization, health education, data

collection and distribution of health commodities by the VHTs it is clearly seen that over 70% of the VHTs carried out these roles very irregularly i.e. once in three months period as seen from analysis of the results above. However the MOH requires that VHTs carry out these roles and responsibilities on a regular basis.

Basing on the above findings we can therefore conclude that the performance of VHTs in the district of Soroti falls short of the expected standard of performance as per MOH guidelines.

Findings of the multivariate analysis.

This study also carried out correlation of three key variables namely motivation, knowledge/skills, and level of training versus performance of VHTs. The analysis of the findings reveal the following:

The coefficient of determination for motivation and performance of VHTs is 2.89%.

The coefficient of determination for knowledge/skills and performance of VHTs is 38%

The coefficient of determination for the level of training and performance of VHTs is 1.53 %

Overall the coefficients of determination for levels of knowledge/skills, level of training and motivation versus performance of VHTs is $(38 + 1.53 + 2.89) \% = 42.42 \%$.

In conclusion the implication of the multivariate analysis is that 42.42 % of the VHTs performance is explained by the factors of motivation, level of training and knowledge and skills but there other factors besides these three that explain for the remaining 57.58 % of the performance of VHTs which this study recommends for another study. A further discussion of these findings and their implications is being presented in the following chapter 5 of the report.

CHAPTER FIVE.

DISCUSSION OF RESEARCH FINDINGS.

Introduction.

It is clear and apparent from the findings from the questionnaires, interviews and Focus Group Discussions in this study that the VHT strategy is faced with daunting challenges and obstacles which affect their day to day operations.

This chapter will discuss the key variables that have been investigated by this study in relation to the performance of VHTs in the district. Evidence from document reviews and previous researches will also be used to augment on the findings of the study.

Motivation.

In this study motivation was looked at mainly in terms of incentives and rewards like allowances given to the VHTs in appreciation for the work they do, means of transport to do the work like bicycles, tools and equipment to facilitate them to do work.

On the type of incentive received, the study found out that the VHTs could commonly access transport allowance during seminars and workshops. 96 % of the respondents admitted that they ever received a token of money as transport refund or after an activity. 2% said bicycles was another type of incentive while 1 % said protective wear was also another incentive given. From this particular finding it is clear that it was basically the small money which was given to the VHTs as an incentive.

On the frequency of getting incentive of money 87 % of the respondents said they got it rarely, at least once in six months.

About the source of this incentive, 89 % said they got it from mainly NGOs. About the amount of incentives 77 % of the respondents said they received between Ug.shs 1000-3000 each only during seminars and workshops and once in a while when there is a special programme.

About the level of satisfaction 86 % of the respondent strongly disagreed that this incentive was satisfactory, while 14 % disagreed that it was satisfactory.

One member of the FGD expressed his sentiments about the lack of motivation for the VHTs and the government's inability to recognize it as a critical problem affecting them.

“The government should stop deceiving us. Today there is Nothing for free, what can one buy with Ug.shs 3000 given to us after long period of work during a programme like Polio Eradication. Moreover we spend the whole day without a meal and when we go home our husbands expect us to account for the day's time by producing some money for food. For us we are willing to work but let government consider our problems as human beings who need to be motivated and facilitated”
(FGD, one member of VHT from Gweri sub county, Soroti)

From another FGD one local area Chairperson Lc111 made his personal views about motivation of VHTs.

“The work of VHTs is quite visible and is well appreciated by most community members. They have strong commitment. I want to emphasize that VHT members do a good job, they like their work; they mobilize and work hand in hand

*With lcs. I only want to implore the government to look into
Issues of their motivation and facilitation.”(FGD, area local
leader, Arapai, sub county, Soroti District).*

From the above findings it is vividly clear that motivation is one important factor that has demoralized the VHTs in Soroti District and their morale continues to sink and the consequences are that their performance has been compromised.

The findings of the bivariate analysis about motivation and performance indicate that there is a significant association between motivation and performance

A study on community health workers in Uganda with focus on VHTs strategy conducted in 2007 by Dr. D.K Sekimpi, Uganda National Association of Occupational Health (UNACOH)

advanced that motivation and recognition of VHT members could address some of the critical challenges faced by the VHTs and would enhance their performance. This study however did not attempt to establish any association between motivation and performance as done by the current study.

Another study by Nguyen Thu Huong showed that motivational support for VHTs from various sources like family, local leaders and health professionals enhanced the performance of VHTs.

These studies are in line with the findings of the VHT study in Soroti and help to illuminate the bare fact that motivation of VHTs influences performance and therefore should be taken as a very critical factor and would contribute to their improved performance and subsequently lead to improved health services delivery in the district.

Level of Knowledge and skills.

This study also investigated the existing level of knowledge and skills among VHTs to find out if this influences performance. The study investigated the existing level of knowledge of the VHTs on the key principle functions and roles they are expected to carry out on day to day basis by asking them whether these were their responsibilities. The respondents would answer on strength basis depending on the way they perceived these as their responsibilities and roles.

Further deeper analysis was made to find out whether they knew how to carry out these roles and how often they carried out these roles.

On finding their level of knowledge about home visiting, 91 % of the respondents strongly agreed that it was their responsibility and 2 % just agreed while 5% were not decided.

On how often they carried out home visiting 82 % said they did it on quarterly basis.

On finding out knowledge of what they normally assess during home visiting, the level of understanding was 67 % of the VHTs knew it thoroughly well and 22 % was good, while 6 % was fairly good and 2 % was fair.

On knowledge about home visiting 89% of the respondents strongly agreed that is their role, 6% just agreed, 2 % were not decided.

Investigation about the level of knowledge about health education, 89 % strongly agreed that it was their role, 6 % just agreed and 2 % were not decided

On what topics they often covered during health education, the level of knowledge was that 67 % was very good, 25 % was good and 2 % was fair.

On the level of knowledge about mobilization of mothers for antenatal the level of knowledge was 35 % was very good, 34 % was good, 28 % was fair and 1 % was poor.

On knowledge about data collection, 84 % strongly agreed that it was their responsibility, 11 % just agreed while 1 % was not decided.

On further investigation about the type of data they normally collect the knowledge level was 67 % was very good, 21 % was good, 8 % was fair and 2 % was poor.

Findings from the bivariate analysis indicate that there is a strong association between knowledge /skills and performance. The findings showed that 38 % of the performance of the VHTs is influenced by knowledge and skills

From these findings it is generally construed that VHTs knowledge about their roles is generally high and is above 80 %. However, variations in the level of how to carry out these roles exist. Knowledge about how to carry out home visiting, health education, and data collection was generally high among most VHTs almost 70 % level.

Several reasons can be used to explain these variations, and it ranges from the level of initial training, amount of time they take practicing these roles and also about refresher training and the amount of support supervision given to them.

The findings of the correlation analysis between knowledge /skills and performance in this study indicate that there is a strong relationship between knowledge/skills and performance and these findings is are in line with the findings of the studies carried out by Kumnerdmarn K, Rahman M and Soongkhang I. which indicated that knowledge of VHV had significant association with their performance. Another study by Nguyen Thu Huong, found a appositive correlation between knowledge and performance of VHV. This study showed that VHV with good knowledge have a tendency to result in good performances.

Looking at both the findings of this study and the findings of the previous researchers we can conclude that knowledge and skills has a significant influence on performance of VHTs and

should therefore be considered as a critical factor of performance for VHTs in the district of Soroti

Support supervision.

This study also aimed at establishing the level of support supervision by the district and sub county health officials to the VHTs.

On investigating the level of supervision by the District health officials, 61% of the respondents strongly disagreed that District health officials often supervised them, 19% simply disagreed, 12 % agreed and 6 % strongly agreed that they were supervised by the District officials.

On the frequency of supervision by the District health officials 68% said not all, 19% said once a year , 5 % said once in three months and 4 % said once a month.

On the level of supervision by sub county health officials, 66% of the respondents agreed that sub county health officials supervised them, 29% strongly agreed while 2% strongly disagreed.

On the frequency of supervision by the sub county officials 88 % said once in three months, 6% said monthly while 2% said once in two years.

On the time duration of supervision by both District and sub county officials,53% said they spend only 2 hours,19% said six hours 12% said one hour.

From these findings it becomes apparent that the level of support supervision to the VHTs is very inadequate. 61% of the respondents strongly disagreed that district officials supervised them while 19 % disagreed. Whereas the respondents agreed that 66 % of the sub county officials visited them it was also found that this was once in three months.

Moreover the duration of the supervision by both district and Sub County was generally 2 hours which is still a very short time for effective supervision and mentoring of staff.

A study by Rationan S. found out that most sources of emotional support and instrumental support to VHVs was from health officers during supervision. The study also found that the first priority of the support to VHVs was from health officers. It showed that the emotional support from health officers to VHVs had effects on the participation and performance of VHVs.

The findings of the current study are in line with the findings of the previous researchers and from these findings we can conclude that support supervision and mentoring influences performance of VHTs

Training.

This study also aimed at establishing the level of training that the VHTs received and subsequently use the findings to suggest if the level of training is a contributing factor to the poor performance. The study looked at both the initial training given to the VHTs before assignment of roles and responsibility and also the refresher trainings afterwards.

On the initial training 95% of the respondents said they received and 3% said they did not. It is possible this is a section of VHTs who were recruited later after others dropped off.

On the duration of initial training, 84% of the respondents said it was for one week, 12% said it was for two days while 3% said it was one day.

On refresher training, 93% said they had refresher training, while 5% said they did not. These findings generally indicate that VHTs in Soroti received adequate training.

On correlation of training and performance this study found out that there was positive association between training and performance of VHTs as seen in table 5 above (at 1.53 %)

These findings are in line with the findings of other researchers like a study by Tiewsuwan B. showed that the training experience in terms of monthly meetings was significantly associated

with VHVs performances. The proportion of satisfactory performances was higher among VHVs who had high monthly meetings as compared to those with moderate and low monthly meetings.

Another study by Uthonthavikam Na Ayuthaya S. showed that continuing knowledge provision from health officers had an effect on VHVs practice at a satisfactory level.

From the findings of this current study and the findings of other researches we can conclude that training has a significant influence on the performance of VHTs in Soroti District.

We also conclude from these findings that while the level of training for the VHTs in Soroti District is generally satisfactory but because of other factors that this study has not established the performance has remained poor.

Level of education

This study also investigated the level of education of VHTs so as to suggest whether this was contributing to the level of poor performance or not

The study found out that 66% of the VHTs were of Ordinary level of education, 9% of Advanced level, while 3% got tertiary education .There was a small proportion of 2% who admitted having no education.

The literacy level was found to be high, 96% could read and write in local languages while 98% could read and write in English.

A study conducted by Surendra Kumarshetha showed that there was significant association between education and job satisfaction and recommended that educational background should be considered in selecting the Village Health Volunteers.

Another study conducted by KhinMyyitzu Han also showed that there was significant association between education and performances of the VHV.

Generally the findings of the current study are in line with the previous studies quoted above and we can conclude that the level of education has positive influence on the performance of VHTs in the district of Soroti

Duration of work as a VHT.

This study found out that 77% of the VHTs interviewed had the longest period of time working as VHTs, ranging from 7-9 years. This formed the majority of the VHTs in the system. 12% of the VHTs had worked for a period of time ranging from 4-6 years and while 10% of the VHTs had worked for a period of time between 1-3 years representing the minority. Longer duration of time in work is usually attributable to acquisition of wider and relevant knowledge, skills and experience which is essential for better performance in work.

These study findings are in line with a study carried out by Rationans . This study found out that many Village Health Volunteers 66% served as VHV for half a year to six years and spending 0.5 hours to 3 hours per day for VHV work. This study concluded that there was a positive effect of longer duration of work to the performance of work among VHTs.

In one Focus Group Discussion one elderly woman shared her experience with the rest of the members about the impact of long service as a VHT.

“Previously we had our Village Birth Attendant who is also our VHT, she used to tell us that mothers delivering for the first time were not handled at their level, Only at the health facility, but for some time our VHT has worked for many years and can now handle every case. Now our village doctor can even deliver better than those doctors and midwives in the Hospital

*(FGD one community elderly woman from Oculoi village
Katine sub county, Soroti District.”*

From the findings of this study, those of the previous researchers and the observations made in the FGDs we can conclude that duration of work as VHTs has some influence on the performance of the VHTs. The implication is that for effective performance of VHTs sustainability of tenure is very important and need to be embraced to by the District.

Relevancy and appropriateness of the VHT strategy.

The approach of using VHTs in the improvement of health care at the grass root population especially was generally hailed as good initiative by almost all the Key Informants and Focus Group participants. Respondents of FGD were almost unanimous in their appreciation of the approach and highly commended government for this initiative.

Challenges faced.

However despite the high level of appreciation expressed by the participants of the FGDs about VHTs, they generally raised the issue of motivation as the major challenge affecting the effectiveness of VHTs in their work. This further elaborates the findings from the questionnaire about motivation of VHTs as discussed above.

From the key informants a challenge of inadequate staffing, lack of funding and lack of clarity of roles especially among sub county health personnel in the process of support supervision was raised as a big challenge. They also raised the issue of intermittent supplies of the necessary equipments and lack of logistics like bicycles as a serious problem affecting the work of VHTs.

Perceptions and attitudes of the Community about VHTs.

Most members of the community expressed appreciation about VHTs and generally for the work they do. The positive expressions and testimonies from some community members quoted above are clear evidence about this. However they observed that the vigor that the VHTs initially had was gradually fading and they too attributed this to lack of motivation among other factors.

Satisfaction with the work of VHTs.

Despite the problems the VHTs face both community members and the local leaders expressed satisfaction about their work.

However there were also some members who held some reservations about the level of professionalism of the VHTs, some of which i think are related to lack of adequate sensitization and others are merely misconceptions. All are important to report because they have implications about the acceptability of the VHT approach.

Expectations of the VHTs.

The VHTs unanimously expressed strong views and feelings about motivation. However, they too admitted that their performance was declining but attributed this to low morale due to lack of incentives.

They recognized the fact that VHT concept is voluntary in nature; however they expressed willingness to work if government could give incentive benefits such as regularly rewarding them with certificates of recognition, paying reasonable allowances for special health programmes, meetings, workshops, and providing them with free treatment .They also expressed the views that the government should keep to the promises made, unlike a situation where by they are asked to visit households to make lists for distribution of Insecticide Treated Nets (ITNS) or any other health commodity and finally government fails to provide them. Because of

this communities have often developed mistrust about VHTs and some even have intimidated VHTs while doing their work. The issue of deliverables has not been provided to the VHTs for a long time, this sometimes makes them think that they are no longer relevant and it weakens their position in the communities they serve.

On the Non-Governmental Organizations (NGOs) VHTs generally expressed a deeper appreciation for the support and facilitation they have extended to them in terms of transport allowances and some bicycles. However they expressed fears of lack of sustainability of this support because the timeframe of most NGOs is short. They therefore urged government to take full responsibility of supporting VHTs on a sustainable manner.

Generally the views and feelings that have been expressed here by the VHTs are in line with the findings of the questionnaire and are all pointing out the most important factor about motivation of VHTs

CHAPTER SIX.

CONCLUSIONS AND RECOMMENDATIONS.

This chapter presents conclusions drawn from the findings of this study, and it combines both quantitative as well as qualitative findings and gives recommendations that may be used to improve on the performance of VHTs and generally to improve on service delivery at the grass root through a strengthened VHT system.

Since this was a simple cross sectional survey with a simple sample carried out within Soroti District most of the findings of this study can be applied majorly within the district of Soroti and may not be generalized and used outside Soroti District

Conclusions.

In this study, most of the VHTs fall within the age range of 31-40 years (59 %) presumed to be the most stable , active and committed group. This is commendable for the District for investing resources and time in selecting and training the most resourceful team. In this situation the district can exploit this opportunity by adequately facilitating and motivating them to harness their full potential in doing work. Also the study findings revealed that 85 % of the VHTs were married this still provides great opportunity to district because marital status enhance stability of tenure and reduces on attrition for example due to social issues related to lack of marriage. Duration in work by the VHTs was another aspect that the study investigated. The findings showed that 77 % of the VHTs had a long serving period of time ranging from 7-9 years. This was very good because it enabled acquisition of the necessary knowledge, skills and experience thus enhancing their competence and confidence at work and consequently improving on their performance.

From these findings it can therefore be concluded that age, marital status, and duration of work are currently not threat factors to the performance of VHTs in the District.

From the analysis of the questionnaire findings and the information obtained from the FGDs and key informants interviews motivation of the VHTs was generally found to be very inadequate. Whereas 96 % of the respondents for the questionnaire admitted getting a mere token of money ranging from Ug.shs 1000-3000 as allowance commonly referred as transport refund, the general outcry was that this was very little. Besides this little incentive was commonly from NGOs and not government which put the VHT system in place and therefore its sustainability is highly questionable due to the fact that NGOs time frame is limited. 86% of the respondents were therefore strongly dissatisfied with this available incentives and generally the motivation.

Basing on the findings of this study it can therefore be concluded that the factor of motivation for the VHTs in Soroti is critically very poor and can be taken as having a very high degree of influence on the performance of VHTs in the District.

From the analysis of the findings in the questionnaire tool in this study, it was generally observed that knowledge level among VHTs was very much above average. This can be reflected from the findings that above 80% of the VHTs interviewed clearly knew their roles and functions. This was very commendable. However there were variations in regard to the technicalities of performing these roles. The study found out that 60% and above of the VHTs were found competent enough to demonstrate technically how to perform these roles effectively. For example 67% of the VHT knew the various types of health data they normally collect and also 67 % knew the key important issues that are covered during home visiting.

Basing on these findings it can be concluded that the VHTs in Soroti have fairly good level of knowledge to effectively perform their roles and this may not have serious implications on their

performance. However the few inadequacies noted can be addressed by provision of regular support supervision and mentoring, refresher trainings and continuous engagement of the VHTs in doing their work.

This study also investigated the level of education and training of VHTs.

On the level of education of the VHTs the study findings reveal that generally educational levels of the VHTs in Soroti fit within the minimum standards set by the Ministry of Health for selection and training of VHTs. The guidelines stipulate that a VHT member should at least have some level of education and be able to read and write in the local language. The findings from the study reveal that 66% of the VHTs are of ordinary level of education, 9% are of advanced level of education and 18 % are of primary level of education while 3 % have attained tertiary level of education, these included primary teachers among others. The study also found out that 96 % of the VHTs could read and write in the local languages of Ateso and Kumam, while 98 % of the VHTs could read and write in English. On training of VHTs the study found out the training of VHTs was satisfactorily done, 95 % of the VHTs interviewed reported having initial training and 84 % said the training lasted a week (five) days. Besides initial training, 93 % of the VHTs interviewed reported having received refresher training

On the basis of these findings it can be concluded that generally the VHTs of Soroti received quality training and this is considered a good potential for them to carry out their work.

The level of supervision by the District and sub county health personnel to the VHTs was another important aspect this study investigated. From the findings generated mainly by the questionnaire tool it is generally observed that the level of support supervision and mentoring by both District and sub county health officials to the VHTs was critically inadequate. According to the findings of the study, 80 % of the VHTs generally said the District health officials did not

provide support supervision to them and even those 12% who said they were supervised by the District officials reported that they came at least once a year and spend on average one hour. About support supervision by the sub county health officials, 66% of the respondents reported that the sub county health officials supervised them at least once in three months period and they too generally spend about hours.

Basing on these findings it can be concluded that the level of supervision by both district and sub county health officials is critically very low and because of this we can suggest that lack adequate and effective support supervision is also one of the reasons why the VHTs in Soroti are not performing to the expected standard despite the good level of training they were given initially.

From the broad and general analysis of all the findings of this study in both the quantitative and qualitative data, there are majorly two distinct and very apparent critical problems that the VHTs in Soroti are faced with and can heavily impact on the performance of the VHTs in the District. Lack of motivation and the inadequate level of support supervision and mentoring have been identified by the study as the two critical issues and generally it can be concluded that these two factors are directly contributing to the poor performance in work among VHTs in the District of Soroti.

Recommendations.

1. Though the issue of motivation of VHTs through payment of monthly salary is generally dismissed on the grounds that VHTs are voluntary community workers, this issue should be looked at critically for the future of the strategy. A mechanism needs to be developed through which the District local and peripheral local governments such as sub counties and village local councils commit resources to meet the basic requirements and to facilitate the work of VHTs.
2. The types of incentives needed by VHTs are majorly greater recognition and tools for their trade rather than salary. A systematic programme that should be coordinated by the Ministry of Health is needed to remind all actors how they can demonstrate appreciation to the VHTs and the work they do.
3. Materials that are necessary for the VHTs to do their work effectively without being compromised by the communities, like VHT record books, VHT monthly reporting form books and the required health commodities that the communities need should be provided on regular and sustainable basis. This will minimize mistrust about VHTs and also enhances their confidence.
4. The District should strengthen the support supervision and mentoring system for VHTs be able to detect early those VHTs who drop out and put in place a mechanism of continuous replacement, training and support for new entrants.
5. The system of VHT is a more appropriate way than single function volunteers who have often been promoted by NGOs to provide specific health care services to communities with multiple health problems. It would be more cost effective for all partners in the health sector and government to pool resources that could be used to support and build the capacities of VHTs to

provide varied health care services other than creating parallel single action community structures which are not sustained after the departure of the partners.

6. As the VHTs system goes to scale it is critical not to allow short cuts in the process of training them. Standardized training programmes and guidelines should be maintained and used for the development of a strong VHTs system. Regular refresher courses and quarterly support supervision meetings for VHTs are essential and need to be adhered to as provided by the Ministry of Health.

7. Capacity for supervision of VHTs by District and sub county health professionals need to be built at district and lower levels. This will address the weaknesses identified by the study. Supervision may be poor for several reasons including inadequate training of supervisors, inadequate staffing, or ambiguity on roles, such issues need to be identified and addressed appropriately.

8. Integrated quarterly meetings of supervisors of VHTs should be held at District and Health sub District to improve on supervisors' performance.

While the above recommendations can best be addressed by Soroti District, specific recommendations need to be addressed by the central government and include the following:

9. The central government should spearhead advocacy for the VHT system through various channels and in the process enlist the support of partners to support VHT system.

10. Facilitate and provide funding for VHT system, facilitate their work, provide means of transport and support regular retraining of VHTs.

11. Central government should also play a key role in revising policies that govern the operations of VHTs.

12. At community level central government should facilitate mass sensitization of communities on the roles and functions of VHTs and enlist their support for VHT work.

13. Lower level health staff like Health Assistants, health unit in charges, local councils 1 and 2 need to be re- orientated and empowered to support their partners in health promotion the VHTs.

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APPENDICES.

Appendix 1.data collection instruments

Basically three tools/instruments will be needed to collect data namely:

The questionnaire will be used to collect data from the sampled VHTs respondents.

The focus group discussion guide will be used to collect qualitative data basically selected focus groups (basically the VHTs and the Sub county local officials)

The key informants guide will also be used to collect qualitative data from the purposively selected key informant (District Health Officials).

However, a review of the records and reports in the Health Department about VHTs will also be done to augment on the information obtained from other tools.

Questionnaire for village health teams interview

Date/ day/month/ year.....

The questionnaire serial number.....

Village.....Parish..... Sub
county..... District.....

Name and signature of the interviewer.....

Introduction

Hello, my name is.....and I am a student of/ research assistant on behalf of International Health Sciences University (IHSU). I am conducting a study on Village Health Teams of Soroti district. The information obtained will be used by the district for planning purposes.

Instructions on how to use the questionnaire

This questionnaire is designed to be filled by the researcher/research assistant.

Confidentiality

This questionnaire will be strictly confidential; it is to be administered to all the sampled VHT members. Their responses should be anonymous; that is, respondents must not be required to write down their names on the questionnaire or provide any kind of identifying information.

Consent

I am going to ask you some personal questions about your work as a VHT member in the sub-county. Please feel as free as possible.

Your answers are completely confidential; I will not ask your name and will not record it anywhere. I will not tell anyone about your answers to the questionnaires.

However, your honest answers to these questions will help the district to better plan and carry out better health services delivery.

I will appreciate your taking part in this study; it will take about 30mins to fill out this questionnaire.

At this time do you want to ask me anything about this study?

May I begin the interview now?

SECTION A: SOCIAL DEMOGRAPHIC INFORMATION

No.	Questions and filters	Coding categories
A1.	Sex of respondent <input type="text"/> <input type="text"/>	Male 1. Female 2.
A2.	How old are you <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	20 – 30 Years 1. 31 – 40 Years 2. 41 – 50 Years 3. 50 Years above 4.
A3.	How long have you been working as a VHT member? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1 – 3 Years 1. 4 – 6 Years 2. 7 – 9 Years 3. 9 Years above 4.
A4.	What is your current marital status? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Married /cohabiting 1. Single 2. Divorced 3. Separated 4.

SECTION B. MOTIVATIONAL FACTORS FOR VHTS

The next questions asks you about the existing motivations/incentives for work for VHTS

No.	Questions and filters	Coding categories
B5.	Are you given any incentives? <input type="text"/> <input type="text"/>	Yes 1. No 2.
B6.	What is the kind of incentives have you received? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Money 1. Bicycle 2. Protective wear/ T-shirts 3. Further trainings 4. 5.
B7.	How often do you receive incentives? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Monthly 1. Once in 6 months 2. Once in a year 3. Once in 2 years 4. 5.
B8.	What was the source of incentives? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Government (MOH) 1. NGO 2. Government (district) 3. Government (Sub-county)
B9.	How much money are you receiving per month? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	SH 1000 – 3000 1. SH 4000 – 6000 2. SH 7000 – 9000 3. SH 9000 Above 4.
B10.	The amount of incentives given is satisfactory <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Strongly disagree 1. Disagree 2. Neutral 3. Agree 4. Strongly agree 5.
B11.	If not, what do you propose to be satisfactory? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	SH 20,000 – 50,000 1. SH 51,000 – 80,000 2. SH 81,000 – 110,000 3. SH 110,000 Above 4.
B12.	How often do you want to be privatized? <input type="text"/> <input type="text"/> <input type="text"/>	Monthly 1. Once in 6 months 2. Once in a year 3. Once in 2 years 4.
B13.	What means of transport do you have for carrying out work? <input type="text"/> <input type="text"/> <input type="text"/>	Bicycle 1. Motorcycle 2. None at all 3.

SECTION C. LEVELS OF KNOWLEDGE AND SKILLS TO CARRYOUT EFFECTIVELY THE ROLES AND DUTIES

The next set of questions asks you the level of knowledge and skills that enables you to effectively carry out your expected duties and roles.

No.	Questions and filters	Coding category
C14.	Home visiting is important in improvement of hygiene sanitation in households.	<input type="checkbox"/> Strongly disagree 1. <input type="checkbox"/> disagree 2. <input type="checkbox"/> Neutral 3. <input type="checkbox"/> Agree 4. <input type="checkbox"/> Strongly agree 5.
C15.	If yes how often do you carry home visiting in your area	<input type="checkbox"/> Every day 1. <input type="checkbox"/> Weekly 2. <input type="checkbox"/> Monthly 3. <input type="checkbox"/> Every 3 months 4.
C16.	What do you commonly assist during home visiting?	<input type="checkbox"/> Sanitation + Hygiene 1. <input type="checkbox"/> Sanitation + Hygiene + Nutrition 2. <input type="checkbox"/> Sanitation + Hygiene + Nutrition + Malaria control (ITNs) 3. <input type="checkbox"/> Sanitation + Hygiene + Nutrition + Malaria control (ITNs) + Immunisation 4.
C17.	When was the last time carried out home visiting in your area	<input type="checkbox"/> 10 days ago 1. <input type="checkbox"/> 1 week ago 2. <input type="checkbox"/> 1 month ago 3. <input type="checkbox"/> 3 months ago 4.
C18.	Health education is one of important roles you are supposed to carry out?	<input type="checkbox"/> Strongly disagree 1. <input type="checkbox"/> disagree 2. <input type="checkbox"/> Neutral 3. <input type="checkbox"/> Agree 4. <input type="checkbox"/> Strongly agree 5.
C19.	If yes, What topics do you often discuss?	<input type="checkbox"/> Sanitation + Hygiene 1. <input type="checkbox"/> Sanitation + Hygiene + HIV Prevention 2. <input type="checkbox"/> Sanitation + Hygiene + HIV Prevention + Malaria control 3. <input type="checkbox"/> Sanitation + Hygiene + HIV Prevention + Malaria control + family planning 4.
C20.	How often do you carry out health education?	<input type="checkbox"/> Once a week 1. <input type="checkbox"/> Monthly 2.

		Once in three months	3.
		Quarterly	4.
C21.	How often do you carry out mobilization of mothers to attend antenatal clinics?	Weekly	1.
		Monthly	2.
		Once in three months	3.
		Never done it	4.
C22.	Following up people who have been discharged from health facility is also your responsibility	Strongly disagree	1.
		Disagree	2.
		Neutral	3.
		Agree	4.
		Strongly agree	5.
C23.	How many of such cases have you followed up in the last 3 months?	5 Years	1.
		10 Years	2.
		15 Years	3.
		Years above	4.
C24.	Data collection about health matters in your community is another important role?	Strongly Disagree	1.
		Disagree	2.
		Neutral	3.
		Agree	4.
		Strongly agree	5.
C25.	What was the type of data collected?	Sanitation Data	1.
		Sanitation, pregnant mothers	2.
		Sanitation, pregnant mothers, children under five years	3.
		Sanitation, pregnant mothers, children under five years, HIV positive people	4.
C26.	How often do you collect data?	Monthly	1.
		Quarterly	2.
		Annually	3.
		Not at all	4.
C27.	Distribution of condoms, malarials is another important role you carry out to prevent disease?	Strongly disagree	1.
		Disagree	2.
		Neutral	3.
		Agree	4.
		Strongly agree	5.
C28.	When was the last time you did this?	One week ago	1.
		One month ago	2.
		Three months ago	3.
		One year ago	4.

.SECTION D. EDUCATION LEVELS OF VHTS

The next set of questions asks you about your level of education.

No.	Questions and filters	Coding categories
D29.	What is the level of education?	<input type="checkbox"/> None 1. <input type="checkbox"/> Primary 2. <input type="checkbox"/> Secondary 3. <input type="checkbox"/> High school level 4. <input type="checkbox"/> Tertiary 5.
D30.	Are you able to read and write fluently in the local language?	<input type="checkbox"/> Yes 1. <input type="checkbox"/> No 2.
D31.	Are you able to read and write English?	<input type="checkbox"/> Yes 1. <input type="checkbox"/> No 2.

SECTION E. LEVEL OF SUPERVISION BY THE DISTRICT AND SUB-COUNTY HEALTH OFFICIALS

The next set of questions asks you whether the district or sub-county officials come down to supervise.

No.	Questions and filters	Coding categories
E32.	The District Health Officials come to supervise/work with you often	<input type="checkbox"/> Strongly disagree 1. <input type="checkbox"/> Disagree 2. <input type="checkbox"/> Neutral 3. <input type="checkbox"/> Agree 4. <input type="checkbox"/> Strongly agree 5.
E33.	How often do the district health officials come down to supervise you	<input type="checkbox"/> Monthly 1. <input type="checkbox"/> Quarterly 2. <input type="checkbox"/> Annually 3. <input type="checkbox"/> After 2 years 4. <input type="checkbox"/> None at all 5.
E34.	The sub-county health officials come to work with you often	<input type="checkbox"/> Strongly disagree 1. <input type="checkbox"/> Disagree 2. <input type="checkbox"/> Neutral 3. <input type="checkbox"/> Agree 4. <input type="checkbox"/> Strongly agree 5.
E35.	How many times do the sub-county health officials come to work with you?	<input type="checkbox"/> Monthly 1. <input type="checkbox"/> Quarterly 2. <input type="checkbox"/> Annually 3. <input type="checkbox"/> After 2 years 4. <input type="checkbox"/> Not all 5.
E36.	What is the maximum time you have been supervised by the District or sub county officials ?	<input type="checkbox"/> One hour 1. <input type="checkbox"/> Two hour 2. <input type="checkbox"/> Six hours 3. <input type="checkbox"/> One day 4.

SECTION F. LEVEL OF TRAINING

The following set of questions would like to find out the level of training you acquired for VHT work.

No.	Questions and filters	Coding categories
F37.	After being selected as a VHT have you ever had initial training?	<input type="checkbox"/> 1. <input type="checkbox"/> 2.
F38.	How long was the initial training?	<input type="checkbox"/> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4.
F39.	Who carried out the training?	<input type="checkbox"/> County officials 1 <input type="checkbox"/> District health Officials 2. <input type="checkbox"/> Ministry of health officials 3. <input type="checkbox"/> Sub county, District Health and Ministry of Health officials. 4. <input type="checkbox"/> District and sub county health officials 5.
F40.	Have you ever had any refresher training after the initial training?	<input type="checkbox"/> 1. <input type="checkbox"/> 2.
F41.	How many refresher trainings have you had since?	<input type="checkbox"/> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4.
F42.	The trainings were satisfactory.	<input type="checkbox"/> I strongly disagree. 1. <input type="checkbox"/> I disagree. 2. <input type="checkbox"/> Neutral. 3. <input type="checkbox"/> I agree. 4. <input type="checkbox"/> I strongly agree. 5.
F43.	What do you suggest should be included in the trainings?	<input type="checkbox"/> Carrying out immunizations 1. <input type="checkbox"/> Carrying out immunizations, voluntary counseling skills 2. <input type="checkbox"/> Carrying out immunizations, voluntary counseling skills, treatment of common diseases 3.

Focus group discussion guide.

Introduction:

I am Adoa John Steven a student of International Health Sciences University, MSC, PH. I am undertaking a study on Village Health Teams in Soroti District. The study would like to assess the factors that influence the performance of VHTs in the District of Soroti so that measures for improvement can be sought. It is also hoped that the information obtained can be useful to the future policy making.

Please feel free to participate in the discussions. Your participation is based on informed consent, is voluntary and information obtained will be kept confidential and only used for the intended purpose.

Every ones views are very important and please kindly talk one at a time. I also request you to allow me record the issues of the discussion so as to capture an accurate record of what takes place.

Can I start the discussion now?

I want to thank you most sincerely for your participation in this study

KEY QUESTIONS TO GUIDE THE FOCUS GROUP DISCUSSION.

a) These Questions will be targeted at the local leaders i.e. , Sub county chief, selected members of LC111, health workers at their community?

2. What is your view about the VHT strategy?
3. Are you satisfied with what they do?
4. What are the challenges they face as their roles?
5. What do you feel is missing?
6. What do you propose to be done so as to improve on their performance?

b) These questions will be targeted at the VHTs.

1. What are the major roles and responsibilities you are expected to perform.
2. Of these roles which of them do you often carry out?
3. When you carry out home visiting for example, what do you observe?
4. Which roles haven't you carried out and why?
5. What are the major challenges you meet as you carry out these roles.
7. In your view what do you feel is missing.
8. What do you propose to be done to make you work better

Key informant guide

Introduction:

I am Adoa John Steven a student of International Health Sciences University, MSC, PH. I am undertaking a study on Village Health Teams in Soroti District .The study would like to assess the factors that influence the performance of VHTs in the District of Soroti so that measures for improvement can be sought. It is also hoped that the information obtained can be useful to the future policy making.

Please feel free to participate in the discussions. Your participation is based on informed consent, is voluntary and information obtained will be kept confidential and only used for the intended purpose.

Every ones views are very important and please kindly talk one at a time. I also request you to allow me record the issues of the discussion so as to capture an accurate record of what takes place.

Can I start the interview now?

I want to thank you most sincerely for your participation in this study.

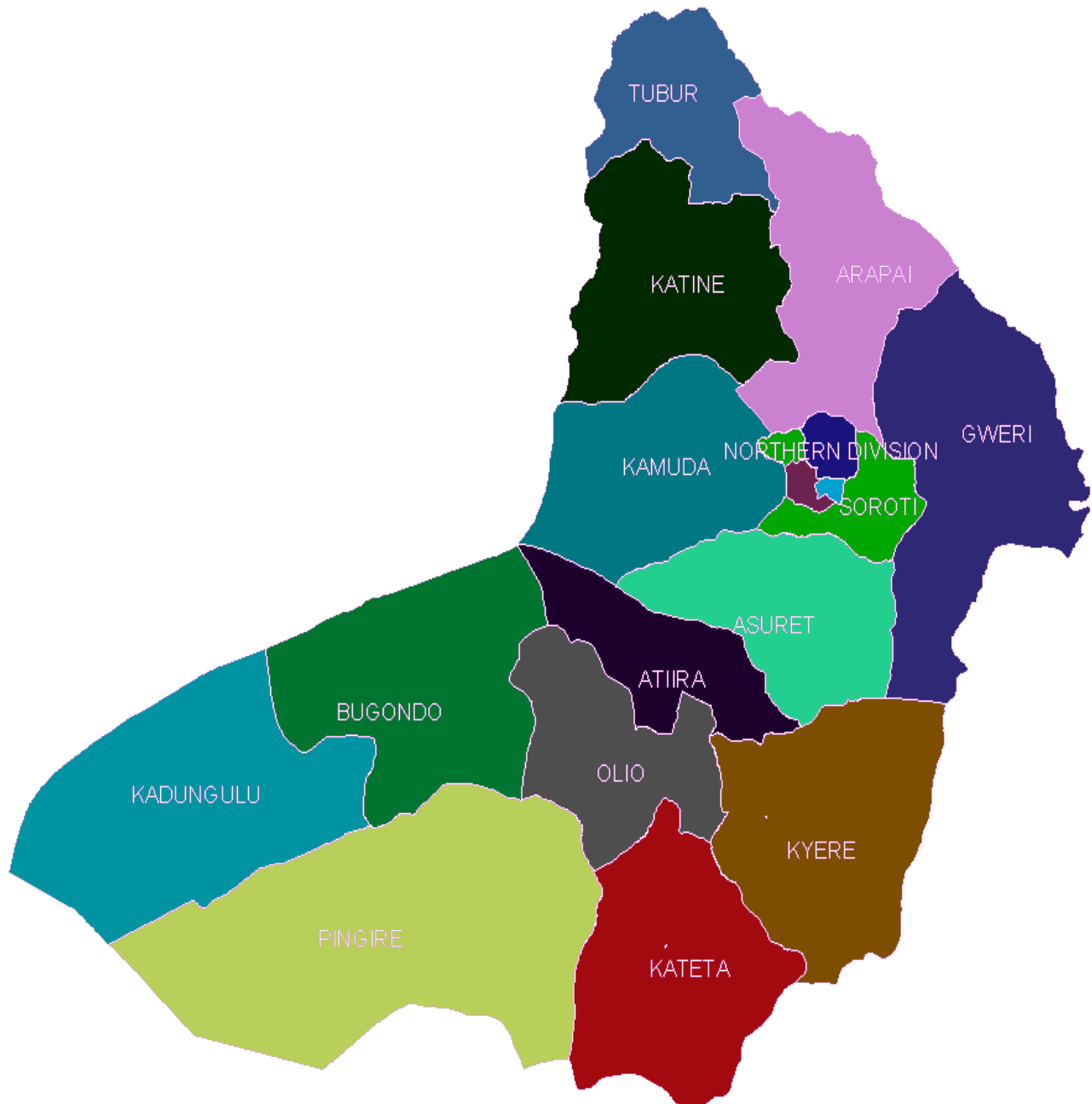
Important questions for the key informant interview.

1. Are you involved in the selection, training and supervision of the VHTs?
2. Is the VHT system a good strategy for the delivery of health services?
3. Do all the villages in the District have VHTs?
4. Are they all trained?
5. How long was the training?
6. What were they trained on?
6. Have they been given any refresher training?
7. How long was the refresher training?
8. What were the topics covered during the refresher trainings.
9. Who were the trainers?
10. Do you think the VHTs are performing their roles effectively?
11. If not why?
12. How often are the VHTs supervised?
13. How many times in the quarter have you participated in this supervision?
14. What are some of the problems you encounter in supervising the VHTs?

15. What is your view about sub county official's supervision?
16. What do you propose?
17. What incentives do you have for the motivation of the VHTs?
18. How often are they motivated?
19. What do you propose?

Appendix 2. Workplan for carrying out the research.

No.	Activity	Place	Time frame												Required items	Output	Remarks	
			J	F	M	A	M	J	J	A	S	O	N	D				
01.	Research proposal Development	IHSU		x	x	x	x									stationery funds for photocopying	Proposal Ready	consultation With supervisor
02.	Research final proposal	IHSU														Funds for photocopying	approval of proposal	University committee approves
	Development of Research tools															Stationery ,funds	all research tools in place	do
03.	Reporting to the	Soroti														funds, transport	Letters of	District health



Appendix 3. Map of Soroti District

Appendix 4. Proposed budget estimates for the study

No	Item	Quantity	Rate	Amount
1	Production of structured questionnaires	180	2,000	360,000
2.	Selection of 5 research assistants (radio announcement)	2	30,000	60,000
3	Training of research asst. Lunch	5	5,000	25,000
4	Stationery (lump sum)	1	30,000	30,000
5	Transport hire for survey five days	5	100,000	500,000
6	Allowances for research assistants 5 days	5	20,000	100,000
7	Data entry and analysis-allowances	5	100,000	500,000
8	Report making and dissemination	1	100,000	100,000
	Total (UG. SHS.)			1,675,000