FACTORS INFLUENCING THE PERFORMANCE OF VILLAGE HEALTH TEAMS (VHTS) IN HEALTH PROMOTION, A CASE STUDY OF MAKINDYE DIVISION

A POST GRADUATE RESEARCH DISSERTATION REPORT PRESENTED TO THE INSTITUTE OF HEALTH POLICY AND MANAGEMENT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF A MASTERS DEGREE IN PUBLIC HEALTH

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DECLARATION

I, Nakigudde Faith, I hereby declare that all the work in this dissertation is original and has not been submitted for another degree in this or any other university or institution of higher learning.

Signature **Date**

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APPROVAL

This dissertation is submitted for further examination with my approval as a university supervisor.

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SIGNATURE

DEDICATION

This book is dedicated to my parents Mr. Nakabaale Grace and Ms. Namirimu Joyce for the love and sacrifice they have bestowed upon me.

Also to my lord and savior Jesus Christ for his grace and mercy towards me. Without him, I would not have completed this thesis.

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Last but not least to my sisters and brothers namely Olivia, Hellen, Juliet, Lillian, Evelyn, Godfrey, Geoffrey, and Samuel. I am so grateful for your love and prayers.

Finally to the respondents, who willingly spared their precious time to participate in this study, thank you very much.

LIST OF ACRONYMS

CBOs	Community Based Organizations
CHWs	Community Health Workers
GMP	Growth Monitoring Promotion
HIV/AIDS	Human Immuno Virus/ Acquired immune deficiency syndrome
M.O.H	Ministry of Health
MUAC	Mid Upper Arm Circumference
UNICEF	United Nations International Children Education Fund
VHT	Village Health Teams
W.H.O	World Health Organization

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ABSTRACT

The study focused on examining the various factors that directly and indirectly influence the performance of VHT activities. The study was based on a scientific fact that incentives, availability of supplies and support supervisions have significant impact on the quality of health services offered by VHTs. Substantively the study has revealed positive results, that incentives influence the performance of VHTs in terms of motivation and retention. Secondly the study has shown that lack of sufficient supplies has negatively affected the performance of service delivery in terms of availability and accessibility. Thirdly, the study has revealed there is a dire need to adopt an effective supervisory mechanism for technical development and for the sustainability of VHT activities in the area. The study was conducted in Makindye division in Central Uganda

In order to capture comprehensive results, the researcher adopted a cross sectional descriptive methods; the researcher employed a questionnaire with both open ended and closed ended questionnaires to gather data. Also, the researcher acquired an interview guide to gather qualitative data.

In need to test for the relationship between the independent variables that is incentives, supplies and support supervision, the researcher ran chi square test and established that there was a significant relationship between variables that is the presence of incentives, supplies and support supervision on VHTs performance and in their absence, it leads to high attrition rate and poor health outcome.

In conclusion, the researcher argued that for quality service delivery by VHTs in health promotion, there is a great need to improve on the availability of incentives, supplies and support supervision; it is only by sincere involvement of community members that health quality in the area can be realized. Therefore, the researcher recommended for horizontal form of management to ensure continuity and sustainability of VHT activities.

CHAPTER ONE

INTRODUCTION

This study is an evaluation of the VHT performance in health promotion in Makindye Division. This chapter presents the background to the study, introduction of research issues, background to the study area, scope of the study, research question, and statement of the problem, purpose of the study, main objective, specific objectives, and significance of the study.

1.1 Background to the study

The purpose of health promotion is to strengthen the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively to exercise control over the determinants of health and achieve positive change (WHO, 1978).

According to the Ottawa Charter (1986), health promotion is determined by a combination of strategies which include developing personal skills, strengthening community action and creating supportive environments for health backed by healthy public policy. Globally, there have been various challenges in health promotion; various countries worldwide have had problems with promoting health to all individuals. In developing economies especially Sub- Saharan Africa the situation is worse. In Uganda, despite efforts by the Ministry of Health to address the country's health challenges, the health care performance is still poor.

The health status of Uganda has slightly improved but there is a lot to be desired; the mortality rate of the country is 350 per 100,000 live births, the infant mortality rate is 76 per 1,000 live births and communicable diseases contribute 80% of disability adjusted life years lost (WHO Statistics 2010; HSSIP 2010/11-2014/15). The concept of primary health care originated before 1978 but was formalized with the Alma Ata Declaration of 1978 and its emphasis was on education on health problems, promotion of food supply and nutrition, provision of safe water and sanitation, maternal and child health care, control of endemic diseases, treatment of common diseases and minor injuries and provision of essential drugs.

It is against this background that the village health teams (VHTs) phenomenon came into play with an objective of decentralizing health care services to the grass roots level. The health system of Uganda has been structured with the Community/ VHT groups at the grass root level as health center I, under the supervision of health center II, followed by health center III, health center IV's (referral facility- public or private not for profit), district health services headquarters, regional referral hospitals, national referral hospitals and Ministry of Health at the top.
Runumi, (2007) HSSIP (2010/11-2014/15).

The VHT system was established by the Ministry of Health through the National Health Policy and Health Sector Strategic Plan in 2003 and managed at the village level. It embraces all former community health volunteer categories. It comprises a team of 9 – 10 members in a village (HSSP, 2000) selected on a popular vote after sensitization and consensus building of all village members from all households and selected on purely voluntary terms to oversee the health status and activities of the community. Each VHT member is in charge of 25 to 35 households (M.O.H,

2009). The major objective of the VHT's is to improve health at the household level and also ease the collection and management of health information.

VHT members are selected based on the Ministry of Health criterion which emphasizes residence in the community, exemplary conduct, literacy skills, interest in health issues, status in the community and prior involvement with community health activities and willingness to work on a voluntary basis.

The VHT members are taken through training covering 36 topics which include communication, community mobilization and empowerment, child growth and development, control of communicable diseases, sexual and reproductive health, environmental health, non-communicable disease, and monitoring and evaluation. The objectives of VHTs are to strengthen service delivery at household and village level; establish a village information system, and empower household members to value health and sustain health actions. (*Village health team collection- VHT booklet, unpublished*) thus bringing services nearer to the people. VHT's roles include identifying community needs, mobilizing health programs, maintaining records; referral of the sick to health center II, distribute health information and services; and act as a link between the community and health providers HSSIP(2010/11-2014/15), *Village health team collection- VHT booklet, unpublished*.

1.2 Background to the Area

Makindye Division is one of the divisions that make up Kampala district; it has a total of 21 parishes. It is located in the south eastern part of Kampala bordered by Wakiso District to the South and West, and Lake Victoria to the east. The road distance between Makindye Division

offices and the central business center of Kampala is approximately 7 Kilometers. Makindye division has a population of about 500,000 people with 164,216 recorded in the health sub district (Nsubuga, 2010); the economic activity is small scale business. The division has two (2) government health facilities, Kiruddu Kampala City Council and Kisugu Health Center; two (2) private- not for profit hospitals, Nsambya Hospital and Wentz Hospital, and many private hospitals and health units, for example IHK and Nsambya General Clinic. The division has a total of approximately 73 VHTs.

1.3 Justification of the study

Many interventions have been implemented by the Ministry of Health to strengthen the public health system; such strategies include the introduction of the village health team system aimed at disseminating services at the community level and encourage community participation. However, although these strategies hold promise for health promotion, they still need strengthening. This study will identify the factors which influence VHT performance and contribute to the strengthening of the VHT system.

1.4 Scope of the study

The research study focused at Village Health Teams (VHTs) in six (6) parishes of Makindye Division; these include Ggaba parish, Buziga, Salaama, Lukuli, Makindye 1 and Makindye 11. A total of 227 respondents were involved in the studied and these include VHTs, health in-charges and supervisors of VHTs, local council chairpersons, Makindye Division health officers and residents.

The study intended to investigate how annual support supervision and training of VHTs, incentives, and availability of supplies (independent variables) influence their performance (dependent variable).

1.5 Research Question

What are the factors that influence the performance of VHTs in health promotion?

1.6 Statement of the problem

Primary health care is the main strategy adopted by the Ministry of Health in the delivery of health services. The approach is aimed at bringing health services closer to the people by creating opportunities for the attainment of health that is affordable, accessible, and acceptable with community participation. Alma Ata Declaration, (1978); Kiggunddu (2006) According to the Health Sector Strategic Plan, 75% of the disease burden in Uganda is preventable through health promotion measures. HSSP (2010/11-2014/15)

The village health teams were developed to implement health interventions at community level, provide access to preventive interventions, promote treatment seeking behaviors, strengthen mechanisms for data collection at the household level for purposes of planning and strengthen advocacy and social mobilization systems for health promotion at household level. VHT training manual, CDFU (September 2010).

The VHTs are involved in promotion of health related programs; they have encouraged utilization of health services, participated in the distribution of drugs, information, education and

communication materials, bed nets, and in the implementation of a community based health management information system. Sekimpi (December, 2007)

It is hoped that the involvement of VHTs at village level will therefore contribute to increasing community acceptance and participation in health programs such as integrated management of childhood illness, nutrition, immunization and distribution of bed nets which in turn will reduce ill health and deaths in the country.

However, support supervision has revealed that VHTs have not achieved the objectives that they were set to achieve and the attrition level is high mainly due to lack of emoluments (HSSIP 2010/11-2014/15). This study therefore intends to investigate the factors that influence the performance of VHTs in health promotion.

1.7 Purpose of the study

The purpose of the study was to generate information which if put to use leads to improved management of the VHT system which results in health promotion at community level and thus better service delivery at the grass roots.

1.8 Main objective

The main objective of this study was to establish the factors that influence the performance of VHTs in health promotion of communities.

1.8.1 Specific Objectives

i. To examine the extent to which incentives influence VHT performance in health promotion
ii. To establish the extent to which availability of supplies influence the performance of VHTs
iii. To determine the extent to which the annual level of support supervision and training influences VHTs performance.

1.9 Research Questions

The researcher sought to answer the following questions

i. To what extent do incentives influence the performance of VHT in health promotion?
ii. To what extent does availability of supplies such as drugs influence the performance of VHTs?
iii. Does annual support supervision and training influence VHT performance?

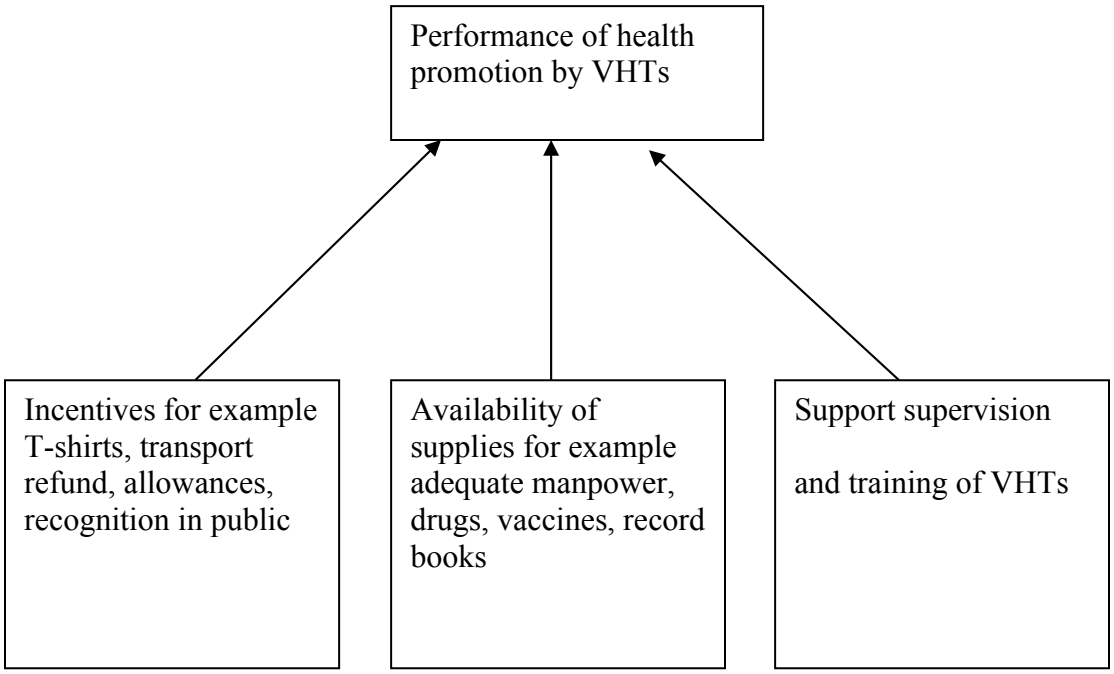
1.10 Hypothesis

a) Unavailability of supplies does not influence the performance of VHTs
b) Inadequate support supervision and training does not influence the performance of VHTs.
c) Lack of incentives does not influence the performance of VHTs in health promotion.

1.11 Significance of the Study

The study findings if put to use will contribute to the pool of knowledge in the strengthening and designing of new interventions which will improve the VHT system in Uganda, and provide information to policy makers and the Ministry of Health

1.12 Conceptual frame work



1.13 Operational definitions

VHT performance refers to the degree to which the objectives set by Ministry of Health for VHTs are achieved and the extent to which target problems are resolved.

Health promotion is all activities whose primary purpose is to promote, restore or maintain health. It can also be defined as the process of enabling people to exert control over the determinants of health and thereby improve their health. WHO, (1988)

Incentives refer to the value the individual places on the outcome such as health status, appearance or financial gain. Kemm. J, (1995)

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter includes a review of the contributions of different scholars to the subject; it will review available contributions of various scholars about VHTs in the world, in Africa and in Uganda.

Different countries have used different names to refer to VHTs such as Lady Health Workers, Community Health Workers, Village Health Guides, Community Health Volunteers, Barefoot Doctors, Female Community Volunteers, Community Health Agents, Safe Motherhood Promoters, and Child Health Volunteers. The literature with similar roles to that of VHTs was reviewed.

2.2 Theoretical Review

The Alma Ata declaration developed the concept of community participation in health promotion and various theories were developed as a result among which include theories of equity in health, decentralization, and the community health action model

2.2.1 Theory of Equity

The Alma Ata Declaration (1978), sought for equity of health services for all people so that the disadvantaged groups can access health care services. Equity means social justice or fairness among the population. To achieve equity, there is need to compare health and its social determinants between those with more and those who are disadvantaged. Braveman P, (2002)

Rawl's theory states that a society consists of free and equal persons of political and personal liberties, of equal opportunities, and cooperative arrangements that benefit the more and the less advantaged members of society. There is need to maximize the income and wealth of the rich so as to distribute goods equally with the least advantaged.

The Distributive Justice Theory advocates for equal allocation of material goods to all members of society Braveman. P, (2002)

Handy (1993), states that the incentive theory indicates that individuals tend to work hard if they are given specific rewards for good performance; however, the theory works better if the reward given is considered to be worth putting in extra effort in work. The performance can be attributed to an individual if the reward is what the individual expects to receive.

2.2.2 Theory of Decentralization

Decentralization refers to the process of state reform composed of a set of public policies that transfer responsibilities, resources, or authority from higher to lower levels of government in the context of a specific type of state Tulia G.F, (2005). The VHT system comes as a result of the need to decentralize health care services to the lower levels of the community.

2.2.3 Community health action model

The model depicts community health promotion in a manner that can be implemented by community members to achieve their collectively and collaboratively determined actions and outcomes to improve the health of the community and for the benefit of all. Community mobilization is a process whereby a group of people have put aside their differences to meet on

equal terms in order to facilitate a participatory decision making process; it also provides an avenue for everyone to participate in the decisions that affect their lives Bartle, (2007).

2.3 VHTs in the world

Pakistan

In 1994, the lady health workers program was initiated in Pakistan where workers from the local community received six months training to provide home visits, counseling mothers on maternal and child health issues, providing nutritional supplements to pregnant women, providing condoms and contraceptives and treating minor illnesses. These workers have an educational background of at least grade 8, and each health worker is responsible for 200 families; the program has recorded success on neonatal survival; however, it faces challenges such as inconsistent health education messages, inconsistency in supply of drugs and some programs such as polio eradication which consumes more time to the neglect of other program activities. Haines et al., (2007)

Mexico

Haines et al., (2007) comments that in a study done in Mexico showed that the use of community health workers was less costly yet more effective than using outreach teams of health staff. All studies showed that with support and training, community health workers can improve child health. He noted that most government programs assume that community health workers are willing to serve voluntarily; however, most programs especially non-government organizations pay their volunteers a salary or an honorarium. The non-financial incentives to improve the performance of community health workers include T-shirts, badges, and working flexible hours.

Bangladesh

Most community health activities in Bangladesh have been carried by NGOs rather than government. Noted experiences from BRAC's community health workers known as "Shastho Shebikas" have trained women on how to prepare oral rehydration solutions to treat diarrhea; Perry,1999 in Hossain,(1999); the program also used community health workers in administering treatment (directly observed treatment) to patients with tuberculosis. The community health workers lived in the same village as patients; this reduced costs for patients with tuberculosis as the distance for traveling was reduced and the DOTS strategy was more effective. Akramu et al., (2002). The community health workers were given basic training for 4 days and refresher training once a month for two years (BRAC website**)** and they were responsible for 150-300 households. Hossain, (1999). The program of Shastho Shebikas started in 1977 in five districts and due to its success, it expanded to 330 sub districts by 1999. Hossain, (1999). The volunteers are not paid a salary but retain a small profit from the sale of drugs prescribed for common illnesses.

U.S.A

In 1960's the federal government supported community health worker programs to expand access to health care in communities. Community health workers in the U.S.A have facilitated health care through outreaches, health education, and linking the mentally ill and those living with HIV to the needed services. Since many are volunteers, they have the potential for reducing labor costs; however, community health workers have faced barriers such as not knowing their scope of practice, limited training, and lack of a secure source of funding. Witmer et al., (1995)

Bhutan

The village health worker program in Bhutan was introduced in 1979 with the aim of improving basic hygiene and prevention of immunizable diseases; the village health workers are responsible for 20 to 30 households and they do not receive any financial benefit from government. The village health workers are motivated through recognition by the community and a satisfaction that they have contributed to the health of their communities. There is a high attrition rate due to lack of government support.

India

In India the government introduced a community health workers scheme in 1979, the name was changed to community health volunteers in 1980 and village health guides in 1981. In April 2002, the government withdrew support for the program and it was supposed to be run by states. However, no state is running the program. Witmer et al.,(1995). The aim of the village health guides was to provide basic curative, preventive and promotive health care at people's door steps. The program selected men as Village Health Guides in 1980's since they were the targets of the family planning program; later focus shifted to maternal and child health care which led to recruitment of women and phasing out of men. The Village Health Guides would receive Rs.200 (equivalent to 10,700 Uganda shillings) monthly during the 3 months training. As incentives Village Health Guides received an honorarium of Rs.50 (equivalent to 2,700 Uganda shillings) per month and basic medicines worth Rs.50. However, by 2001 the Village Health Guides started demanding remuneration. Suresh, 2003 in Witmer et al.,(1995). The Village Health Guides program in India focused on curative services and neglected preventive and promotive services.

China

The barefoot doctor program in China was formally introduced in 1968; the barefoot doctors were recruited from farmers who had been educated to secondary level and they went through a six months training program at a community hospital. Because of this training, the barefoot doctors were able to promote hygiene, practice preventive health care and treat common illnesses; unlike in Uganda where the level of education is not stated.

Nepal

In late 1990's, the government of Nepal introduced a community health volunteer program and this has evolved in the last 25 years to become female community health volunteer program with 48,550 volunteers trained in 75 districts .Government of Nepal, (2003). Female community health volunteers were responsible for health education, community mobilization, and referring patients. These were easily accessible by mothers and they gave good advice. The initial training of female community health volunteers was for 15 days followed by refresher training of two days every six months; however training was not regular. The volunteers who had attended many training sessions were given bicycles, radios and other items to motivate them. Volunteers were also offered incentives such as community recognition, awards and certificates. Supervision was not found to take place in many areas and in others it was irregular and informal except for national programs such as vitamin A supplements and polio immunization days; refresher courses were the major form of supervision Witmer et al., (1995)

Sri Lanka

Community health workers in Sri-Lanka received three months training; their supervision depended on the interest of family health workers who received no incentives for supervising volunteers. Gilson et al, 1989 in UNICEF (2004)

Indonesia

According to a report by UNICEF, village health volunteers in Indonesia were paid by local communities; they were involved in family planning, growth monitoring, health education and treatment of diarrheal diseases. This led to a reduction of infant mortality and improved immunization coverage UNICEF. , (2004)

Brazil

The community health workers program started in mid 1980's; the community health agents were given three months training and assigned between 50 to 250 households. Their role was to provide prenatal care, vaccinations, promote breast feeding and oral rehydration. The community health agents were paid 112 dollars per month and supervised by local nurses. The program led to a 32% reduction in infant mortality and an increase in exclusive breast feeding Cufino et al., 2000 in W.H.O., (2007). The community health agents were integrated into the family health program by 1994; this comprised one physician, one nurse, one nursing assistant and four community health workers. In 2004 the program had covered about 66 million people and there was a drop in hospitalization from 52 to 38 per 10,000 by 2006 W.H.O., (2007)

2.3.1 VHTs in Africa

Tanzania

In a study done by Mushi et al., (2010) in Mtwara district in Tanzania about the effectiveness of community based safe motherhood promoters in improving the utilization of obstetric care, the safe motherhood promoters were tasked to promote the attendance of women in antenatal through follow up of pregnant women, training them as to the danger signs, birth preparedness plans; delivery under the care of a skilled birth attendant increased from 34.1% in 2004 to 51.4% in 2006. Antenatal visits increased from 18.7% to 37.7%. After two years of the study from 2004-2006, 44 (88%) of the safe motherhood promoters were still active. The number of deliveries by traditional birth attendants decreased from 35.7% to 29.9% and those from relatives from 30.2% to 17.3%.

A few of the safe motherhood promoters expressed that their training was too short for them to be competent. The study also indicated that safe motherhood promoters were not paid and had a low educational background; however they actively performed their roles with only six drop outs of the 50 trained safe motherhood promoters (Mushi et al., 2010)

Malawi

World Alive ministries have involved community leaders in identifying male volunteers to provide training, support and supervision to people living with HIV/AIDS. This led to a decrease in gender stereotypes as the female volunteers would not meet the needs of male clients. There was increased acceptance of condom use among men and a decrease in stigma associated with volunteer care work for men (SAT Southern Africa AIDS Trust, 2002-2003 in Jackson et al., 2007).

Ethiopia

In its efforts to reach the millennium development goals, Ethiopia trained 30,000 community based health workers to focus to maternal and child health, malaria and HIV. A trial in Tigray of training community coordinators to train mothers on administering anti malarial drugs to their sick children recorded a 40 % reduction in mortality of under 5's. Haines et al.,(2007) state that community health workers can promote behavioral change in the areas of hand washing, breast feeding, and distribution of insecticide treated nets, prevention of mother to child transmission of HIV, and management of childhood illnesses such as malaria, and pneumonia Haines et al., (2007).

South Africa

Irwin et al., (2007), state that in South Africa volunteers receive financial rewards and non-government organizations have to find ways of financially rewarding volunteers as well. The organizations with volunteers who work on purely voluntary terms has recorded a high attrition rate and the few volunteers that remain become overloaded with work. In order to ensure country wide equity the Ministry of Health committed to paying between R500 to R1000 (equivalent to 178,386.45 to 356,778.20 Uganda Shillings at a rate of R1 equivalent to 356.78 Uganda shillings) per month to community health workers depending on their qualification. In the study fewer projects were still encouraging pure voluntarism. About 65% of the projects received professional supervisors; some used monthly meetings as a means of supervision. Kironde et al., (2001), in a study done in the Northern Cape province, showed that volunteers in the tuberculosis program do not get any monetary incentives; what motivates them to work is the hope that they

will eventually be remunerated. The attrition rate was 22% within one year of joining and 75% of the drop outs gave loss of interest as their reason for leaving.

2.3.2 VHTs in Uganda

Sui et al., (2009), states that the volunteers have the potential to perform but their preparation for health education does not meet the high demand of the task they are to perform. In this study carried out in western Uganda, it was indicated that volunteers are an important entry to the community by health facilities. It was noted that volunteers were trained for a short period of time and the trainers had no skills in health education or volunteer management. Most volunteers expected personal gains such as being employed by agencies and financial gains in terms of allowances. Health education was performed in isolation of the services meant to be provided to the communities for example condoms, pills or HIV testing.

Webster. C. W, (2009), states that in western Uganda, child health volunteers have been offered training on integrated management of childhood illnesses with Health child Uganda; he indicated that Health Child Uganda has had retention of 85% of child volunteers even without pay, and there has been a 25% decrease in child deaths.

Sibley et al., (2003), state that approximately 53 million people in Africa give birth at home without help of skilled birth attendant. Some deliver with the help of the family, friends and traditional birth attendants. According to Sibley et al., (2003), traditional birth attendants have had an impact on neonatal mortality; however, their impact on maternal mortality is questionable. In their study, traditional birth attendants were in a better position to offer intra-

partum care and advice to mothers than untrained traditional birth attendants; however, they were not trained on handling complicated deliveries. They recommended traditional birth attendants needed to be equipped with skills for prevention, recognition and management of maternal complications. In this study it was stated that traditional birth attendants increase knowledge by 90%, attitude by 74%, behavior by 63% and advice by 90% over untrained traditional birth attendants. In the study there was a small decrease of peri and neonatal mortality by 8% and birth asphyxia mortality by 11% by trained birth attendants. Sibley et al., (2003)

2.4 Incentives to VHTs performance

Komakech (2007) states that genuine community participation of VHTs has been derailed by the loss of the spirit of voluntarism; this is mainly due to lack of incentives in the form of finances. In his study of VHTs in Yumbe district, VHTs are expected to be motivated through the feeling that they are able to do good to their community. This is in agreement with the HSSIP 2010/11-2014/15 which states that the attrition of VHTs is high because of lack of emoluments.

VHTs have received allowances during training and meetings which has contributed to reduced dissatisfaction and attrition; however the allowances have not been regular except for a transport refund during training sessions Komakech (2007). When one considered the concept of China's barefoot doctors it is stated that they were given income which was equivalent to the income they would have received from agricultural work and this came from a collective welfare fund and local farmer contributions. This program was successful because barefoot doctors were paid by their own villages and selected by the community itself. However the barefoot program collapsed in 1981 when China's medical system was privatized which forced barefoot doctors to start training as village doctors and they started to charge for their services.

2.5 Availability of supplies to VHTs performance

For the village health system to earn the trust and respect of the community, the local people have to believe that the health system provides quality services and has basic drugs and supplies Sekimpi (2007).They further state that performance depends on a strong outreach system; interventions to improve child health require technical expertise, drugs, and equipment availability in communities.

Sekimpi, (2007), state that performance has been limited by difficulties in storing of supplies such as drugs, stock outs and support logistics to VHTs

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The World Health Report (2000) state that primary health care has failed mainly due to insufficient resources and this has prompted local people to bypass VHTs and seek help at referral centers.

2.6 Support supervision of VHTs

The VHT system in Uganda was established in 60 out of the 112 districts; however, of the established 60 districts, only 31% of districts have trained VHTs. This has been mainly due to inadequate funding and lack of trained health educators HSSIP (2010/11-2014/15). Perry et al., (2009) state that the performance of VHTs depends on a strong outreach system, availability of drugs, vaccines, and equipment for immunization at outreach sites. The workers must be appropriately trained and supported. If they are unpaid volunteers, they must have a limited set of tasks and not be expected to work more than a few hours a week; otherwise they tend to abandon their responsibilities.

Solomon et al., (2001) in a study conducted in Ghana found out that volunteers find it difficult to keep records and to indicate the drugs given, and this would complicate their efforts to account for the drugs given. However the research did not state if volunteers were well trained in keeping records and recording accurate results.

Nurses have been accorded a major responsibility for mobilizing communities to participate in primary healthcare activities; to date there has been little research into the nurse's role or performance in enhancing community participation for primary health care.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology the researcher used to answer research questions that is how incentives, availability of supplies, and the level of support supervision and training influence the performance of VHTs in health promotion. It describes the research design, study population, sampling techniques, sample size determination, study unit, study variables and their indicators, data collection techniques and instruments, data analysis techniques and presentation, and quality control techniques (validity and reliability).

According to Shamian et al (1993) in a study of community participation, primary health care and the nurse in Botswana used both quantitative and qualitative methods, where two rural and two urban communities were selected. Data was collected using questionnaires, focus group discussion and participant observation. The sample population was 206 households. Mushi et al's (2010) study about the effectiveness of community based safe motherhood promoters in improving the utilization of obstetric care used both the qualitative and quantitative designs. The study population was 512 respondents.

c.2 Research Design

In order to capture comprehensive results, the researcher adopted a cross sectional descriptive method in order to measure the current VHT performance in health promotion. A quantitative approach helped to acquire in depth information for proper analysis and making appropriate conclusions and inferences on generalisation to population Mugenda, (1999). Qualitative methods such as interviews were also used to capture in-depth data which would not be possible

to be got by use of a questionnaire. For triangulation of data, both qualitative and quantitative methods were used; open ended and closed ended questions and the questionnaires for the community were used to triangulate the information received from VHTs.

In need to test for the relationship between the independent variables that is incentives, supplies and support supervision, the researcher ran a chi square test and established that there was a significant relationship between variables in that the presence of incentives, supplies and support supervision, VHT's performance was positive and in their absence, it led to high attrition rate and poor health outcome

3.3 Study population

The researcher collaborated with Makindye Division health officers to identify the 57 VHTs in the division using the list provided, both working under the government structure and those under private not for profit organizations in the area. The study population also included members of Makindye Division public health team, local council chairpersons, In-charges for health facilities, and the VHT health supervisors within Makindye Division.

3.4 Sample size determination

A sample size is a subgroup of the population. Sekenan, (2003).This study allowed conclusions from the sample which were generalised for the whole population. The researcher used the Morgan method of sample size determination. There are about 73 VHTs in the division, 6 Health In-Charges, 4 VHT Supervisors, 1 Division health officer and 30 Local council chairpersons.

The total population from which the sample size was to be determined is 114 people

Using $n0 = Z^2p\ q \div e^2$

Where P = 0.50

Z = 1.96

e = 0.05

q = 1 – p

Step I

Using n0 = Z2pq ÷ e2

$$\frac{(1.96)2\ (0.50)\ (0.5)}{(0.05)2}$$

$$\frac{3.84 \times 0.5 \times 0.5}{0.0025}$$

= 384

Step II

$$n = \frac{n0}{1 + \frac{n0 - 1}{N}}$$

$$n = \frac{384}{1 + \frac{384 - 1}{114}}$$

$$= \frac{384}{1+3.3}$$

n= 89

VHTs = $\frac{73 \times 89}{114}$ = **57**

District Health Officer = $\frac{1 \times 89}{114}$ = **1**

Local council chairpersons = $\frac{30 \times 89}{114}$ = **23**

Health in-charges = $\frac{6}{114} \times 89 =$ **5**

VHT supervisors = $\frac{4}{114} \times 89 =$ **3**

The sample size included 57 VHTs, 1 Division Health Officer, 23 Local Council Chairpersons, 5 Health In-charges and 3 VHT supervisors.

For purposes of triangulation 129 community members were randomly selected to be included in the sample population to make a total of **227**

3.5 Study Unit

The study unit was the VHT member involved in community health activities of Makindye division.

3.6 Study Variables and their indicators

Study variables	Indicators
Incentives	- Type of incentives given for example recognition - How often are they given - Transport for home visits
Supplies Availability	- drugs distributed - Immunizations carried out - Number of bed nets distributed
Annual support supervision and training	- Number of health worker's visits to VHTs - Record of visits attended by health workers. - Register of training sessions - VHT register indicating recording of accurate results

3.7 Data collection techniques and instruments.

3.7.1 Focus group discussions

Two focus group discussions were held at Wentz medical center and K.C.C Kiruddu respectively, data was collected from VHTs; this was used to probe for further responses and clarify more on the issues that had been given by respondents.

3.7.2 Questionnaires

Under the quantitative approach, questions were categorized, scaled and coded to minimise bias. This was appropriate because it helps in collecting quantifiable information from a wide range of respondents. In addition they are easy to administer and enable collection of information from a big sample. Both open ended and closed ended questions were used for data triangulation. Questionnaires were used to gather data from the local community about the performance of VHTs in health promotion.

3.7.3 Interviews

In-depth interviews were conducted with opinion leaders such as the local council chairpersons and their secretaries for health, public health officers, health facility in-charges and VHT supervisors of Makindye Division. This was suitable because it caters for the literates and illiterates who enabled the researcher to probe and adapt questions as necessary. (Questionnaires and interview schedules can found in Appendix 1)

3.8 Data Analysis techniques and Presentation

Data was analyzed using the SPSS package and chi-square was used to test for the significance of independent variables and the dependent variable. Data was presented in tables, pie charts and

graphs for presentation of each independent variable indicated and analyzed in relation to the literature reviewed.

3.9 Quality Control Techniques

In order to ensure validity and reliability of the instruments for data collection such as the questionnaire, the researcher conducted consultations from the supervisor and held pre-tests to access the soundness of the tools. Biased data was avoided through using purposive random sampling. Editing and coding were done during and after each field work to ensure competency, uniformity and comprehensibility.

3.10 Ethical Considerations

Respect for respondents

Written permission was sought from the university authority to proceed with data collection; this was taken to the Local Council chairperson, Dr. Ian Clarke, to obtain permission to carry out research in the division. The letter from the Local Council chairperson was presented to the respondents to request for their participation in the research.

Autonomy of participants

Respondent's time and privacy was respected through making appointments in order to avoid any inconveniences and allow more time given to the interviewer. The respondents were given free choice to participate or not to participate in the study.

Beneficence

The respondents were assured that the research was aimed to strengthen the VHT system in Uganda and improve the welfare of the VHTs and the community.

Confidentiality

To deal with the issue of confidentiality, the respondents were assured that all information provided was for purely academic purposes and will be treated with utmost confidentiality. Research assistants were trained on the importance of privacy and confidentiality, and the identities of respondents were not included in the report.

3.11 Limitations of the study

Limitation of published literature describing factors influencing VHT effectiveness; however this was overcome through an effort to find more information about the context of the study through descriptions of other terms used elsewhere such as Village Health Guides, community health workers who share the same role as VHTs.

Non–response of respondent was solved by triangulation through including the local community as respondents.

CHAPTER FOUR

INTERPRETATION AND ANALYSIS OF FINDINGS

4.1 Introduction

This section contains the study findings in relation with the objectives, the results are presented in pie charts, graphs and tables for simplistic interpretation.

4.2 Demographic data

Table 1: Shows Socio – demographic characteristics of respondents

Variable	Frequencies	Percentages
Gender		
Male	50	22%
Female	177	78%
Total	227	100%
Age		
16 – 21 years	10	4.4%
22 – 27 years	45	20%
28 – 33 years	47	21%
34 - 39 years	44	19.4%
40 – 45 years	25	11%
45 and above	56	25%
Total	227	100%
Marital status		
Married	152	67%
Single	36	16%
Widows	27	12%

Separated	11	05%
Widowers	01	0.4%
Total	227	100%
Level of education attained		
Degree	01	1.7%
Diploma	19	33%
Completed secondary level	07	12.2%
Never completed secondary level	08	15.4%
Completed primary level		
Never been to school	16	28.2%
	06	10.1%
Total	57	100%
Duration of residence		
30 and above	61	27%
24 – 29 years	15	6.6%
18 – 23 years	25	11%
12 – 17 years	27	12%
6 – 11 years	47	21.1%
5 and below	52	23%
Total	227	100%

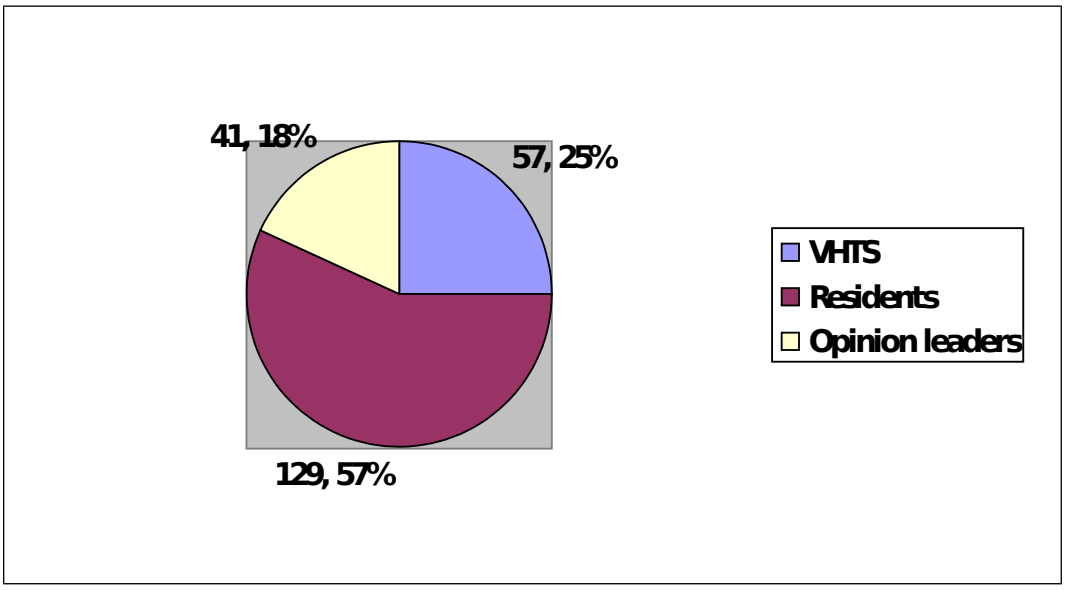
Source: Primary Data

Table 1 reveals that 78% of the respondents were female and only 22% were the male respondents; 25% of the respondents were in the age bracket of 45 years and above, 21% were of 28-33 years, then 20% were of 22-27 years, 19.4% were of 34-39, 11% of 40-45 and 4.4% of 16-21 years.

The table further shows that 67% were married respondents, 16% were single 12% were widows, 5% were separated and 0.4% were widowers; 33% of the respondents were diploma holders, 0.4% degree level, 15.4% never completed secondary level, 12.2% completed secondary level, 28.2% completed primary level and 10.1% did not indicate their education level.

In regard to duration of residence, 27% of the respondents had lived in the area for 30 years or more followed by 23% for a period of 5 years and below, 21.1% for a period of 6-11 years, 12% for a period of 12-17 years, 11% for 18-23 years and 6.6% for a period of 24-29 years.

Figure 1: Respondents by category



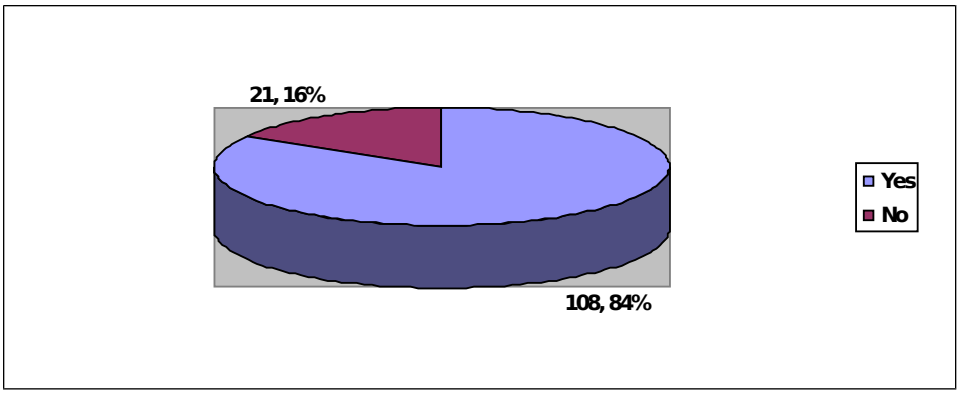
Source: Primary Data

Figure 1 indicates that 129 (57%) of the respondents were residents, 57(33%) VHTs and 41 (10%) were Local Council chairpersons, VHT supervisors and health In-charges.

4.3 Village Health Teams status

4.3.1 Awareness of VHTs in the area

Figure 2: Shows whether respondents were aware of VHTs

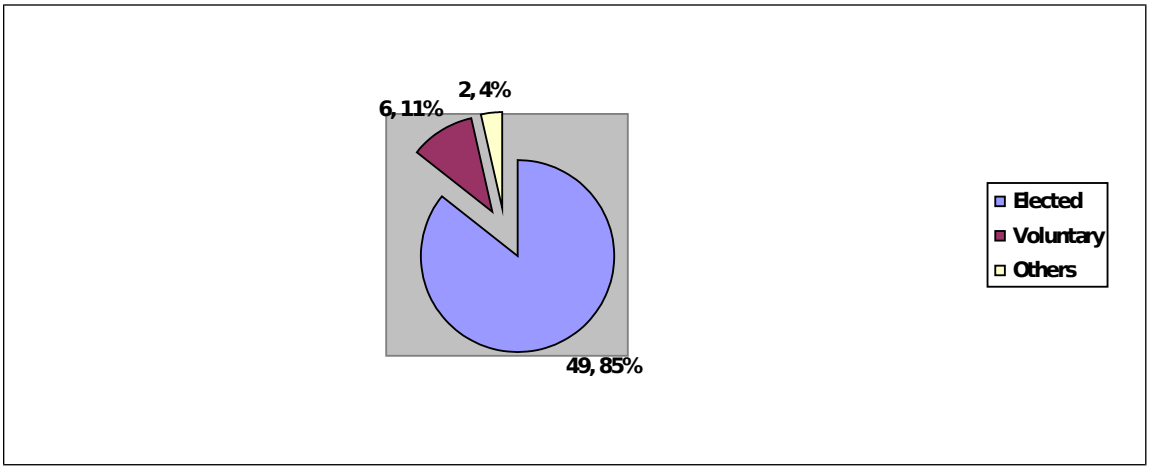


Source: Primary Data

Figure 2 indicates that 108 (84%) of the respondents are aware of VHT activities in the area and only 21(16%) did not know.

4.3.2 Selection criteria of VHTs in the area

Figure 3: Respondents by selection criteria

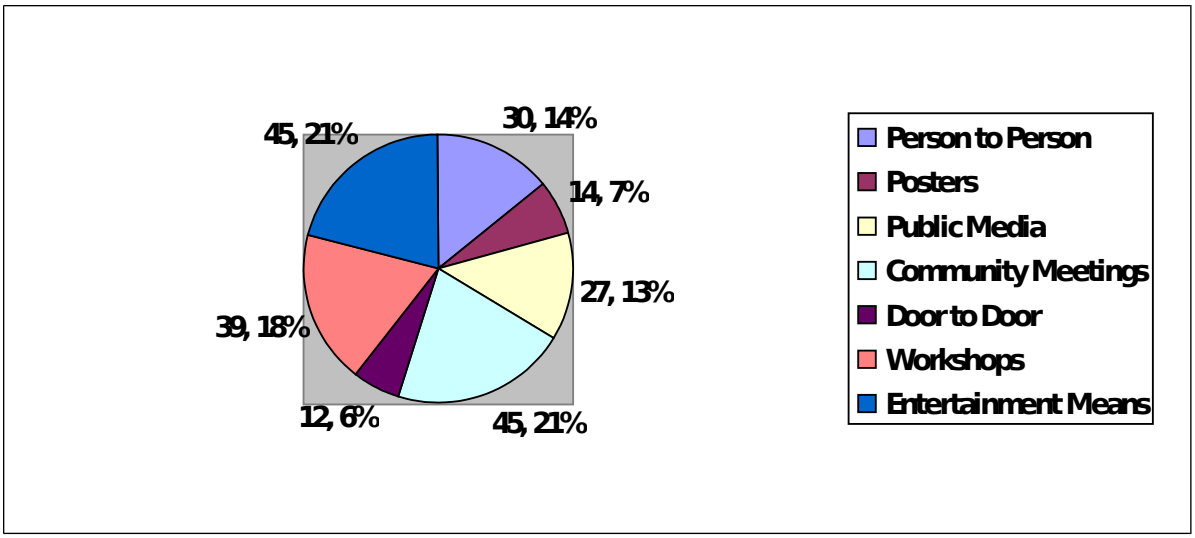


Source: Primary Data

Figure 3 reveals that 85% of VHTs were directly elected, 11% were voluntary involved and 4% indicated other means.

4.3.3 Channels used for health promotion in the area

Figure 4: Shows channels used to deliver health promotion messages

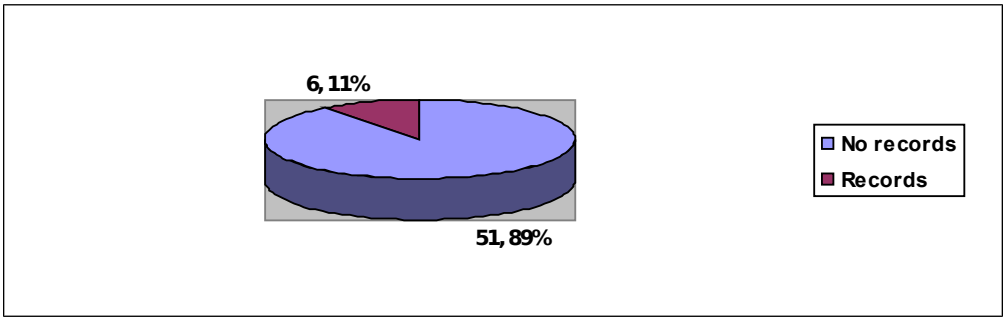


Source: Primary Data

Figure 4 shows that 20% of the respondents indicated that entertainment means for example drama, music, poems and community meetings are the most used channels for health promotion, 17% indicated workshops, 13% person to person, 12% indicated door to door and public media respectively, and 6% noted posters.

4.3.4 Record keeping by VHTs

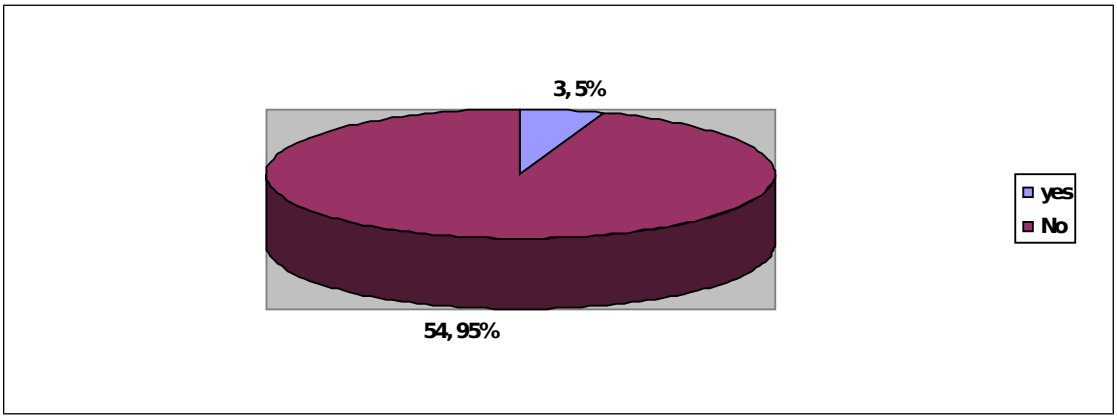
Figure 5: Shows whether there is record keeping



Source: Primary Data

Figure 5 reveals that 51 (89%) of VHTs did not have records and only 6 (11%) noted that they keep records.

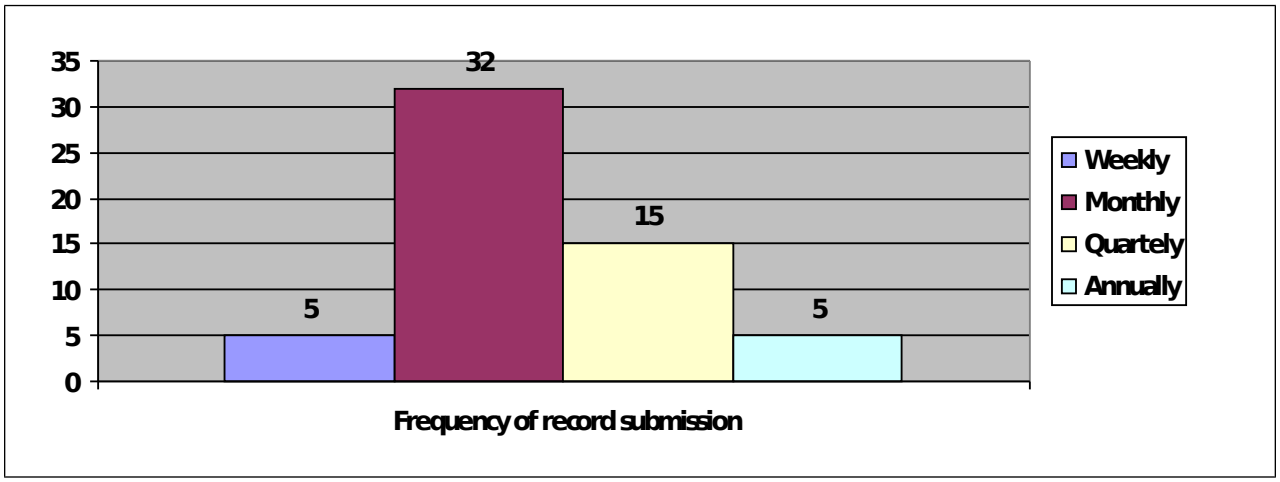
Figure 6: Shows whether records for new live births and deaths are kept



Source: Primary Data

Figure 6 indicates that 54 (95%) of the respondents did not have records for new live births and deaths and 3 (5%) indicated that they had the records.

Figure 7: Shows how often records (reports) are submitted



Source: Primary Data

Figure 7 reveals that 9 % of the respondents noted that records (reports) are submitted weekly, 56.1% monthly, 26.3% indicated that it is quarterly, 9 % noted yearly/annually.

4.3.5 Activities carried out by VHTs

Table 2: Shows activities carried out by VHTs in the area known by residents

	Frequency out of 129	Percentages

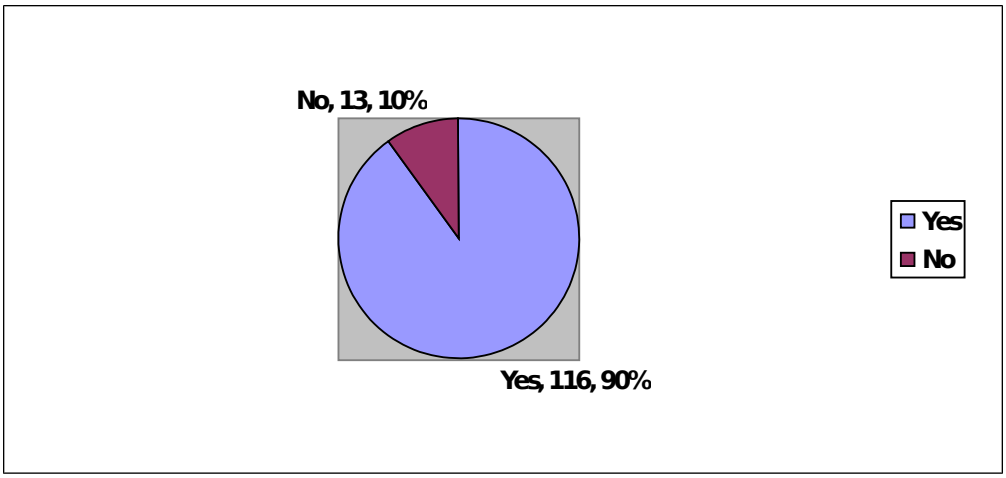
Health sensitization	115	89.1
Promoting sanitation and personal hygiene	55	42.6
Distribution of deworming tablets	97	75.2
Distributing household items to needy households	05	3.9
Immunization	13	10
Domestic violence prevention	18	13.9
Distributing mosquito nets	87	67.4
HIV/AIDS testing activities	30	23.3

Source: Primary Data

Table 2 shows that 115(89.1%) out of the 129 respondents pointed out that VHTs are involved in Health sensitization, 55(42.6%) promoting sanitation and personal hygiene among residences, 5(3.9%) distributing household items to needy households, 97(75.2%) distribution of deworming tablets, 30(23.3%) HIV/AIDS testing activities, 18(13.9%) noted domestic violence prevention campaigns, 87(67.4%) distributing mosquito nets and 13(10%) immunization of children respectively.

4.3.6 Percentage of community members who have ever received VHT assistance

Figure 8: Respondents who have ever received assistance from VHTs



Source: Primary Data

Figure 8 shows that 90% of the respondents have ever received assistance from VHTs and only 10% have never.

4.3.7 Type of assistance received by Residents from VHTs

Table 3: Type of assistances received by residents from VHTs

	Frequency out of 129 residents	Percentages
Advice on child feeding	30	23.2
Family planning services	77	59.7
Nutrition services	35	27.1
Receiving deworming tablets	24	19.0
Child immunization	20	16.0
Provision of treated mosquito nets	25	19.3
Never received assistance	13	10.0

Source: Primary Data

Table 3 indicates that majority 77(59.7%) of the respondents have ever received family planning services from VHTs, 35(27.1%) stated nutrition services, 30(23.2%) noted advice on child

feeding, 25(19.3%) indicated provision of treated mosquito nets, 24(19%) received deworming tablets, 20(16%) indicated child immunization and 13(10%) have never received any assistance.

4.3.8 Health surveys carried out in the area

Table 4: Different health survey carried out in the area

	Frequency	Percentage
Nutrition survey	5	2.2
Family planning utilization in HIV/AIDS patients	8	3.5
Water and sanitation	35	15.4
Mosquito net usage survey	56	24.6
Child care welfare	1	0.4
Domestic violence rate in the area	5	2.2
Malaria prevalence in under 5 years	3	1.3
Do not know	114	50.2
Total	227	

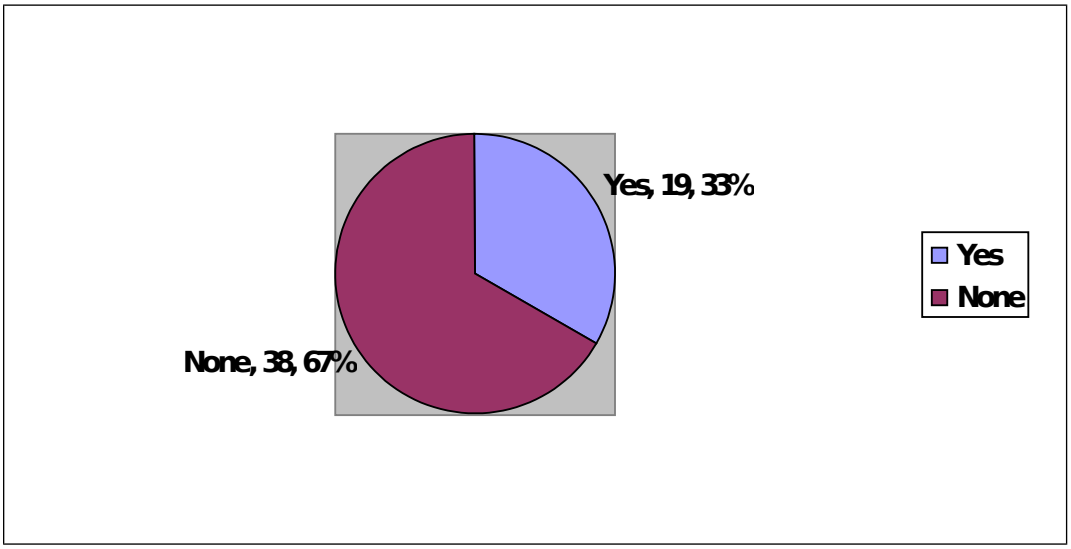
Source: Primary Data

Table 4 indicates 56(24.6%) of the respondents identified mosquito net usage as the most recognized survey that had ever been carried out, 35(15.4%) observed water and sanitation survey, 5(2.2%) noted nutrition survey in Ggaba and Salaama, 8(3.5%) family planning utilization in HIV/AIDS patients, 5(2.2%) domestic violence rate in the area, 3(1.3%) pointed out malaria prevalence in under 5 year respectively, and 114(50.2%) did not know.

4.4 Incentives among VHTs

4.4.1 Percentages of respondents who have ever received incentives

Figure 9: Percentage of VHTs (respondents) who have ever received incentives



Source: Primary Data

Figure 9 indicates that 19(33%) of the respondents agreed that they received incentives and 38(67%) did not receive.

4.4.2 Forms of incentives received by VHTs

Table 5: Kind of incentives received

	Frequency	Percent
Free medical care	08	14.0
Transport refund	11	19.2
Certificate of appreciation	11	19.2
Social recognition	10	17.5
Self-satisfaction for being useful; resource for village	12	21.0
Monetary incentives	05	8.80
Total	57	100.0

Source: Primary Data

Table 5 reveals that 5(8.8%) of the respondents indicated that monetary incentives are received, 10(17.5%) noted social recognition, 11(19.2%) indicated that they receive a transport refund after the meetings at the health centers, 11(19.2%) a certificate of appreciation, 8(14%) pointed out free medical care and 12(21 %) stated self-satisfaction for being useful and resourceful for the village.

4.4.3 Effect of incentives on VHTs performance

Table 6: Effect of incentives on VHTs performance

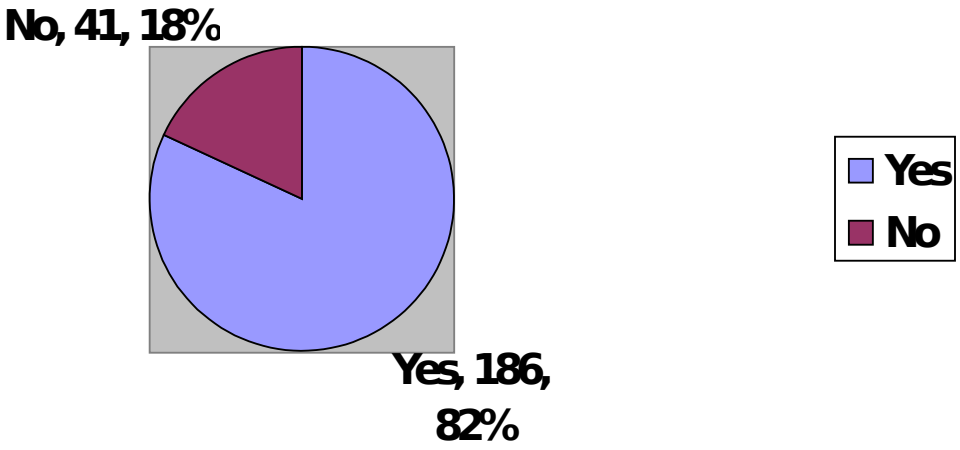
	Frequency	Percent
Serve as motivators for attraction and retention	24	42.1
They serve as performance appraisal	12	21.0
They increase the outreach area of operation	11	19.3
Increase awareness of VHTs operations in the area	10	17.5
Total	57	100.0

Source: Primary Data

Table 6 shows that 24(42.1%) acknowledged that incentives serve as motivators for attraction and retention of VHTs, 12(21%) state that they serve as rewards for good performance, 11(19.3%) agree that they increase the outreach area of their services, and 10(17.5%) state that they increase awareness of VHTs operations in the area.

4.4.4 Views to whether incentives helped improve on VHTs services in the area

Figure 10: Respondents' views on whether incentives availed have improved VHTs services in the area



Source: Primary Data

Figure 10 reveals that 41(18%) of the respondents stated that incentives supplied did not improve on the VHT services in the area and 186(82%) agreed that incentives improved on the VHT activities.

4.4.5 Reasons to why availed incentives have had less positive impact on VHT performance

Table 7: Reasons to why supplied incentives have not improved on VHT performance

	Frequency	Percent
Inconsistence with supply	19	33.3
Not evenly distributed	4.0	7.00
They are not adequate compared to the needs	15	26.3
The number of times reward incentives are given is unrealistic	8.0	14.0
Lack of transparent mechanisms for promotions and rewards	11	19.3
Total	57	100

Source: Primary Data

Table 7 indicates that 33% noted that there was inconsistence in supply of incentives to VHTs, 7% indicated that supplies are not evenly distributed, 26.3% recorded that incentives are not adequate compared to the needs, 14% state that the number of times incentives are given is unrealistic, and 19.3% state lack of transparent mechanisms for promotions and rewards.

4.5 Availability of supplies for VHT activities

4.5.1 Reaction of respondents on availability of supplies among VHT activities

Table 8: Respondents' reaction whether there is availability of supplies to VHT activities

		Frequency	Percent
Do you receive adequate supplies for service delivery	No	45	79.0
	Yes	12	21.0
	Total	57	100.0
Are the available supplies in line with the immediate needs of the community	No	14	24.6
	Yes	43	75.4
	Total	57	100.0
Is there continuous supply of resources	No	55	96.5
	Yes	02	3.50
	Total	57	100.0
The population outweigh the VHTs manpower	No	09	15.8
	Yes	48	84.2
	Total	57	100.0

Source: Primary Data

Table 8 reveals that 45(79%) of the respondents noted that they do not receive adequate supplies for service delivery and 21% do agree that they do receive adequate supplies, 75.4% agreed that indeed the available supplies are in line with the immediate needs of the community, 96.5% stated that there is no continuous supply of resources, and 84.2% noted that the population outweighs the VHTs manpower thus negatively affecting the performance of VHTs.

Likewise, Pick W (1995) postulated that poor performance by VHTs is associated with low accessibility and utilization of antenatal can, insufficient supply and distribution of supplements, inadequate training and motivation of health workers, insufficient and inappropriate counseling

of mothers, lack of motivation of mothers and failure of effective screening and referral procedures.

4.6 Support supervision on performance of VHTs on health promotion

4.6.1 VHT's views as to whether they receive support supervision for health promotion

Table 9: VHT's views on whether they receive support supervision

		Frequency	Percent
Do the health staff demonstrate any technical skills related health promotion	No	13	22.8
	Yes	44	77.2
	Total	57	100.0
Do the health staff help you to solve problems related to community health issues	No	17	29.8
	Yes	40	70.2
	Total	57	100.0
Do the health staff provide you the material needed to extend health services	No	45	78.9
	Yes	12	21.1
	Total	57	100.0
Do health staff supervise you regularly since you joined	No	50	87.7
	Yes	07	12.3
	Total	57	100.0
Government frequently supports/partner with VHTs	No	40	70.2
	Yes	17	29.8
	Total	57	100.0
Do you receive sufficient support	No	51	89.5
	Yes	6	10.5
	Total	57	100.0

Source: Primary Data

Table 9 indicates that 51(89.5%) of the respondents noted that they do not receive sufficient support, 50(87.7%) stated that health staff do not supervise them regularly, 44(77.2%) affirmed

that the health staff demonstrate technical skills related health promotion, 40(70.2%) noted that health staff help them to solve problems related to community health issues, still 45(78.9%) noted that health staff do not provide them with urgent materials needed to extend health services in the communities and 40(70.2%) state that government rarely supports VHTs activities to reach out to needy communities respectively.

4.6.2 Effect of insufficient support supervision on VHTs on health promotion

Table 10: Shows effects of insufficient support supervision on VHT activities

	Frequency	Percent
Demoralizes the VHTs	21	36.8
It limits service quality	18	31.6
Loss of direction in service delivery	6.0	10.5
Increases VHTs attrition rate	12	21.1
Total	57	100.0

Source: Primary Data

Table 10 shows that 21(36.8%) pointed out that insufficient support supervision demoralizes VHTs, 18(31.6%) affirmed that insufficient support limits service quality, 12(21.1%) of the respondents stated that insufficient support supervision increases VHTs attrition rate, and 6(10.5%) stressed that insufficient support leads to lose of direction in service delivery.

4.7 Performance of VHTs

4.7.1 Level of performance of VHTs on health promotion

Table 11: Respondents' level of agreement on the performance of VHTs

		Frequency	Percent
Service quality is not satisfactory	Disagree	52	22.9
	Undecided	73	32.2
	Agree	102	44.9
	Total	227	100.0
Sanitation of the area is still poor	Disagree	33	14.5
	Undecided	31	13.7
	Agree	163	71.8
	Total	227	100.0
There is disease control	Disagree	39	17.2
	Undecided	33	14.5
	Agree	155	68.3
	Total	227	100.0
Remarkable supply of free health services	Disagree	37	16.3
	Undecided	61	26.9
	Agree	129	56.8
	Total	227	100.0
Considerable reduction on mortality rate	Disagree	18	7.9
	Undecided	49	21.6
	Agree	160	70.5
	Total	227	100.0
There is time delay in responding to health issues	Disagree	32	14.1
	Undecided	62	27.3
	Agree	133	58.6
	Total	227	100.0
There is lack of resource materials and practitioners for advice and support with regard to specific challenges	Disagree	52	22.9
	Undecided	52	22.9
	Agree	123	54.2
	Total	227	100.0

Evidence for the performance of VHTs in health promotion can easily be found	Disagree	14	6.2
	Undecided	44	19.4
	Agree	169	74.4
	Total	227	100.0

Source: Primary Data

Scale

Below 50% indicates poor performance of VHTs and above 50% indicates good performance of VHTs in the area.

Above 50% indicates inadequate provision of incentives, supplies and support supervision

Table 11 indicates that 169(74.4%) of the respondents agreed that evidence for the performance of VHTs in health promotion can easily be found, 163(71.8%) agreed that sanitation of the area is still poor, 160(70.5%) agreed that there is a considerable reduction in mortality rate, 155(68.3%) agreed that there is disease control in the area, 133(58.6%) agreed that there is time delay in responding to health issues in the area, 129(56.8%) agreed that there is remarkable supply of free health services in the area, 123(54.2%) agreed that there is lack of resource materials and practitioners for advice and support with regard to specific challenges and 102(44.9%) agreed that service quality is not satisfactory.

One of the community members cited that there have been reduced cases of measles in the community due to the advice given to mothers to immunize their children.

4.8 Constraints/factors that hinder the performance of VHTs on promotion of health

Table 12: Shows factors that hinder the performance of VHTs on promotion of health

	Frequency out of 227	Percent
Reluctance of community members to get involved	98	43.2
Less time commitment	50	22.0
Heavy workload compared to VHTs	72	31.7
Communities' preference for curative services	25	11.0
Poor remuneration	116	51.1
Limited supply of required services	24	10.6
Transport constraints	22	9.7
Lack of male involvement in health promotion	18	7.9
Belief in witchcraft	14	6.1
Lack competent VHTs	47	20.7
Poor follow up measures	22	9.7

Source: Primary Data

Table 12 indicates that 98(43.2%) pointed out reluctance of community members to get involved, 50(22%) of respondents identified less time commitment by VHTs, 72(31.7%) identified heavy workload compared to VHT numbers, 25(11%) stated that communities prefer curative services to prevention measures, 116(51.1%) stated poor remuneration as a factor that negatively affects the performance of VHTs, 24(10.6%) agree to limited supplies that VHTs need to perform, 22(9.7%) recognized transport constraints, 18(7.9%) indicated lack of male involvement, 14(6.1%) state that people believe in witchcraft, 47(20.7%) cited the lack of

competency among VHTs to perform, and 22(9.7%) cited that there are poor follow up measures in place.

4.9 Interventions that can be taken to improve on VHT's performance

Table 13: Suggestions to mitigate the identified hindrances

	Frequency out of 227	Percent
Improve on transportation	84	37.0
Increase supplies needed by VHTs to facilitate services	104	45.8
Local government's involvement may be of significance	40	17.6
Men should be urged to get involved	37	16.3
Continuous training of VHTs	85	37.4
Have a place where VHTs can meet those in urgent need.	40	17.6

Source: Primary Data

Table 13 indicates that 104(45.8%) noted the need to improve on the supplies needed by VHTs to facilitate services, this was followed by a desire for continuous training of VHTs at 85(37.4%), 84(37%) of the respondents pointed out the need to improve on transportation of VHTs to respond promptly to the needs of the communities, 40(17.6%) cited the need to have a meeting place where VHTs can meet those with urgent needs, 40(17.6%) urge for the involvement of local government in supporting VHT activities and 37(16.3%) pointed out the need to urge men to get involved.

4.10 Health issues still dire in the area

Table 14: Shows some of unsolved health issues in the area

	Frequency out of 227	Percentages
Poor sanitation	97	42.7
Drainage system is poor	119	52.4
Malaria is still a health problem	85	37.4
Poor nutrition of household especially children	34	15.0
Teenage pregnancies	35	15.4
Drug and alcohol use	21	9.3
Air and water pollution	23	10.1

Source: Primary Data

Table 14 indicates the different health issues that are still dire in the area, 119(52.4%) of the respondents recognized poor drainage in the area, 85(37.4%) cited malaria as a health problem still affecting the area of study, 97(42.7%) indicated poor hygiene and sanitation, 34(15%) pointed out poor nutrition of household especially children, 21(9.3%) cited drug and alcohol use, 35(15.4%) cited teenage pregnancies, 23(10.1%) noted air and water pollution.

4.11 Relationship between variables

4.11.1 Table 15: Shows Chi-square test using bivariate analysis of Incentives and performance of VHTs

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Monte Carlo Sig. (2-sided)			Monte Carlo Sig. (1-sided)		
				Sig.	99% Confidence Interval		99% Confidence Interval		Sig.
					Lower Bound	Upper Bound	Lower Bound	Upper Bound	
Pearson Chi-Square	54.949[a]	4	.000	.000[b]	.000	.000			
Likelihood Ratio	65.804	4	.000	.000[b]	.000	.000			
Fisher's Exact Test	61.780			.000[b]	.000	.000			
Linear-by-Linear Association	16.983[c]	1	.000	.000[b]	.000	.000	.000	.000	.000[b]
N of Valid Cases	227								

a) 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.02.

b) Based on 10000 sampled tables with starting seed 957002199.

c) The standardized statistic is 4.121.

Following the chi square test the findings reveal a significant link between incentives on the performance of VHT services in promoting health issues in communities. The findings in table 15 reveal that the p=value is less than p=0.05 (p=.000<0.05) thus the null hypothesis is rejected. Therefore, it is concluded that provision of incentives has a significant influence on the effectiveness of VHTs on promoting health services.

4.11.2 Availability of supplies on the performance of VHT services in promoting health

Table 16: shows a chi-square test of availability of supplies and VHT performance

Chi-Square Tests

				Monte Carlo Sig. (2-sided)			Monte Carlo Sig. (1-sided)		
					99% Confidence Interval		99% Confidence Interval		
	Value	d.f	Asymp. Sig. (2-sided)	Sig.	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Sig.
Pearson Chi-Square	33.526[a]	4	.000	.000[b]	.000	.000			
Likelihood Ratio	41.234	4	.000	.000[b]	.000	.000			
Fisher's Exact Test	37.863			.000[b]	.000	.000			
Linear-by-Linear Association	11.130[c]	1	.001	.001[b]	.000	.001	.000	.001	.000[b]
N of Valid Cases	227								

a) 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.73.

b) Based on 10000 sampled tables with starting seed 726961337.

c) The standardized statistic is 3.336.

Following the chi square test, the findings indicate that there is a significant relationship between availability of supplies on the effectiveness of VHT services in promoting health issues in communities. The findings in table 17 reveal that the p=value is less than p=0.05 (p=.000<0.05) thus the null hypothesis is rejected. Therefore, it is concluded that availability of supplies has a significant influence on the effectiveness of VHTs on promoting health services.

4.11.3 Support supervision and performance of VHTs

Table 17: shows a chi-square test of availability of supplies and VHT performance

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Monte Carlo Sig. (2-sided)			Monte Carlo Sig. (1-sided)		
				Sig.	99% Confidence Interval		99% Confidence Interval		Sig.
					Lower Bound	Upper Bound	Lower Bound	Upper Bound	
Pearson Chi-Square	45.245[a]	4	.000	.000[b]	.000	.000			
Likelihood Ratio	55.350	4	.000	.000[b]	.000	.000			
Fisher's Exact Test	51.804			.000[b]	.000	.000			
Linear-by-Linear Association	21.584[c]	1	.000	.000[b]	.000	.000	.000	.000	.000[b]
N of Valid Cases	227								

a) 1 cell (11.1%) has expected count less than 5. The minimum expected count is 4.12.
b) Based on 10000 sampled tables with starting seed 754262874.
c) The standardized statistic is 4.646.

Basing on the chi square test the findings reveal that there is a positive relationship between support supervision and effectiveness of VHT services in promoting health issues in communities. The findings in table 17 reveal that the p=value is less than p=0.05 (p=.000<0.05) thus the null hypothesis is rejected. Therefore, it is concluded that availability of support supervision has a significant influence on the effectiveness of VHTs in promoting health services.

CHAPTER FIVE

DISCUSSION OF FINDINGS AND SUMMARY

5.1 Introduction

This chapter presents the discussion and summary of findings of the study in relation to the objectives of the thesis.

5.2 Discussion of finding and Summary

5.2.1 Demographic data

Findings in table 1 indicated that the majority 177(78%) of the respondents were female and only 50(22%) were the male respondents. This was also cited by Wainer (2004) who asserted that, in the majority of countries, women are the primary caregivers. This means, as women make up an increasingly large proportion of the health profession, it is important to consider the different needs of female health workers when developing incentives. VHT's have other jobs in addition to their role. They need flexible time to allow them perform their duties at home, and at their work place. There is need for an effective management in terms of incentives and supervision to initiate female oriented procedures and mechanisms.

5.2.2 Village Health Teams

Education of VHTs

Results in table 1 also show that 19(33%) of VHTs are diploma holders and 16 (28.2%) completed primary level. This is in agreement with Ministry of Health guidelines which state that VHTs should be literate.

It is widely acknowledged that health workers, as an integral part of health systems, are a critical element in improving health outcomes. The World Health Report 2006: "Working together for

Health" sounded the alarm that, without sufficient numbers of adequately trained and supported health workers; there is a significant risk of not attaining the health-related Millennium Development Goals (MDGs) (WHO, 2006). This implies that education and technical knowledge of VHTs is a crucial aspect that directly affects the quality of health services.

Accordingly, Dreesch et al. (2005) postulated that evaluations of disease-oriented programmes have found that the lack of appropriately trained and motivated health workers is one of the major bottlenecks in implementing evidence-based health interventions to improve maternal and child health, and to address HIV/AIDS, malaria and tuberculosis. The absence of well educated and properly managed health workers was also identified as one of the health systems constraints to achieve the MDGs, along with poor infrastructure, drugs and supply systems, and information systems (Travis et al., 2004).

Selection criteria of VHTs

Results in (Figure 3) reveals that 49(85%) of the respondents indicated that they were directly elected, 2(4%) through training and 6(11%) were voluntary involved.

According to WHO, VHTs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations (WHO 1990). Additionally, Witmer et al (1995) defined a VHT as community health workers stemming from community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to

adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs

Selection of VHTs is a critical factor on the success and performance of VHTs (Ofosu-Amaah, 1983). It is therefore stated that poor selection is the central reason for the continuous "turn-over of VHTs. Additionally, CARE (2002) noted that participatory selection of community workers before training was key to the success of community project. Thus selection criteria ought to be jointly developed and agreed upon between the community members, leaders and the NGO. In all aspects, the community must be given the final responsibility in selecting the VHTs. The sole reason for this is the fact that the sustainability and performance of community based activities is dependent on the level of community participation in the set activity.

Activities performed by VHTs

Table 2 indicates that VHTs perform a wide range of activities which include health sensitization, promoting sanitation and hygiene practices, distributing deworming tablets among others.

This is in agreement with Ofosu-Amaah (1983) who found that the VHTs are expected to perform a wide range of functions, which according to reports generally include: home visits, environmental sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, communicable disease control, community development activities, referrals, record-keeping, and collection of data on vital events.

It is also in agreement with the report from M.O.H that pointed out that VHTs and other community volunteers carry out the following interventions at community level, nutrition assessment of all age categories, carry growth monitoring promotions, counseling at the community level, referral of individuals needing medical attention, follow up of patients and sending reports to the health centers. Some VHTs assist in therapeutic feeding at health facilities and screening programs including outreach (M.O.H, 2009).

Channels of communication used by VHTs to deliver health promotion messages

Figure 4 indicate that VHTs adopted different channels among which 20% of the respondents indicated that entertainment means and community meetings were the most used channels for health promotion; this is in support with World Health Organization (WHO) and the Pan American Health Organization (PAHO) that noted, that local and international NGOs, ministries, and other organizations engaged in health communication work, increasingly rely on entertainment-based strategies to promote healthy life styles and behaviors. One of the key vehicles of these health communication campaigns is television drama, particularly soap operas.

Additionally, studies by Signorielli (1993) and Montgomery (1990) revealed that today's citizens are increasingly more exposed to health information through mass media than they are to health information from visits to doctors or health professionals. In many cases, individuals might be exposed to certain health issues only via mass media (Wahl, 1995). A study conducted by Signorielli (1990) revealed that for every person who got their information from a physician, 25 got it from the media (Atkin and Wallack, 1990).

Type of assistance received by residents from VHTs

Table 3 indicates that residents receive assistance from VHTs in form of family planning services, advice on child feeding and nutrition, child immunization and mosquito nets.

These findings are supported by Engle et al. (2000) who stated that, community-based programs under many circumstances provide this crucial contact. Their role is partly in improving access to technology and resources, but it is also important in fostering behavior change and, more generally, in supporting caring practices (UNICEF 1990). Such programs also play a part in mobilizing social demand for services and in generating pressure for policy change.

Additionally, in community-based programs, VHTs interact with households to protect their health and nutrition and to facilitate access to treatment of sickness. Commonly, VHTs go regularly to a central point in their community for example, for growth monitoring and promotion or are visited at home by a health and nutrition worker.

5.2.3 Incentives on the performance of VHTs towards promoting health services in the area

The findings of the chi square test reveal that there is a significant relationship between incentives on the performance of VHTs in health promotion.

This is in line with the findings of W.H.O (2004) which stress that all workers require adequate facilities and conditions to do their jobs properly. While most evidence is anecdotal, the benefits of improving working and living conditions appear to be significant. It is generally understood that health workers value working conditions that include appropriate infrastructure, water, sanitation, lighting, drugs, equipment, supplies, communications and transportation. Hence, a range of non-financial incentives are needed to complete a package that can attract VHTs –

especially to rural and remote areas – and encourage them to stay in the workforce. Among these they include the broad categories of improved working and living conditions, continuing education, training and professional development, improved supervision and management, and gender-sensitive considerations.

Also table 6 confirms that there is a positive relationship between incentives and VHT performance on promotion of health services, the study indicated that both monetary and non monetary incentives are instrumental in terms of motivating and facilitating VHTs activities. This is in agreement with the study done by Bhattacharyya et al. (2001) who noted that monetary incentives can increase retention. VHTs are poor people trying to support their families. However, he reveals that monetary incentives often bring a host of problems because the money may not be enough, may not be paid regularly, or may stop altogether. Monetary incentives may also cause problems among different cadres of development workers who are paid and not paid. However, there are some success stories of programmes paying CHWs. Many programmes have used in-kind incentives effectively; this was revealed by Bhattacharyya et al. (2001) who argued that, non-monetary incentives are critical to the success of any VHT programme. CHWs need to feel that they are a part of the health system through support supervision and appropriate training. Relatively small things, such as an identification badge, can provide a sense of pride in their work and increased status in their communities. Appropriate job aides such as counseling cards and regular replenishment of supplies can help ensure that CHWs feel competent to do their jobs.

In addition, it is also argued that peer support as working regularly with one or two other VHTs, frequent refresher training, or even VHTs associations serve as indirect incentives that have positive effect on VHTs performance. In the end, the performance of VHTs comes down to VHTs' relationships with the community. Programmes must do everything they can to strengthen and support this relationship.

First, programme planners must recognize the social complexity of communities and that communities are not all alike. Different communities will need different types of incentives, depending on the other job opportunities available, prior experience with VHTs, the economic situation of the community, and other factors. This is the reason why the findings in figure 10 revealed that 18% of the respondents stated that incentives supplied did not improve on the VHT services in the area and 82% agreed that incentives improved on the VHT activities.

In relation to the above, the study is in line with Chen et al. (2004) who stated that low salaries, poor working conditions, weak support and supervision, and limited opportunities for professional development is associated to poor VHT outcomes. This is especially so in rural and remote areas where the provision of services is difficult because of limited health budgets and scattered populations living in isolated villages or islands. Thus, improved salaries and benefits are major financial incentives for VHTs to remain in the health sector (WHO, 2004).

Therefore, Amare (2009) recommended that in order to stir up VHT motivation there is need to involve and train leaders of community anchors such as idirs [burial associations], churches, mosques, youth and women's associations as well as kebele [community associations] leaders, to

support and motivate CHWs in ways appropriate to their special attributes. They can do so by promoting VHTs and recognizing their work through providing morale support to VHTs, promoting better health practices and providing a forum for VHTs and facilitating and following up in the implementation of health practices promoted by VHTs.

According to study findings in table 6, it was found that 19.3% of the respondents acknowledged that incentives increase the outreach area of their services; this is supported by Walker and Jan (2005) who stated that VHTs increase the coverage and equity of health service delivery compared with alternative modes of service organization. But most studies, while useful and necessary for decision-making, leave out key elements of VHT programmes such as altruism, volunteerism, community norms, reciprocity and duty; these tend not to be reflected well in estimates of cost effectiveness.

Still under incentives on VHTs performance, the study revealed that 42.1% of the respondents noted that incentives serve as motivators for attraction and retention of VHTs. This is agreement with Bhattacharyya et al. (2001) who cited that attrition rates for CHWs was attributed to multiple causes especially to inadequate pay.

The findings in table 7 revealed that there was lack of transparent mechanisms for promotions and rewards, 7% noted that incentives are not evenly distributed which infringes on VHT services, 14% found that the number of times reward incentives are given is unrealistic, 33.3% noted that there was inconsistency in supply of incentives to VHTs and 26.3% stated that they are not adequate compared to the needs. This finding are in support with Janssen (2004) who held that workers with positive attitudes would devote more efforts in their work, and if their organizations rewarded them fairly in the exchange process, they are likely to continue investing

their skills, time, and efforts. This ultimately translates to higher levels of retention. In essence, the social exchange theory implies that positive attitudes as a result of fair rewards by firms enhance workers' willingness to stay in service for longer duration. Therefore incentives are a key factor on the performance of VHTs in health promotion activities.

Reasons to why supplied incentives have not improved on VHT performance

Table 8 indicate that the reason why supplied incentives have not improved VHT performance is due to inconsistency in supply, inadequate supplies compared to the need, lack of transparent mechanisms for promotions and rewards and the number of times rewards are given.

These results are supported by Dieleman et al. (2003) who argued that transparent mechanisms for promotions and rewards is positively associated with performance of VHTs if the essence of incentives is to be felt by VHTs. A study carried out in Vietnam, revealed that rural health workers demonstrated that those seeking to upgrade their skills through training for a diploma or certificate did not understand the criteria for the selection of candidates and therefore felt that the process was arbitrary. Whereas in Nepal, health workers in rural areas were critical of a policy that offered the potential for sponsored higher education abroad but did not link these opportunities to performance (Ferrinho et al, 2004). Better information, communication, job descriptions, accountability and criteria for rewards could increase transparency and health worker motivation.

5.2.4 Availability of supplies on performance of VHTs towards promoting health services in the area

The chi square test findings indicate that there is a significant relationship between availability of supplies on the performance of VHTs.

According to W.H.O, (2004) the provision of essential supplies and specialized training is significant for the promotion of health services. Resources are limited and training opportunities are scarce. A way of improving training opportunities, which was suggested by the WHO migration study, involves using open learning courses to provide updated knowledge to medical staff. Findings from Fiji suggest that this would alleviate the need for doctors to travel overseas to study, making it less likely to 'lose' them as a result of a combination of favorable overseas experiences and a lack of job satisfaction at home.

Caldwell and Caldwell (2002) contended that availability of a range of supplies is of paramount importance in determining the effectiveness of services. Therefore, expansion in the availability of supplies makes accessibility of these services affordable.

There is indeed a positive correlation between the availability of supplies and better health outcomes, as well as increased coverage of essential health interventions. These correlations have been demonstrated in a number of cross-country ecological analyses (Anand and Barnighausen, 2007). The current system of health services and settings is often poorly equipped to meet the diverse acute and preventive health needs of communities (Lawrence, 2009). Although there is urgent need for health services, many people remain underserved due to limited supplies needed to meet the high demand hence limiting the performance of VHTs. It

should also be noted that, not only is there lack of equipment but also the supply of competent VHTs to meet the ever increasing demand for health care.

This is in accordance with the World Health Report 2006, which estimated that the world lacks about 4 million health workers, if a minimum level of health outcomes is to be achieved (W.H.O 2006). The report identified 57 'crisis' countries as being the most affected by this dearth in health personnel, predominantly in Sub-Saharan Africa and Asia. Such shortages are symptoms of a poorly managed health workforce and health care system. The causes of the crisis are complex, and have to do with insufficient production capacity, but also with an inability to keep the workers that are being produced in the places where they are most needed. Therefore, because of the complex web of factors that influences the mobility of health workers, any efforts to scale up the health workforce in response to the crisis must be combined with effective measures to attract and maintain both existing and newly trained health workers where they are needed most. Notably, in the majority of countries, rural and remote areas are usually lacking sufficient numbers of health workers. Approximately one half of the global population lives in rural areas, but these areas are served by only 38% of the total nursing workforce and by less than a quarter of the total physicians' workforce.

5.2.5 Support supervision on performance of VHTs towards promoting health services in the area

The chi square test finding indicated that there is a positive relationship between support supervision and performance of VHTs, thus rejecting the null hypothesis.

This finding is in line with Holland and Adams (2002:228) who pointed out that the right supervision supports professional development, enhances personal and collaborative enquiry, promotes critique, and helps people learn. To this, Acheson and Gail (2003) highlighted that supervision is not autocratic but collaborative and interactive. Furthermore it is not directive but democratic. It is also more teacher-centered rather than being an authoritative supervisor-centered activity. Dieleman (2003) puts it aptly when he stresses that the supervisor can be seen as "a teacher of teachers". Thus, Sachs (2003) observed that health workers are engaged in a wide variety of tasks which are additional to face-to-face teaching. Systems appear to be demanding more and more of VHTs. These extra duties include: health pedagogy design and development; planning; marketing and community relations. Further still, Young (1998) claims that morale is often influenced more by outside factors than internal ones. Rogers (1992) identifies both internal and external factors as influencing morale, highlighting 'pace of bureaucratic change; discipline and management concerns; staff and staff relations; time and workload pressures' as the most common stressors for VHTs.

Therefore, the significance of supervision is based on the notion that support supervision which enhances professional development opportunities encourage VHTs to engage in critical thinking about current ways of teaching, develop new approaches, and evaluate how new interventions that affect service quality (Kelleher, 2003). Effective professional development changes VHTs' values, beliefs, and practices in order to positively impact health promotion (McDonald, 2009; Desimone et al. 2006). However, professional development should not be held in the traditional division-sponsored or one-day workshop manner because that type of professional development focuses on transmitting knowledge to VHTs rather than VHTs constructing and internalizing

knowledge (McDonald, 2009). Therefore, effective professional development for improving VHT's performance encompasses long-term commitment, reflective practice and collaboration in order to change health practices (McDondald, 2009; Stronge, 2002).

W.H.O (2006) postulated that good supervision and management should include adequate technical support and feedback, recognition of achievements, good communication, clear roles and responsibilities, norms and codes of conduct which are critical to the performance of the health system and the quality of care. Weak support supervision and management have been identified as factors in job dissatisfaction in many countries, in this case among VHTs in Uganda (WHO, 2004).

According to findings of this study in table 10 revealed that 50% of the respondents noted that they do not receive regular supervision from health staff. This in line with Ofosu-Amaah (1983) and Bhattacharyya et al (2001) who asserted that the success of VHT programmes hinges on regular and reliable support and supervision. It is equally acknowledged, however, that supervision is often among the weakest links in CHW programmes in the nation.

W.H.O (1990) reported weakness of support supervision in VHTs' activities, which are often irregular or nonexistent, and it accounts for poor service delivery among VHTs. It is further noted that in the worst cases, VHTs do not even know who their supervisors are or what they can expect from them (Gray and Ciroma, 1988). Gilson et al. (1989) pointed out that often the need for supervision has been either overlooked or underestimated, or not adequately planned for. Also the supervisor's knowledge of what their tasks are is often ill-defined. Ofosu-Amaah (1983)

revealed that supervision is often left mostly to staff (mainly nurses) in the health services instead of community participation in supervision since in most cases community supervision has recorded multiple successes. They, however, may not understand the CHWs' or their own role properly and furthermore may resent the additional task (Gilson et al., 1989). Most importantly, however, the greatest need for supervision exists in the most remote areas, where health services are most overstretched and ill-equipped.

In accordance with the study findings, 45% of the respondents noted that health staff do not provide them with urgent materials needed to extend health services in the communities and government rarely supports VHTs activities to reach out to needy communities respectively. This was echoed by Stinson et al. (1998) who found that, although supervision is often identified as the vehicle through which the quality of health care services can be assured, it typically receives neither the human nor financial support needed to fully conduct and sustain the necessary supervisory activities. In the current decentralization of health services management occurring in many countries, full responsibility for the supervision of facility and community health workers has been shifted to area and district levels, often without providing the training and resources needed to undertake supervisory functions.

Furthermore, the activities with which supervisors are charged are often poorly defined. Health care systems have a wide range of options in developing a locally appropriate and sustainable supervision strategy at the primary level. Key issues are who supervises and how often, and the use of supervisory job aids in measuring the quality of care.

Accordingly, the study in table 10 revealed that insufficient support increases the VHT's attrition rate; this is in agreement with Charleston (1994) in their study of the impact of a nutrition intervention on a CHW programme. They found that continuous supervision diminishes the sense of isolation that VHTs usually experience in the field and helps to sustain their interest and motivation to do their assigned tasks (Charleston, Johnson & Tam, 1994).

Further still, 31.6% of the respondents affirmed that insufficient support limits service quality, 36.8% pointed out that insufficient support demoralizes VHTs and 10.5% stressed that insufficient support leads to loss of direction in service delivery. This in light with Gilson et al. (1989) who noted that support supervision work hand in hand with other forms of support, in particular logistics and infrastructure support. Issues such as the reliable provision of transport, drug supplies and equipment have been identified as another weak link in VHTs performance. Reasons can again be found in the fact that VHTs as a rule operate on the periphery, both organizationally and geographically. They are the first to lose training opportunities and supervisory visits, but also transport and drug supplies (Gilson et al., 1989). The result is not only that they cannot do their job properly, but also that their standing in communities is undermined. Failure to meet the expectations of these populations destroys the credibility of the VHTs (Ofosu-Amaah, 1983). If CHWs are used in programmes that have drug treatment at their core, the situation becomes more critical (Farmer et al., 2001), but most programmes include the need for supply of drugs and/or equipment, including transport (SOCHARA, 2005).

Also lack of support system in the health sector negatively affects outcomes. For instance Bhattacharyya.K, et al, (2001) noted that training is a means of supervision. It is well established and accepted that careful and regular supervision impacts profoundly on the quality of service

delivery. Without supervision, staff easily feel unappreciated and insecure, particularly in the implementation of new policies and treatment regimes.

This sense of insecurity and lack of appreciation may in turn lead to disenchantment with, and resistance to, the transformation process in the health sector and hence render the health service insufficient. Yet despite overwhelming agreement on its importance, support and regular supervision remains one of the weakest aspects in health sector. It is imperative that both national and local government health departments explore mechanisms to improve supervision, particularly of staff working at lower levels of the service and in rural areas. This requires skills development of supervisors, but also the incorporation of supervisory duties into the contracts and workloads of professionals employed at different levels of the service (including in provincial and regional tertiary and secondary level facilities). While nurses in primary care facilities must be obliged and enabled to accompany CHWs on their rounds in communities, professionals working in management, academic institutions and hospitals might in their performance agreements be required to spend part of their time supporting and supervising nurses and managers in clinics, sub-districts and districts.

Amongst the 22 recommendations issued in its Task Shifting Guidelines, the WHO proposed that: “Countries should define the roles and the associated competency levels required both for existing cadres ‘VHTs’ that are extending their scope of practice, and for those cadres that are being newly created under the task shifting approach”. These standards should be the basis for establishing recruitment, training and evaluation criteria (WHO, 2008). Support supervision and clinical mentoring should be regularly provided to all health workers within the structure and functions of health teams. Individuals who are tasked with providing support supervision or

clinical mentoring to health workers to whom tasks are being shifted should themselves be competent and have appropriate supervisory skills in this way, the performance of VHT can be enhanced (WHO, 2008).

Additionally, WHO pointed out that countries need to recognize that essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short term or part time basis, trained health workers who are providing essential health services, including community health workers, should receive adequate wages and / or other appropriate and commensurate incentives (WHO, 2008).

Factors that hinder the performance of VHTs in health promotion

Table 12 indicates that among the factors that hinder the performance of VHTs is reluctance of community members to get involved, less time committed to VHT activities, lack of men's involvement and transport constraints among others

Similarly WHO, (2006) noted that dramatic inequities, but also insufficient absolute numbers of health personnel, have been identified as one of the key impediments in the improvement of health systems performance worldwide. The 2006 World Health Report puts the global shortage of health workers at 4.3 million. The lack of skills is aggravated by insufficient supervision, particularly in rural areas where community service VHTs finds themselves as the only doctors in health facilities. Not only do they find themselves often not knowing what to do, but also not knowing who to ask for assistance (Reid S, 2003).

Also the study reveal attitudes as serious hindrance to the quality of health promotion as it was noted by Gilson et al., (1989) who stated the attitudes and interactions of health personnel in the formal health services with CHWs have an immediate impact on critical aspects of CHW

programme management, such as selection, continuing training and supervision. In many cases these interactions have been affected by how programmes have been introduced. CHW programmes have commonly been advocated by enthusiasts with local experience, who persuade policy-makers to scale up initiatives and implement programmes on a large scale. This has frequently resulted in the implementation of inadequately thought-through schemes without the full participation of health personnel at the local level. In many programmes, the VHTs are usually not involved in the planning, implementation, monitoring and evaluation of such programmes which make them lend little support to these initiatives.

Among the measures suggested to improve VHT performance include improvement on transportation, local government's involvement, continuous training of VHTs and encouraging men to get involved.

In the same vein Moore et al. (2007) asserted that the use of mid-level health workers plays an important role in VHT health promotion, as it widens access and coverage, and ensures service delivery in areas, which are otherwise severely underserved. International experience suggests that mid-level workers, if properly trained and supported, can render health care within their scope of practice, which is of equal or better quality than that rendered by health professionals.

Likewise, the training of mid-level and community-based cadres requires acceleration and standardization. If VHTs associates are to substantially strengthen staffing in community health programs in the near future, numbers of trainees should be substantially increased and their training and deployment carefully monitored. The training of CHWs remains wholly unsatisfactory. While certain minimum standards have been set in the policy, these are not being met. Regional health departments should ensure that staffing, resources and infrastructure for the

compulsory training of all CHWs are available, and that training is conducted as well as monitored regularly and reliably Steinlechner et al, (2006).

Health issues still dire in the area

Among the health issues still dire in the area include poor sanitation and drainage, malaria, teenage pregnancies, poor nutrition, and drug and alcohol abuse.

The findings are in line with the 1997 Kampala Declaration on Sanitation (KDS) guides that found that the promotion of hygiene and sanitation in Uganda is still poor, for example national latrine coverage is at 62.4% and this is below the target of 70% at the end of HSSP II. The situation is worse in some districts such as Abim, Kabong, Kotido Nakapiripirit and other rural and slum areas, where latrine coverage is less than 10%, and housing conditions are also poor with three quarters of the households having floors made of earth, sand or dung. Only 14% of the persons wash hands with soap against a target of 70%. Overall during the HSSP II period there was a decrease in the incidence of diarrhoeal diseases. The annual incidence of cholera fell from 15/100,000 in 2005 to 3/100,000 in 2009 and that of dysentery decreased from 288/100,000 in 2005 to 254/100,000 in 2009. There was also a decrease in case fatality rate of diarrhoeal diseases. Cholera Case Fatality Rate (CFR) fell from 2.5% in 2005 to 2.1% in 2009; dysentery CFR fell from 0.11% in 2005 to 0.08% in 2009; and acute watery diarrhoea Case Fatality Rate fell from 1.2% in 2006 to 0.9% in 2009; but persistent diarrhoea CFR increased from 0.7% to 1.3%. Inadequate resources, high levels of poverty, inadequate awareness, poor enforcement of public health bye-laws and cultural factors in some regions (e.g. in Karamoja) are major challenges that have affected the implementation of environmental health programmes.

In brief, the study is in agreement with earlier findings that revealed that the health conditions in Uganda are still bad. And these can partly be attributed to the poor incentive packages, limited availability of supplies and weak support supervision system (Ministry of Health, 2009).

5.2.6 Relationship between incentives, availability of supplies and support supervision on performance of VHTs on health promotion

A chi square was run and results revealed that there was a positive association between incentives, availability of supplies and support supervision on performance of VHTs in health promotion. These findings are supported by the study of CARE (2002) that sustainability of the community based workers is not only dependent on the provision of financial and other resources, but equally on effective and good supervision. These two are almost equally expensive, yet critical.

It is stated that the operational environment has many different actors, with different cultures and approaches, and should be streamlined to avoid creation of too much dependence, or occasions where communities hold projects at ransom for salaries and other material benefits. For sustainability, community action plans generated at village/parish levels for improved health are directly related to adopted incentives, availability of supplies and support supervision; in line with community participation and leadership and other funding or service providing partners for implementation rather than only to the mother organization (CARE, 2002).

In the similar vein, Fowler (1996) suggested that supervision provided on an individual basis aims to enable the supervisee to do the job better, and to provide informed, enhancing interactions, such as professional support, role development, improving confidence, intra- and

inter-professional networking and improved job control and satisfaction with a view to improving students' outcomes.

CHAPTER SIX

CONCLUSIONS, RECOMMENDATIONS AND AREA FOR FURTHER STUDIES

6.1 Conclusion

In conclusion, the study has found the significance of VHTs in promoting health practices to be positive. Results have substantially revealed that in the presence of well facilitated VHTs, the health conditions of Makindye Division can be actualized. This implies that the performance of VHT activities is dependent on the adopted incentives, availability of supplies and support supervision. Once these aspects are well managed and channeled to VHTs then the levels of health conditions will be realized.

Hence, results suggest that there should be comprehensive management strategies in terms of incentives to increase recognition and social acceptance of VHTs so as to increase job satisfaction and motivation. Following a study of rural health workers in northern Vietnam, it was revealed that appreciation by supervisors, colleagues and the community was a major motivator (Dieleman et al. 2003). This finding asserts the importance of incentives on VHT activities from within and out. The lack of positive feedbacks when the VHTs performed well negatively affected the health outcomes of VHTs.

In addition, the study has revealed that the lack of adequate and regular supply of key inputs or facilitates negatively affected VHT's performance; it slows the progress of accessing the neediest people in remote areas. Likewise, the significance of support supervision has also been established to be positively associated with the performance of VHT activities.

On the other hand the study found that women were the main participants in VHT activities compared to their counterpart the men. Also it is widely presumed that the reluctance of men to be involved in VHTs negatively impacted the performance of the health practices. In short, incentive packages are used as a means to attract, retain and motivate VHTs; thus they should be embedded in comprehensive workforce planning and development strategies. Availing supplies needed by VHTs is essential for the sustainability of health projects; and lastly, encouraging support supervision is of great significance in terms of enhancing technical skills, motivating and keeping the VHTs positively committed to the advancement of health promotion.

An effective management system needs to have the capacity to regularly assess the performance of VHTs and the engagement of well-trained health workers in the supervision of VHTs. While this may be difficult in rural and remote areas where supervision and management are weak, simplified systems can be developed, drawing on health workers themselves to assist in designing a system

6.2 Recommendations

Based on the study findings, the researcher suggests that in order to ensure sustainability and good performance of VHTs, it would be worthwhile to improve on incentives given to VHTs especially transport refund in order for them to respond promptly to the local needs.

There is also need to improve on the supply of services offered to the communities through VHTs. The services need to be consistent and based on locally relevant priorities and issues identified by various community representatives.

There is need for continuous supervision and training of VHTs and their supervisors especially in the area of record keeping and report making. The community members can be involved in the supervision and monitoring of VHT activities in the areas.

These recommendations are derived from the fact that community members are the main stakeholders that can positively and constructively support the success of VHT activities in terms of incentives, supplying simple but sound inputs and offering support supervision on the activities carried out by VHTs. Hence community-based monitoring involves drawing in, activating, motivating, capacity building and allowing the community and its representatives for example community based organizations (CBOs), people's movements, and voluntary organizations to directly give feedback about the functioning of VHT health services. The community monitoring process involves a three-way partnership between health care supervisors and providers (health system); the community, community-based organizations. The emphasis is based on the developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding. Garg and Laskar., (2009).

6.3 Area of further studies

Basing on the investigation, the researcher suggests that there should be a further study in examining the prevalence of attrition among VHTs in Makindye Division. The rationale of this gesture is the fact that attrition of VHTs negatively affects the health sector in the area, since

VHT's activities are said to be associated with wide service coverage when supported with local and national institutions.

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APPENDIX I

QUESTIONNAIRE

Introduction

VHTs – 65

Residents - 129

Dear respondent, I am a student of International Health Sciences University offering a Master's Degree in Public Health carrying out a study on the **factors influencing the effectiveness of Village health teams (VHTs) in health promotion**. Kindly fill in this Questionnaire. All information provided will be for purely academic purposes and will be treated with the utmost confidentiality. Tick appropriately.

SECTION A: DEMOGRAPHIC DATA (Please tick your most appropriate answer)

1) **Sex: What is your gender**?

Male ☐ Female ☐

2) **Duration: For how long have you been serving in this organization?**

1-3 years ☐ 4-6 years ☐ 7 & above ☐

3) **Position: What position do you hold?**

……..

4) **Education: Please indicate your level of education:**

O-level ☐ A-level ☐ Undergraduate ☐ postgraduate ☐

5) How were you selected to be a VHT

Elected Volunteered others specify

6) Residence: Where do you reside?

7) Years: For how long have you been in this area?

Less than 5 6-11 12-17 18-23 24-29

30 & above

8) Marital Status: Married Single Separated Widower Widow

PUBLIC HEALTH ISSUES

What are the health concerns in your area?
In what ways have the members of this community taken responsibility for their own health?
Are you aware of VHT?
When did you start hearing about VHT activities in your area?
What are the activities of VHTs in promotion of health in your area?
What health surveys have been done in your area?

Do you have a record of all VHTs in your area?
Do you hold meetings with VHTs in your area?
Yes No
If yes, how many meetings have you held in last quarter?
How many VHTs are still in operation in the division?
In your opinion, have VHT activities contributed to health promotion of your area?
What factors have hindered effective health promotion by VHTs?
In your opinion, how can VHTs bring about effective health promotion?

Level of incentives that influence VHT effectiveness in Health promotion

	As a VHT, do you receive any kind of incentives?		
	If, yes, what are they? (You can specify more than one) Free medical care Per-diem received at the meeting in health centre Certificate of appreciation Social recognition Self-satisfaction for being useful resource for the village Bicycles, Radios		
	Do you satisfy with those incentives?		

Availability of supplies on the effectiveness of VHT in health promotion

	Do you receive adequate supplies for service delivery		
	Are the available supplies in line with the immediate needs of the community		
	Is there continuous supply of supplies		
	In your opinion does the population outweigh the VHTs manpower		
	Are the supplies evenly distributed among populations		

Level of support supervision/training on effectiveness of VHT in health promotion

	Do the health staff encourage/motivate you to do the activities		
	Do the health staff demonstrate any technical skills related health promotion when they supervise		
	Do the health staffs help you to organize and plan your work?		
	Do the health staffs help you to solve the problems related to….activities		
	Do the health staffs provide you the material needed to extend health services		
	Do health staff supervise you regularly since you joined		
	Supportive organization frequently partner with VHTs		

Level of effectiveness of VHTs services in promotion of health

	Service quality is satisfactory		
	Sanitation of the area is promising		
	There is disease control		
	Remarkable supply of free services		
	Control of infant maternity rate		
	Timely response to health issue in the area		
	Resource materials and conceptual tools are available for wide range of health promotion strategies, initiatives and processes		
	Networks of researcher and practitioners are available for advice and support with regard to specific challenges		
	Evidence for the effectiveness of heath promotion can easily be found		
	Stimulating and innovative ideas about promoting health are widely accessible		

Constraints that hinder the effectiveness of VHTs

	What constraints can you identify that hinder the effectiveness of VHTs? Reluctance community Involvement, Uniform selection criteria and process Time commitment Workload, Communities' preference for curative services, Remuneration Limited supply of required services Transport constraints Incentives (continuity, source, uniformity), Prospect for career advancement High attrition rates etc Poor follow up measures		

What can be done to enhance VHT effectiveness in health promotion?

	Improve on transport means		
	Facilitate VHTs with required equipments needed to deliver		
	Local government's involvement in VHT activities		
	Men's involvement		
	Continuous training of VHTs		
	Stationed offices where VHTs can carry out their activities		

Role of VHTs

	Health training		
	Offering counseling about HIV/AIDS among others		
	Distribution of deworming tablets		
	Distribution of household items to needy people		
	Referring the sick to health facilities		
	Home visits		
	Record keeping of health information regarding visited homes		

APPENDIX II

Where do you reside

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Kisenego (Kawuku)	17	7.5	7.5	7.5
	Buziga	10	4.4	4.4	11.9
	Njambi	2	.9	.9	12.8
	Wabigalo	2	.9	.9	13.7
	Ggaba	7	3.1	3.1	17.2
	Kawaala	2	.9	.9	18.1
	Katwe	1	.4	.4	18.5
	Luwafu	5	2.2	2.2	20.7
	Kabalagala	1	.4	.4	21.1
	Nsambya Estate	4	1.8	1.8	22.9
	Kisugu Health Centre	2	.9	.9	23.8
	Salaama kruddu	1	.4	.4	24.2
	Masaja Kulekona	1	.4	.4	24.7
	Bunga	32	14.1	14.1	38.8
	Ggaba Trading	5	2.2	2.2	41.0
	Nsambya Central	2	.9	.9	41.9
	kibuye I	2	.9	.9	42.7
	Kyamula Salaama	6	2.6	2.6	45.4
	Lower Kawuku	24	10.6	10.6	55.9
	Katoogo	1	.4	.4	56.4
	Ggaba Water LC1	1	.4	.4	56.8
	Buziga Salaama	2	.9	.9	57.7
	Luwafu Salaama	1	.4	.4	58.1
	Iwase Stage	2	.9	.9	59.0
	Kibuli	1	.4	.4	59.5
	Bbunga T	2	.9	.9	60.4
	Butambala	1	.4	.4	60.8
	Upper Kawuku	18	7.9	7.9	68.7