CONTRIBUTIONS MADE BY TRAINED VILLAGE HEALTH TEAM MEMBERS IN THE PROVISION OF INJECTABLE FAMILY PLANNING METHODS IN APAC DISTRICT

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REG. NO. 2015-M271-10003

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A POSTGRADUATE RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF HEALTH SCIENCES UGANDA MARTYRS UNIVERSITY, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER IN PUBLIC HEALTH, POPULATION AND REPRODUCTIVE OF HEALTH OF

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This work is dedicated to my dear sister Mrs Lillian Akono for the role she has been playing as a mother substitute to me. Thank you for the great care you offered to me since I was a child up to now. Thank you too for extending that care and love to my children. May God bless you abundantly.

I also want to dedicate this work to my lovely sister/ mother Mrs Sophie Opio for the wonderful work she has done in my life. She played a very important role in my life by upbringing and a motherly care for since childhood up to now.

I also dedicate to my four boys Amos, Haggai, Promise and Jeremiah together with their father Okwel Tom and our family friend Mr Bwonyo Patrick and his family.

Lastly I wish to dedicate this work to Population and Reproductive health students 2015 – 2016.

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Search terms

I. Contributions made by village health teams in provision of injectable family planning methods.

II. Accessibility of injectable family planning services provided by village health teams at the grass root level.

III. Quality of injectable family planning services provided by the VHTs.

IV. Perception of communities about the services provided by the VHTs at the grassroots level.

V. Challenges faced by the district health managers in supervising/working with the VHTs in provision of injectable FP methods.

VI. Expanding Access to Family Planning Services at the Community Level.

VII. Challenges face by VHTs while providing injectable FP methods.

VIII. Family planning and the village health teams

IX. Strategies to overcome challenges faced by VHTs in provision of injectable FP methods.

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OPERATIONAL DEFINITIONS

Accessibility

Access to comprehensive, quality health care services which is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It focuses on four components of access to care: coverage, services, timeliness, and workforce(Millman, 2010).

Universal health coverage is when people actually obtain the necessary and required health services they need.

Access is the opportunity or ability to do both of these things. Hence, universal health coverage is not possible without universal access, but the two are not the same(Boerma et al., 2015).

Community Based Distributors:

These are usually village women and men who are trained to educate their neighbors about family planning and to distribute certain contraceptives methods; they also provide some primary health care services.

Community Health Worker is a frontline public health worker who is a trusted member of or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (Association, 2017).

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her

pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.(WHO, 2015).

Reproductive Health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and process.

Village Health Team is a non-statutory community (village) structure selected by the people themselves to manage all matters related to health and crosscutting issues. The Village Health Teams are chosen by their own communities to promote health and wellbeing of all village members (MOH, UGANDA, 2015).

Unmet need for family planning is the percentage of women of reproductive age, either married or in a union who wants to stop or delay childbearing but are not using any method of contraception(UNFP, 2014)..

Utilization In health care is the consumption of services or supplies, such as the number of office visits a person makes per year with a health care provider, the number of prescription drugs taken, or the number of days a person is hospitalized(Farlex, 2009).

Contraceptive prevalence rate is the proportion of couples married or in union who will report using or having used any family planning methods in the last two years preceding the study.

ABBREVIATIONS /ACRONYM

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CBD	Community Based Distributor
CEHW	Community Extension Health Workers
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
DMPA	Depot Medroxy progesterone Acetate
FHI	Family Health International
FP	Family planning
H/C	Health Center
H/F	Health Facility
HIV	Human Immune virus
HSD	Health Sub District
IPs	Implementing Partners
IUD	Intrauterine Device
MDGs	Millennium Development Goals
MOH	Ministry Of Health
NRH	National Referral Hospital
PATH	Program for Appropriate Technology in Health
RH	Reproductive Health
RRH	Regional Referral Hospital
SDGs	Sustainable Development Goals
TB	Tuberculosis
UBOS	Uganda Bureau Of Statistics
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

VHT	Village Health Team
WHO	World Health Organization

ABSTRACT

Introduction: This study was about assessing the contributions made by the trained village health teams (VHTs) in the provision of injectable family planning methods in Apac district. The study specific objectives included: assessing the quality of injectable family planning methods provided by the village health teams, ascertaining the perceptions of the community on injectable family planning services offered by the VHTs; identifying the challenges faced by the VHTs in provision of injectable FP methods and to establish the challenges faced by the district health managers in supervising/ working with the VHTs in provision of injectable FP methods in Apac District.

Methodology: The study used a descriptive cross-sectional study design which employed both qualitative and quantitative techniques of data collection. A total of 156 respondents were sampled and enrolled into the study. The respondents included; 11 district health managers, 53 Members of District Village Health Teams involved in provision of family planning methods, 56 women of reproductive age (15-45 years) and 36 community members.

Findings: The study found that accessed to injectable family planning methods was made easy through the VHTs participation and this led to improvement in utilization of injectable family planning methods as evidenced by increase in the unmet need of contraception and community members were supportive of the contributions made by VHTs while providing this service to the women.

Recommendations: The In charges of health center IIs should continue supervising the VHTs and make sure they submit their reports on time, VHTs who are attached to the health centers III s should also be trained to beef up the efforts of their colleagues in health center IIs. Government should recognize the contribution of VHTs towards quality health service delivery and attach a salary to their services as a way of motivation and appreciation. As the ministry of Health is moving away from VHT to community extension health workers I appeal that those VHTs that have the qualification be given the opportunity to work as community extension health workers.

CHAPTER ONE

INTRODUCTION

1.0 Introduction to the chapter

A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy. Family planning is a means of child spacing which is achieved through use of contraceptive methods and the treatment of involuntary infertility. It allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births (Waled et al., 2016).

The recommended minimum interval between any two births is 18-23 months, to reduce morbidity and mortality risks for the mother and baby (WHO, 2005). Research has shown that short birth intervals are closely associated with poor health of children, especially during infancy. Longer birth intervals, on the other hand, contribute to improved health status of both mother and child. They allow the mother to recover physically and emotionally before she becomes pregnant again and must face the demands of another pregnancy and birth, with the added stressors of breast feeding and child care (UDHS, 2012).

Lack of access by adolescent girls to FP including contraceptive information, education and services, is a major factor contributing to unwanted teenage pregnancy and maternal death. In low and middle income countries, complications of pregnancy and child birth are the leading causes of death amongst adolescent girls' ages 15-19 years. Contraception allows people to

decide, plan and attain their desired number of children, as well as determine the spacing of pregnancies. World Contraception Day is an annual event which gives voice to the millions of people across the planet without access to contraception and family planning. At present, an estimated 225 million women living in low- to middle-income countries have an unmet need for contraception. It is important therefore that contraception is made widely available and accessible through trained health workers to anyone who is sexually active, including adolescents (WHO, 2015).

At least 12 per cent of married or in-union women are estimated to have had an unmet need for family planning worldwide. The level was much higher, 22 per cent, in the least developed countries. Many of the latter countries are in sub-Saharan Africa, which is also the region where unmet need was highest at 24 per cent in 2015 which doubled the world average (Biddlecom et al., 2015).

Modern contraceptive methods constitute most contraceptive use for 57 per cent of married or in-union women of reproductive age, constituting 90 per cent of contraceptive users. Method-specific contraceptive prevalence varies widely across the world (Biddlecom et al., 2015).

The contraceptive injection is one of the family planning methods which contain a progesterone hormone. It has been used mostly since the 1960s and is used worldwide. This includes Depo-provera (injection) which is the brand used mostly and it is often given every 12 weeks. Sayana Press is very similar to Depo-Provera and is also given after every 12 weeks. Noristerat is another brand which is given after every eight weeks. The injection is given into a muscle, usually in the buttock, or into the thigh or tummy (abdomen) and Sayana Press can be self-administered(Tim, 2016).

Traditionally, all injections are provided by qualified health workers. However, due to the severe shortage of health workers in Uganda and many other developing countries (Lincoln et al., 2006), unmet need for FP has been high and on the increase.

As a result of the human resources for health crisis, Uganda's National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, new evidence and a growing international consensus support the provision of injectable contraceptives by community health workers (UNFPA, 2005). As a result, the Ministry of Health Uganda has approved community health worker provision of injectable contraception (MOH, 2010).

Over 50% of contraceptive users in Uganda prefer injectable contraception over other methods because there is no pill burden since it is administered once after every 12 weeks.

Therefore, utilizing Village Health Teams and other community health workers to provide this service has the potential to increase access to family planning, reduce the total fertility rate, and improve method mix and choice at the community level. Village Health Teams are the primary health care providers in the community; they reside and work with the community and are known to community members. Therefore, integrating injectable contraceptives in the existing services offered by Village Health Teams trained in the practice has the potential to increase the uptake of an effective and highly acceptable family planning method. This initiative will help to reduce the workload of over-worked health professionals and short staffed health systems (MOH, 2010).

To prepare the VHTs to provide injectable FP methods, they were first trained on a pilot basis in Apac District in 2014 by the trainers of trainee (TOT) in the District and two central facilitators from the Ministry Of Health who trained 100 VHTs in two groups at the HSD headquarters and a training guideline from the MOH was used,(MOH, 2014).

Hence this study looked at the provision of injectable FP methods only by the VHTs. They were trained on different methods of family planning but much emphasis was put on injectable methods only and it was the method they were given to go and provide to the community.

According to the Village Health Team Strategy and Operational Guidelines, the Village Health Team (VHT) is a non-statutory community (village) structure selected by the people themselves to manage all matters related to health and cross-cutting issues. The Village Health Teams are chosen by their own communities to promote health and wellbeing of all village members (MOH, 2010).Many studies have been conducted about the performance of VHTs in Uganda but there is no literature about provision of injectable family planning methods by VHTs. Therefore, this study looked at the contributions made by VHTs in providing injectable methods of FP specifically in Apac district.

1.1 BACKGROUND TO THE STUDY

Currently, more than 200 million women in developing countries desire to space or limit pregnancies; however they lack access to FP options. Amongst women in reproductive age in developing countries, 57 percent (867 million women) need access to contraceptive methods because they are sexually active but do not want a child in the next two years. Of these women, 645 million (74%) are using modern methods of contraception; the remaining 222 million are not

using any method, resulting in significant unmet need for modern FP methods and one of the reason is inaccessibility to the FP methods, leading to increase in number of unwanted and unplanned pregnancies hence more money needed for treatment of complication of unsafe abortions/provision of post abortion care (MOH, UGANDA, 2014).

The provision of health services in Uganda has been decentralized with districts and health sub-districts (HSD) playing a key role in the delivery and management of health services at district and health sub-district levels respectively.

Although many organizations are implementing family planning activities, the Ministry of Health deemed it fit to standardize the training content and aimed at achieving the Millennium Development Goals number 5 and the MOH strategic plan of increasing contraceptive prevalence rate up to 50 percent by 2015 but it was not meet during the MDGs periods and it has now been transformed into SDGs5 target number 6(Odiyo et al., 2011),(Ezechi.O et al., 2012).

VHTs are responsible for identifying the community's health needs and taking appropriate measures, monitoring utilization of all resources for their health; mobilizing communities for health interventions such as immunization, malaria control, sanitation and promoting health seeking behaviors. They also serve as the first link between the community and formal health providers and they play a key role in community based management of common childhood illnesses including malaria, diarrhea, and pneumonia; as well as distribution of any health commodities availed from time to time (Ezechi.O et al., 2012).

Family planning is recognized as a key strategy to promote social, economic, and environmentally sustainable development, to realize sexual and reproductive health and reproductive rights, and to improve the health of women and their children by preventing unintended pregnancies and improving child spacing, thereby reducing maternal and neonatal morbidity and mortality. Family planning has the highest level of support from the President of Uganda who pledged to commit $5 million USD (12.5 billion UGX) annually to funding FP services in Uganda at the London FP 2020 Summit in 2012. The President further committed to reducing unmet need for family planning to 10 percent by 2020, only that in most cases these commitments are not put into action although this is 2017 and remaining only four years but the commitment is not yet fulfilled (Gribble et al., 2012).

The Village Health Team (VHT) concept that serves as a community's initial point of contact for health care became part of Uganda's National Health Strategy in 2001 (Kimbugwe et al., 2014). (UN, 2015), Uganda found that community-based health workers can be effectively trained to deliver injectable contraceptives, reducing the burden on the clinic-based delivery system. Therefore, this study looked at the contributions made by the VHTs in the provision of family planning methods in Apac district after they were trained by PATH in March 2015 and given the methods to go with them to their homes for easy accessibility by women.

The training about family planning was conducted for 100 VHTs and it went on for seven days and there were 13 objectives that were met during the seven days training. There was practical activity for two days and all the VHTs gave an injection to a client. They were attached to Health center II facilities were they where to give five injections under the supervision of the in charge

of the H/C II before they were given the drugs to go and administer from their respective homes. Before the training, VHTs used only to mobilize the communities to go for FP services at the health facilities especially during the outreaches mainly by Marie Stopes.

The purpose of training VHTs in Uganda's FP programme activities is to serve the community members and to influence their values, knowledge and attitudes, encouraging communities to make informed choices that lead to healthy timing and spacing of pregnancy. VHTs can also play an effective role in the delivery of FP services which are an important component of the health delivery system.

Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa, according to a meeting which was held in March 2010 with 12 African nations at Kigali. The 12 countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress towards the MDGs now SDGs (Odiyo et al., 2011).

A study was conducted in Lango and Teso sub regions by Arise project in 2016 to determine the unmet need of family planning; it was found that the methods are available at the health facility but a woman who has gone for only injection has to wait for hours before being attended to by a health worker. So it was realized the VHTs would provide the injection faster (Bukuluki et al., 2015).

Injectable family planning methods are preferred because they are easy to use, no pill burden and you only get one injection in three months. It is even used by all women of reproductive age

unless one has a condition that contradicts its usage. The failure rate is only one percent (Kenny, 2016) and many women preferred it as they can use it without the knowledge of their spouses and it has fewer side effects although this varies from one woman to another(Tim, 2016).

1.2 LEVELS OF HEALTH SERVICES IN UGANDA

The provision of health services in Uganda has been decentralized with districts and health sub-districts (HSDs) playing a key role in the delivery and management of health services at district and health sub-district (HSD) levels, respectively.

The health services are structured into National Referral (NRHs) and Regional Referral Hospitals (RRHs), general hospitals, health centre IVs, HC III and HC IIs. The HC I have no physical structure but a team of people the Village Health Team (VHT) which works as a link between health facilities and the community. Where VHTs are functional, they have contributed to increasing health awareness, demand and utilization of health services and significantly led to decongestion at health facilities as they timely treat minor illnesses. VHTs have further helped to increase community participation in local health programmes (USAID/UGANDA BEST Action Plan For Family Planning, 2011).

A network of VHTs has been established in Uganda which is facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health (MOH, UGANDA, 2015). The VHTs are responsible for Identifying the community's health needs and taking appropriate measures; mobilizing community resources and monitoring utilization of all resources for their health; mobilizing communities for health interventions such as immunization, malaria control, sanitation and promoting health seeking behaviors;

maintaining a register of members of households and their health status; maintaining birth and death registration; and serving as the first link between the community and formal health providers.

Community based management of common childhood illnesses including malaria, diarrhea, and pneumonia; as well as distribution of any health commodities availed from time to time are some of the other functions of VHTs (MOH, UGANDA, 2011)

Currently, more than 200 million women in developing countries desire to space or limit pregnancies; however they lack access to FP options. Amongst women in reproductive age in developing countries, 57 percent (867 million women) need access to contraceptive methods because they are sexually active but do not a want child in the next two years. Of these women, 645 million (74%) are using modern methods of contraception; the remaining 222 million are not, resulting in significant unmet need for modern FP methods (MOH, UGANDA, 2014).

Women with unmet need are broadly defined as the percentage of women of reproductive age who are either married or in union and wants to postpone their next birth for two years or more, or not have any more children, but they are not using contraception (Bradley & S.E.K., 2012; MOH, 2014).

The unmet need for contraception remains too high. This inequity is fuelled by both a growing population, and a shortage of family planning services. In Africa, 23.2% of women of reproductive age have an unmet need for modern contraception. In Asia, and Latin America and the Caribbean regions with relatively high contraceptive prevalence the levels of unmet need are 10.9 % and 10.4%, respectively (WHO, 2015).

The Village Health Team (VHT) concept that serves as a community's initial point of contact for health care became part of Uganda's National Health Strategy in 2001(Kimbugwe, 2014).

Uganda found that community based health workers can be effectively trained to deliver injectable contraceptives, reducing the burden on the clinic based delivery system therefore this topic is looking at the contributions made by the VHTs in provision of family planning methods in Apac district after they were trained by PATH in March 2015 and given the methods to go with them to their homes for easy accessibility by women.

Apac district has a total of 735 villages with the total number of VHTs 2860 and active VHTs are 1900 and out of these 1900 only 100 are trained by PATH and those villages near the Health Center IIs and they were selected for the training as individuals where five (5) VHTs were selected per village and only those VHTs attached to the Health Center two (II) were trained, however there is also need to train more VHTs to make their work easy and to improve on the accessibility of the services and lastly to achieve the goal of the Ministry of Health reaching the community with family planning services, most VHTs that were trained are also community vaccinators so they have a lot of work and yet they are not paid completely except those who are vaccinators that are given some allowances from outreach clinics after three months from PHC fund at the end of the quarter (UGANDA, 2015).

Monetary and non-monetary forms of VHT motivation is provided to them. Financial motivation included lunch and transport allowances during training or a meeting are provided to them by IPs. Non-monetary forms of motivation include verbal recognition during a meeting. Capacity

building in the forms of educational short courses, trainings and mentorship are ways of motivating VHTs. They are also provided with tools and supplies such as uniform, bags, gumboots, umbrellas, identity cards, bicycles although not every VHT in the district receive these things (Aurelie et al, 2011).

A national curriculum for community based family planning(MOH, 2012) was developed and used by all partners in training village health teams (VHTs) to provide family planning, including injectables, door-to-door in hard-to-reach areas(MOH, 2011).

Expanding access to family planning (FP) at the community level was a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs) which is now SDGs, particularly goal 5b, universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa specifically, according to meeting which was held in March 2010 with 12 African nations at Kigali. The 12 countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs (Odiyo et al., 2011).

Many organizations such as Marie Stopes, Pathfinder International and PATH have trained VHTs on family planning and of these organizations PATH has gone to the extent of giving the injectable methods of family planning to VHTs and some are sent to Health centers II but still there is low utilization of the services, although several trainings were conducted to both the health staff and the village health teams about family planning.

Despite the fact that a study was conducted in Lango and Teso sub regions by Arise project to meet the need of family planning services in 2014 to address unmet need of family planning and it was found that the methods are available at the health facility but there was shortage of staff and knowledge gap to be addressed but this stills remains a problem especially in Apac where the study is to be conducted (Bukuluki et al., 2015).

The district trained 100 VHTs with support from PATH and they were trained on both short term and long term methods but after the training, they were given only injectable methods but still the problem is not solved as these VHTs were not given other drugs to manage the side effects of the injectable methods, the VHTs however are providing Sayana press mainly.

1.3 PROBLEM STATEMENT

There is high unmet need for FP, with severe consequences for mothers, children and countries; and the main reason for unmet need is a shortage of staff. Because studies have shown that the FP methods and commodities are actually available. VHTs were introduced to provide FP methods as a way of addressing the staff shortage. Although administering injectable FP methods is a technical skill above the competence of VHTs, they received the necessary training. However, there has been no follow up evaluation to determine the effectiveness of VHTs in providing quality injections, the perception of users on the quality of FP injections offered by the VHT or the challenges face by the VHTs and their supervisors in giving injectable FP methods, and how such challenges are overcome. Lack of such information leads to inadequate support supervision, poor quality of care by the VHTs, wastage of resources, possible health consequences for the users, persistent low FP uptake and subsequent high unmet need for FP.

Therefore, the purpose of this study is to determine whether the involvement of VHTs has led to reducing the unmet need for FP.

1.4 RESEARCH QUESTIONS

1. What are the contributions of the VHTs on the use of injectable FP services?

2. What are the perceptions of the community on injectable FP services offered by VHTs?

3. What are the challenges faced by VHTs in provision of injectable FP methods?

4. What challenges are faced by the district health managers in supervising/working with VHTs in the provision of injectable FP?

5. What are some of the strategies which can be employed by the stakeholders to overcome the challenges faced by the VHTs in provision FP services?

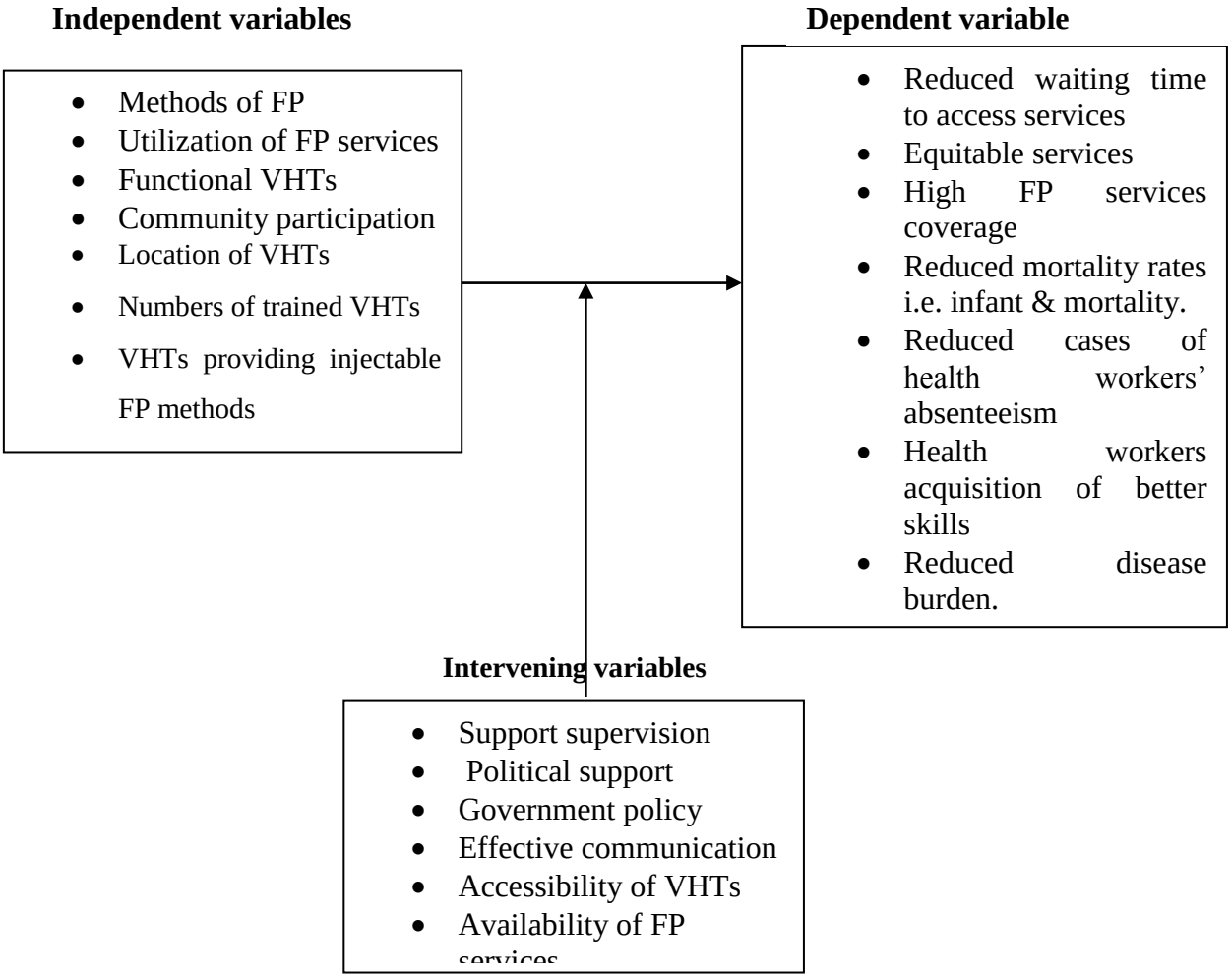
1.5 CONCEPTUAL FRAMEWORK

The study was based on the concept that with other factors remaining constant, when any government policy is to be successful and effectively implemented there should be coordination and involvement of everyone concerned from top to bottom for its success. The problem of human resource for health is a cross cutting issues which affects implementation of most of the issue of major concern in the country. Therefore, VHTs are introduced in FP provision simply to reduce staff shortage.

Where there is VHTs participation in implementation of health care services, there is a possibility for programme enhancement.

The conceptual frame work therefore, represents three categories of variables whereby government policies, district health programmes and the entire range of activities at the health centers form independent variables. The involvement and participation of VHTs are the mediating variables, whereas the ultimate health situation or outcome within the communities is the dependant variables in the study as illustrated in the figure below.

Figure 1: Conceptual Framework



1.6 NARRATIVE OF THE CONCEPTUAL FRAMEWORK

The contributions made by the VHTs in provision of injectable family planning methods in Apac district depends on reduced waiting time to access services since the service is made available at the grass root level, the service is at the easy reach by every woman in the community and it will improve on the FP services coverage. Once there is improve FP coverage, there will be reduced mortality rates i.e. infant & mortality and reduced disease burden.

This will go hand in hand with availability of FP methods with the VHTs, and the utilization of FP services by the women when there is a functional VHT and the community has embraced the injectable FP methods provided by the VHTs. The VHTs are also allocated within the community with 50% of them being trained.

For the proper functionality of the VHTs, there should be continued support supervision, political support, operational guideline and government policy on VHTs through effective communication and social mobilization of the community about injectable FP methods being provided by the VHTs.

1.7 GOAL

To assess the contributions made by the village health teams in the provision of injectable family planning services in the selected health centers IIs in Apac district.

1.8 SPECIFIC OBJECTIVES

1 To identify the contributions made by the VHTs in provision of injectable FP methods.

2 To establish the perception of the community on injectable FP services offered by the VHTs.

3 To identify the challenges faced by the village health teams in provision of injectable FP methods.

4 To establish challenges faced by the district health managers in supervising or working with the VHTs in the provision of injectable FP methods.

5 To explore strategies to overcome the challenges faced by the VHTs in the provision of Injectable FP methods.

1.9 SCOPE OF THE STUDY

The research was intended to be significant to a number of stake holders in the health systems, which include the following:

It was anticipated that findings of the study would provide empirical evidence regarding the performance of VHTs, which can facilitate and guide any crucial planning. The Ministry of Health also would use the findings as a baseline when carrying out supervisory roles in districts, especially reviewing VHTs contribution to the health sector.

It limits its scope of investigation to accessibility of family planning services before and after VHTs were allowed to give injectable FP methods; the level of utilization of family planning services since VHTs were permitted; and the perceptions of communities on the injectable FP services provided by VHTs at the grassroots level.

The District Local Government and other lower local governments would use the research findings as a guide on how to deploy VHTs at different levels of health facilities. Also, the District Health Team (DHT) would use the research findings for lobbying from different health stakeholders for funds to train the VHTs. As many Non-Governmental Organizations worldwide would like to fund different activities like trainings, the research findings would also help those (NGOs) to identify areas where to put or inject their funds towards contributing to effective management of health facilities.

To the academicians and researchers' the findings would also serve as reference material for further inquiry in to the subject matter, and more particularly in the feasible strategies to improve the contribution of VHTs.

To the Village Health Teams, the findings would further be useful in creating awareness among members (Village Health Teams) to demand for their involvement and participation in health care services.

1.10 SIGNIFICANCE OF STUDY

It is anticipated that the findings of the study will enable the government through the Ministry of Health to improve the overall provision of family planning services in the district based on the recommendations relating to the utilization and access to the services by the communities served. Additionally, the recommendations may inform policy formulation for family planning services by the MOH, which could improve reproductive health service delivery.

It is also anticipated that these study findings can be used by healthcare service managers for effective planning, organization, implementation, monitoring and evaluation of family planning services in rural communities.

For researchers and the academia, it is anticipated that the findings of the study will add on to the general body of knowledge, inform related studies and provide a basis for further research into the effectiveness of VHTs in Uganda's healthcare system.

For implementing partners whose programs involve offering family planning services, it is anticipated that the results of the study shall be a reference source for evidence and base line data for preparing funding proposals and informing practice/implementation.

1.11 JUSTIFICATION OF THE STUDY

The study area of Apac District is purposely selected, because it is among the 11 districts that PATH trained their VHTs on family planning and much emphasis was put on injectable methods. Although other methods were also taught, this study intends to look at injectable contraceptives only (Sayana press and Depo-Provera). To this end it is anticipated that the findings of this study will be of significance to various categories of people.

There is domestic violence in some families when, their women go for family planning methods and on returning home they are beaten by their spouses as to why they went for the services and they took long in the H/C. Yet, due to shortage of staff these women who have gone for only injection should also follow the long queues so they have no option, yet these women may still want to postpone their pregnancies for reasons best known to themselves.

CHWs programs eliminate transportation and cultural barriers for community members that limit their access to care. Therefore, communities should participate in the delivery of health

services through VHTs and health unit management committees, adequate resources should be made available in order to ensure that all VHTs have been trained during the implementation of the HSSP III.

Since unmet need of F.P in Apac district is high and there is also high fertility rate of 7 children per woman, and the population growth rate of 3.3% against the 3.0% of the national population growth rate, the pressing reason for carrying out this study was to identify the contributions made by VHTs, perception of the community on VHTs providing these methods, the challenges being face by the VHTs in provision of injectable FP method and the challenges faced by the district health managers while supervising/ working with the VHTs in provision of injectable methods.

The study provides updated data on the VHTs trained which may assist the district, IPs and MOH in policy formation and determining need for training VHTs from other districts as well in order to meet the unmet need of F.P in other districts.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter contains related literature on provision of health services by the VHTs/CHWs with much emphasis on family planning services. The literature is presented according to the study objectives.

The government of Uganda faces a lot of challenges in the health care arena, from ensuring that health care services are delivered in the most equitable manner, to structuring health care delivery system to be more effective, to waging campaigns against the leading cause of mortality and morbidity (Ezechi.O et al., 2012).

It needs the best information on existing situations to devise strategies to successfully meet the challenges (Hutchinson et al, 1999). Since, the adoption of the strategy of using VHTs as the first point of healthcare service provision among rural communities in Uganda, the quality of healthcare at the primary healthcare level has considerably improved.

VHTs has been responsible for Identifying the community's health needs and taking appropriate measures, mobilizing community resources and monitoring utilization of all resources for their health, mobilizing communities for health interventions such as immunization, malaria control by distributing anti-malarial and deworming tablets in the communities to population groups mainly under five, distribution of mosquito nets, sanitation and promoting health seeking behavior, maintaining a register of members of households and their health status, maintaining

birth and death registration. Other responsibilities include identification of people suffering from tropical neglected diseases, sensitization of the communities on the importance of using health services such as HIV testing, antenatal care and family planning including distribution of condoms and serving as the first link between the community and formal health providers(MOH, UGANDA, 2015; Akol, 2011).

To date, they are trained even in other countries to offer family planning services including administration of injectable methods, distribution of condoms and contraceptive pills. Other countries that trained their community health workers to provide injectable contraceptives are Malawi trained community based distribution of DMPA by the health surveillance assistants and for a period of 14 moths, the number of clients increased from 32 to 5998 who are receiving their injections from them(Haub, 2010), Zambia trained 40 of them from 2 districts and results showed that in a period of 12 months a total of 4241 clients had received their injections from the community based drug distributors(Mbewe et al., 2011).

Senegal also trained 45 community health workers to provide injectable contraceptives and after a period of 8 months 1078 client (62%) were receiving their injections from them and 99% of the clients said they will continue with the community health workers(MOH, 2013).
Additionally, they offer referral services and health education ((Mugisha & Reynolds, 2014; Huber et al., 2010).

Even though the resourcefulness of VHTs in Uganda's healthcare system is well documented, their specific contribution to the important reproductive health concern of family planning services in remains unclear in some areas. Similar studies may have been carried out in other

parts of the country, however, aware of the unique differences among communities, and the differences in the methodologies that may have been used in the various studies.

It is relevant to assess their contribution on a case by case basis, this study therefore sought to explore the contributions of VHTs to the uptake of injectable family planning methods in Apac District. This chapter reviews the general body of literature relating to the purpose of the study, while limiting itself to the specific objectives stated above. Except for sentinel papers and specific relevant reports, the study will consider only the literature between 2010 and 2016, taking a global, continental, national and local approach to the contextual analysis. The flow of discussion will follow the arrangement of the specific objectives which will be discussed following an analysis of the historical perspective of the emergence of the concept of VHTs in Uganda's healthcare system.

2.1 History of VHTs in Healthcare

The concept of using community members to offer some basic services to the communities is about 50 years old in the world now. The Chinese barefoot doctor programme is the best known of the early programme, although a country like Thailand has used the village health volunteers and communicators since the early 1950s .These barefoot doctors were health auxiliaries, who emerged in the mid-1950s and became a nationwide programme from the mid-1960s, and they ensured basic health care at the community level and later a number of countries began to experiment with the village health worker concept(Akol et al., 2013; MOH, 2015).

In Africa the village health workers started in Tanzania and Zimbabwe in their early phase. Both were set in the political context of wholesale systemic transformation, and both were focused on self-reliance, rural development, and the eradication of poverty and societal in equities (MOH, UGANDA, 2015).

Uganda adopted the Village Health Teams strategy in 2001 as a bridge in health service delivery between communities and health facilities and the overall objective was to improve the national status functionality of the health system in Uganda in order to improve planning and delivery of health services to households and communities((Mugisha & Reynolds, 2014).

The Village Health Team concept that serves as a community's initial point of contact for health care became part of Uganda's National Health Strategy in 2001. Maternal and new born/ infant mortality and morbidity rates in Uganda is the highest globally and in response to this crisis, the Uganda Ministry of Health created this program to bring basic preventive care to rural villages((Mugisha & Reynolds, 2014).

A VHT covers the geographical size of the Local Council 1 (Village) with members' selection done on a popular vote and the team must be gender balanced with at least a third women (Kimbugwe et al., 2014).

The five specific objectives of Uganda were to establish the number and socio-demographic profiles of the VHTs in Uganda and the result showed that the majority of them were men and most of them have attained ordinary level education. Another objective was to establish the training that was provided to the VHTs in terms of type of training; duration of the training; the

content, methods, and materials used for the training among others. The last objective was to review the extent to which the VHTs are implementation guidelines from Ministry of Health, the districts and partners and to identify approaches to motivate VHTs and to assess the functionality of VHTs in Uganda (Orach et al., 2015).

In 200I, the Uganda Health Sector Strategic Plan 1 recommended the establishment of Village Health Teams to bridge the gap and increase equity in access to health services. The VHTs were responsible for empowering communities to take control of their own health and wellbeing and to participate actively in the management of the local health services (NHP, 1999). The decision to establish VHTs was in line with the Alma Ata (1978) and the Ouagadougou (2008) Declarations on primary health care,(MOH, UGANDA, 2015).

2.2 Quality of injectable family planning services provided by the VHTs

Quality improvement activities should include injectable contraceptive service delivery at community level with focus on competence of the provider, management of resources, documentation and record keeping which is being done through the village health team members (PROJECT, 2016).

After the training, VHTs were stationed at health facilities, where under the supervision of a trained provider (usually a nurse or midwife), they were then required to lead a community health talk, provide general family planning counseling to clients, and correctly administer five injections each of Sayana Press and DMPA-IM, following the observational checklist, before they were certified to offer family planning in their community (MOH, 2014).

These VHTs are also followed to their respective homes to assess the questions about adherence to proper procedure and reviewed client records and methods of FP commodities storage and waste disposal. A report by the Director General of Health Services indicated that the community health workers administered the DMPA injection to a client and spoke with members of the community about the services and their FP needs ((Mugisha & Reynolds, 2014).

Competence and performance of VHTs are central to the delivery of quality injectable contraceptive services, promotes professionalism and attracts and retains clientele. VHTs should ensure clients' safety at all times (Kaboré, 2016).

Through support supervision, the supervisors provide regular supportive feedback to the VHTs on their performance and should also report on VHT performance monthly at community level and quarterly at district level. During supervision, there should be development of on job training activities and a check list which should be followed to ensure that VHTs are providing safe injections. Fifty-seven percent (57%) of women in Uganda who currently use family planning prefer injectable contraception over other methods; meanwhile, 50.8% of women in Uganda who plan to use family planning in the future say they would like to use injectable contraceptives. Therefore, integrating injectable contraceptives into the existing services offered by Village Health Teams in Uganda has the potential to increase access to family planning and reduce the total fertility rate (MOH, 2010).

A study conducted by ARISE in 2015 showed that the VHTs explained that medical workers are few and have many cases, emergencies and routine work to manage unending flow of patients

seeking treatment and care. Therefore clients seeking FP services come at the end of the priority continuum (Bukuluki et al., 2015).

Partly this is a human resource matter but can also be associated with inadequate "task shifting" in facilities with one or two doctors who might be too busy to attend to those that need only injections. Yet injections can be given by the VHT while the doctors perform female or male sterilization. Over time acceptance of injectable family planning method is slowly increasing and those who have joined FP from the VHTs have no regret. There are testimonies by women using FP that show that communities are slowly accepting family planning provided by VHTs (Bukuluki et al., 2015).

The VHTs have narratives of violent reception from their target groups in the past (USAID/JHU, 2012). Over time, the reception has changed and their messages are more acceptable by community members and many women seek FP services from the VHTs. Many women are eager to ask questions about reproductive health in general and FP in particular from the VHTs. Referrals from VHTs are also noticeably effective since potential clients turn up at static facilities for further technical guidance, counseling, assessment and initiation to modern FP services(Asingwire et al., 2016).

Against this backdrop, the Uganda Ministry of Health, Save the Children and FHI 360 conducted a pilot study in 2004-2005 to assess the safety, quality and feasibility of adding injectable FP methods to the existing community-based distribution family planning program, focusing on the cadre of community health workers in Nakasongola District who are supported by NGOs (USAID/UGANDA BEST Action Plan For Family Planning, 2011).

The research, conducted with 777 women, confirmed that VHTs were well-selected trained community health workers who are experienced in condom and pill provision can safely provide injectable contraceptives. Further, the study showed that women were equally satisfied with quality of care, whether women received DMPA from a VHT. They (women) recommended that the VHTs providing injectable FP should continue in Nakasongola and the practice should be expanded to other areas. This was started in Busia and Bugiri Districts (Kirunda et al., 2016).

In the first 12 months of this expansion, 1,364 women accepted injectables from 44 VHTs. Of these women, 30% were first-time users of the method. Clients reported high quality services. Nearly all intended to continue receiving injectable FP from a VHT, and most said they would recommend the service to a friend (Kirunda et al., 2016).

Village health teams' provision of injectable is an innovation that deserves consideration by decision makers who are seeking measures to strengthen family planning services. This is especially true in Sub-Saharan Africa, where injectable dominate the contraceptive method mixed, and the majority of women in need lack convenient access to clinic services and they prefer receiving the injection from the village health team (Hoke et al., 2012).

Countries around the world have demonstrated that allowing trained community health workers or village health teams to administer injectable family planning methods can expand access to a woman's preferred contraceptive method, reduce unmet need for family planning in underserved areas, and address the critical health workforce shortage in many countries (Kaseba-, 2014).

In addition, community-based family planning (CBFP) programs that add injectable FP to the list of contraceptives available can increase the contraceptive prevalence rate. In Kenya for example, adding community-based provision of injectable contraceptives to the method mix dramatically increased contraceptive uptake and improved method choice during their pilot program,(Kaseba-, 2014).

Because community-based access to injectable contraceptives (CBA2I) has the potential to significantly expand access to and use of modern contraceptive methods, several countries are employing CBA2I strategies to help achieve their FP2020 goals. The Family Planning 2020 (FP2020) goal of reaching 120 million new users of family planning by 2020 can only be achieved if contraceptive services are extended beyond the facility and into communities through the VHTs and there is a significant history of improving access to family planning through community-based services, as demonstrated in countries such as Bangladesh, Ethiopia, Indonesia, Kenya, and Malawi. Expanding this model of community-based family planning can reach more women and couples, increase the available contraceptive options, improve continuation of contraceptive methods, and increase the number of new family planning users, thus helping to meet the goals of FP2020(Kaseba-, 2014).

The study conducted in Nakasongola district between 2003-2005 indicated that the CHWs competently counseled clients and provided injectable FP methods, achieving continuation rates and client satisfaction comparable to that of clinic-based injectable FP methods provision. Another study conducted by Madagascar's Ministry of Health in 2006 indicated that the CHWs demonstrated competence in injection technique, counseling, and managing their clients' reinjection schedules,(Hoke et al., 2012). The same study in Kenya between 2009 and 2010

showed that the CHWs gave 2,453 injections during the pilot period, with no needle stick injury or injection site infections reported. The 12-month continuation rate was 68%, and about three-quarters of DMPA clients who had previously received DMPA from a clinic opted to switch to CHWs (Kaseba-, 2014).

The pilot study in Senegal between 2012-2013 indicated that Most CHWs correctly and confidently provided injectable family planning methods and counseling (Kaseba-, 2014). Clients were satisfied with the services (99%) and overwhelmingly (94%) stated their intent to get their next injection from CHWs. The latest WHO task-sharing recommendations state that trained CHWs can, with targeted monitoring and evaluation, initiate and reinject injectable contraceptives using a standard syringe (Kaseba-, 2014).

Advancing Partners and Communities (APC) works with the Ministry of Health (MOH) in Uganda to increase access to family planning (FP) in 16 districts through community health workers known as village health team members.

Nearly all clients reported that they would recommend to a friend that she get an injection from the VHTs who gave them their injection. The main reasons they would recommend injectable FP methods from a VHT are that VHTs make service more accessible, the VHTs are good/kind provider of FP services and they keep information confidential; the method or provider is easily available, and that injectable family planning is beneficial and prevents unwanted pregnancy (Hoke et al., 2012).

Nearly all of the VHTs who were observed established and maintained rapport with the client, in Malawi they showed respect and did not judge the client, and maintained privacy. The clients confirmed said that throughout their visits, VHTs were friendly and they trusted them to protect their privacy. In terms of general counseling, direct observation showed that VHTs asked their clients about their reproductive goals and counseled them on all methods. Some VHTs were observed to use the checklist to rule out pregnancy, and others used the checklist to screen for eligibility for injectable methods (Katz et al., 2010).

In 2011, the then Ugandan Director General of Health services stated that community based delivery of injectable contraception is the best avenue to increase access to the most popular family planning method in Uganda, particularly for women living in hard-to-reach areas. To achieve these VHTs should be given knowledge and resources because the population is concentrated in rural areas and most of the women are moving into their sexually active years ((Mugisha & Reynolds, 2014).

Uganda was one of the original pilot countries for the community-based distribution of injectable contraceptives and, following a recent policy change to formally allow this practice, also is intensifying its efforts to scale it up. This was done with support from USAID to train VHTs who could potentially provide this service to many women of reproductive age with access to injectable methods. Other countries such as Afghanistan and Madagascar also trained their VHTs in providing other services including provision of injectable family planning methods which showed improvement in the uptake of FP leading to reduction of maternal mortality (Huber et al., 2010; Akol, 2011).

A research carried out in Rwanda showed that much as children are taken as wealth for cultural and historical reasons, the country adopted the VHTs strategy in reducing fertility rate and at the 2012 London Summit on Family Planning, donors and national governments committed to provide access to modern contraceptives by 2020 to an additional 120 million women around the world who have unmet need for family planning, as well as to focus on the human rights of women and girls and to launch a reinvigorated global platform for achieving universal access to family planning. Rwanda started using the VHTs to fulfill its commitment on the London summit on FP (Bertrand et al., 2015).

In the East, Central and Southern African Health Community (ECSAHC) region, the majority of the population lives in the rural areas, where health services are poor compared to those in urban areas. In Malawi, four in every five people live in rural areas, and most of them need services at the community level due to poor transportation systems and long distances to district and other lower health facilities (Odiyo et al., 2011).

The entire East, Central and Southern African Health Community (ECSAHC) countries faces similar challenges. The rural-urban demographics have a major impact on key indicators for meeting the SDG 5, target 6 of Ensuring universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. The rural areas have fast-growing youth populations, high unmet need for FP, high total fertility rates, high maternal mortality rates, high rates of unintended pregnancy and high rate of unsafe abortions. Urban areas have better rates in

all of these measures and this can be solved by using the VHTs to reduce on the above burden by providing injectable FP methods (Odiyo et al., 2011).

Village Health Team members (VHTs) or women that had been using contraceptives (peer mothers) are able to speak widely about FP. This led to improvement from 17% in March to 31% in April in Jinja in 2014 at Bukuuku H/CIV 2014 through community interventions in conducting community sensitization and mobilization done by both the VHTs and midwives, focusing on addressing the myths and misconceptions. They targeted various gatherings, such as the worship centers, village meetings, market places, and immunization outreaches to dispel the myths and misconceptions about injectable FP methods (Bukuluki et al., 2015).

In addition, the VHTs conducted home visits and follow-up of clients who received injectable contraceptives from them and continued counseling them. During sensitization sessions, VHTs gave testimonies and experiences about using injectable contraceptives, while the midwife talked about the benefits of FP, where to access injectable FP services, and what to do in case of side effects which also lead to improvement on the uptake of injectable family planning (Bukuluki et al., 2015).

The study conducted in Senegal demonstrated that distribution of Depo Provera by matrons and community health worker is feasible, and the community level providers felt confident and comfortable after proper training,(Kaseba-, 2014). The same study indicated that clients and communities appreciated the service, were satisfied with the service and the stakeholders,

including facility based providers and health management teams, saw benefits in this task-sharing approach,(MOH, 2013).

Clients reported their satisfaction that matrons/CHWs were providing accurate information on F.P in an environment of respect and free choice. Up to 98% of interviewed clients reported that they were free to choose the method they desired, and 84% reported being counseled on side-effects, while matrons/VHTs expressed being comfortable providing Depo Provera with confidence,(MOH, MALAWI, 2010).

During a conference which was organized in February 2015 with many development partners, districts, all stakeholders who have implemented the Village Health Team Strategy called upon the Ugandan Ministry of Health to prioritize the Village Health Teams and to acknowledge their contribution, (Orach et al., 2015). Equally a member of the Uganda Medical and Dental Practitioners Council remarked that VHTs' roles cut across all health aspects of nutrition, tuberculosis, malaria, HIV/AIDS, and cervical cancer including provision of family planning services((Mugisha & Reynolds, 2014).

District leaders expressed appreciation of the contribution that VHTs have made in promoting hygiene at household level such as mobilizing and sensitizing communities for health services where antenatal attendance and deliveries at health facilities were reported to be high. Despite these remarkable achievements, district leaders expressed the need to motivate VHTs even when their mandate is to offer voluntary health services (Uganda, 2015).

Majority of the VHTs said that they were maintaining privacy during FP counseling to overcome such barriers which includes distance to health facilities, long waiting time and strong misconceptions from the community on family planning (USAID/JHU, 2012). Similar findings were reported in a study in Eastern Azerbaijan, Iran and Ethiopia where it was found that maintaining privacy, confidentiality and communication were necessary components for FP,(Prata et al., 2011).

VHTs consider FP as part of their job description and play a major role in record keeping, most importantly of eligible couples and other FP clients in their respective areas. They are promoting modern contraceptive methods except for long term and permanent methods of family planning. They were found to have good knowledge of injectable FP concepts and considered important factors before starting FP, (Abdul et al).

2.3Perception of the community on injectable family planning services offered by the VHTs

To reduce the high unmet need for family planning in Uganda, USAID consistently invests large sums in contraceptive commodity procurement and remains the largest donor in this area of family planning and to make the services reach the rural communities through the use of VHTs and at the same time USAID is making sterilization closer to communities through mobile outreach and other community based service delivery strategies (Bukuluki et al., 2015).

VHTs increased the uptake of FP methods as seen in most women who came to know about FP through them and they were enrolled on after being sensitized during the antenatal visits at the

health centers and after their delivery they started using family planning from the VHTs six weeks postpartum. As a result there is now reduced domestic violence as these women have enough time to attend to their husbands. Some were giving birth every year and they had to give attention to the children all the time, which was very stressful to them. They were always ill and looking very tired (FOWODE Uganda, 2012).

With continuous health education talks by the VHTs many women understood FP and the myths associated with different methods of FP. The satisfaction indicators for these women included: provision of information about FP, distance to the government health facility is reduced; availability of FP commodities in their communities; level of privacy; no/reduced waiting time; hygiene / cleanliness of health facility and unhealthy behavior of health worker are not experienced by the women when they go for services provided by the VHTs from their homes (FOWODE Uganda, 2012).

Initiatives to link communities to the health system made through the establishment of village health teams (VHTs) are being undertaken and, with sufficient funding and training, these units could greatly enhance and expand the delivery and demand for health services at the community and household level. VHTs, once fully functional, will serve as an essential link between home, community, and health services (Babihuga et al., 2013).

Uganda committed itself to universal access to family planning and to reduce unmet need for family planning from 40% to 10% in 2020(MOH, UGANDA, 2014). It will increase the annual government allocation for family planning supplies from US $3.3 million to US $5 million for the next five years and improve accountability for procurement and distribution in order to avoid

stock out and minimizing expiry of contraceptives when it is easily accessed by women of reproductive age and if integration of family planning into other services, including partnerships with the private sector, by supporting the alternative distribution channel for the private sector and scaling up of innovative approaches, such as the community-based distribution, outreaches, social marketing, and youth friendly service provision. Uganda will strengthen institutional capacity of the public and community-based service delivery points to increase choice and quality of care at all level (Gribble et al., 2012; Sizomu & Muwonge, 2014).

Family planning counseling and commodities should be accessible for both men and women, including youth (Asingwire et al., 2016). There are numerous supply-side barriers to accessing contraception in Uganda; for example, clients are often unable to access care due to geographical distances and the lack of supplies or equipment at facilities. Rural populations and the poorest populations in urban areas also face lack of continuing access to FP which could be solved by using the VHTs (Asingwire et al., 2016).

With the majority of Ugandans residing in rural areas, distance to health facilities is a barrier to FP access for nearly 41 percent of women. Those who decide to use family planning often find distance to a facility providing FP services a barrier to access. Additionally, stock-outs of FP commodities at facilities further impede access. Reducing inequities related to poverty, HIV status, gender, age, and marital status in access to and use of family planning are continuing challenges. Married and unmarried sexually active youth also face challenges related to access and cost of FP services but after introduction of the VHTs in the provision of injectable the problem of access was resolved (Najjuma, 2015).

Results from the study carried out on Evaluation of the Village Health Team Radio Distance Learning Program in Mukono District indicated that knowledge of at least three benefits of family planning almost doubled from 22% at baseline to 40% at follow up of VHT members (USAID/JHU, 2012). The level of knowledge of all the four Long Acting and Permanent Family Planning Methods increased fivefold from two percent upward to eleven percent at follow up. Because the study needed to detect a 10% change in the proportion of respondents who have full knowledge of family planning methods, assuming that 50% of VHT's have full knowledge of injectable family planning methods and they were providing health education talks on family planning and providing the injectable methods as well at their respective villages(USAID/JHU, 2012).

Generally, when VHTs have increased and adequate knowledge and information about family planning, in turn they will convey correct family planning messages among their target communities and individuals. This will in turn help the communities and individuals to be able to develop a rational approach to use of injectable family planning services from the VHT member,(USAID/JHU, 2012).

A study carried out in Malawi on evaluation of community based distribution of FP methods showed that all the VHTs believe that most women know they can get injectable family planning methods from them,(Katz et al., 2010).The majority felt it has been easy to gain community confidence in their ability to provide the service amongst which was to inform the community of the health programs and activities. However, it was somehow difficult for the VHTs to relay the information due to unclear sources of information. In some instances the lack of confidence

arose where some clients had heard about the program and seemingly the VHTs were not well informed. The study also revealed that the VHTs primarily discussed with women during outreach activities like the immunization and also told community leaders and groups of women about the program. Clients in turn were most likely to have heard about it from someone at the outreach site or health facility, from the VHTs themselves, or from someone in their communities (MOH, MALAWI, 2010).

Most of the groups feel that the community view on the provision of the services by VHTs is positive. The majority of the clients feel that people in the community accept the program. By far the most positive thing heard by most people is that women can get access to injectable FP services more easily when it is with the VHTs (Bailey.C, 2015).

Nonetheless, some clients have heard complaints about the program. The complaint heard most often is that clients do not like the side effects associated with injectable FP. Other complaints heard are that women report that the VHTs or the drugs are not available, or fertility does not return after stopping the use of injectable FP methods; male partners do not allow women to use injectable FP methods that makes people (women) develop cancer; they do not like that the drug is administered in the lower abdomen or buttocks; that some VHTs are not friendly; and that during the process of administering the drug their wives could be raped by the VHTs (Bailey.C, 2015).

There were also a few clients who said they were not at all satisfied with the VHTs provision of FP methods. A small number said they would not recommend that a friend get the injection from their VHTs The reasons why they would not recommend that a friend get an injection from their

VHTs (though only 1 to 3 clients mentioned these reasons) were that a woman has a right to choose the method and providers. They would advise her to use the hospital for injectable FP methods and that the male partner needs to be advised from the hospital (Bailey.C, 2015).

Supervisors also believe that VHTs' provision of the injectable methods of FP is acceptable and beneficial to their communities in Malawi. The main benefits cited include that women in hard to reach areas have access from the villages which increases contraceptive prevalence in remote areas and it helps decrease the health center workload as these mothers no longer go at the health facility for injectable FP services (Katz et al., 2010).

Similarly, the majority of supervisors of the VHTs report that the number of family planning clients at their health centers has decreased since VHTs starting providing the injectable FP methods. Overall, the VHTs were observed to be establishing a conducive environment for their clients. As a result the provision of the injectable PF methods by VHTs has reduced the congestion in health facilities. This is regarded as a benefit since the facilities have few human resources and those that are there are overworked and may not be able to provide services effectively (Katz et al., 2010).

People believed that injectable FP services are well accepted by communities because of several factors including getting one injection after three months, sometimes a woman does not experience menstruation hence reduced spending on pads, reduced failure rate and you do not become pregnant if you do not go back a day after the appointment(Babihuga et al., 2013).

In addition, the fact that no complaints have reached the authorities of the facilities reinforces their belief that the community accepts the program. Not only does community acceptance of the program appear to be positive, but client satisfaction with injectable methods and VHTs services also appears to be high. Most clients reported that they were very much satisfied with the counseling and information they received from the VHTs during the first visit. VHTs make service more accessible and they keep information confidential, the method or provider is easily available, and injectable family planning is beneficial and prevents unwanted pregnancy (Hoke et al., 2012).

Another study that was conducted in Zambia on Expanding Community Based Access to Injectable Contraception provided by community-based distributors on Acceptability and Satisfaction indicated that clients suggested that family planning in general, injectable methods specifically, and being provided by the community drug distributors are all acceptable to the communities that these community drug distributors serve(Katz et al., 2010).

Most of the community drug distributors felt that the majority of women they visit were interested in using injectable family planning, though fewer felt that most men accepted the idea of their partners using a method. In terms of provision by the CBD, the majority of CBD felt that it was easy to gain the confidence of the community in their ability to provide injectable methods however; some CBD thought it was either very difficult or a little difficult gaining community confidence (Boerma et al., 2015).

As already noted, the availability and provision of injectable FP methods by community drug distributors appears to have increased contraceptive use; some of the clients reported that their

first injection of injectable FP method was the first time they had ever used a family planning method. Of those clients who had used a method before, some had used an injectable method from another source while most of the rest started using it through the village health teams(FHI, 2010).

The three main reasons why clients chose to use injectable FP methods were because it is very effective, they only need an injection every three months, and it is easy to use. Most clients reported that their partner knew and supported their use of injectable methods although only few reported that their partner did not support injectable use, and the rest did not tell their partner. Women's experiences with injectable methods appear to be positive despite experiences with side effects (FHI, 2010).

A large percent of clients reported side effects from injectable methods and the most common ones reported were amenorrhea, heavy bleeding, and headache. Nonetheless, the side effects did not seem to affect client satisfaction with injectable FP methods which are being administered by the VHTs and most of the clients reported that they were very satisfied with injection as a family planning method which is provided by the VHT members (FHI, 2010).

Satisfaction with an injectable method is further evidenced by the numbers of clients who reported that they opted to receive a second injection from the VHTs. Most clients received their second injection, and a similar percent plan to have another injection still through the VHTs. Although most women are interested in continuing with the methods some clients who did not plan to get another injection, the reasons given by the largest number was because they wanted to get pregnant and others were being told by their husband to stop (FHI, 2010).

The study conducted shows that there has not been much dissatisfaction with receiving the injections from the community drug distributors or the VHTs, as most of those who plan to have another injection said that they would like to receive it from VHTs. The VHTs themselves believed that clients are generally satisfied with provision of injectable FP methods (Bertrand et al., 2015).

The comments in the community about community drug distributors or VHTs on provision of injectable FP methods were generally positive as cited by some of them who heard comments, with most reporting that people are happy that family planning services are nearer to the communities than before when it was at the health centers and people like the injectable methods specifically. While all of the VHTs who have provided second injections reported that they have clients who come for their next injections without reminders (Katz et al., 2010).

Despite the increased workload most of the VHTs feel positive about the additional work and they are happy. Nearly 40% feel good about injectable FP provision because FP helps women and also play a major role in reducing maternal death even the VHTs gets more clients and they believe the workload is manageable (Mbewe et al., 2011).

However, most supervisors did not agree with this assessment. Only four DHO out of how many supervisors felt that the CBD workers were fully prepared to provide injectable FP methods once they had completed their training but the rest of the DHO, Supervisors and both Child Fund Zambia supervisors felt that the community drug distributors were not fully prepared (Mbewe et al., 2011).

Another study conducted in Madagascar and Ethiopia indicated that injectable FP methods are now the method of choice for over 70% of women using modern methods of contraception, compared with almost no utilization as recently as 1990 .Ethiopia is like any developing country with shortage of highly-skilled health-care providers and its government launched extension health worker whose work is like that of VHTs in Uganda and one of their function is to provide the injectable FP methods(Prata et al., 2011). The Ethiopian Ministry of Health's National Reproductive Health Strategy 2006–2015 sets a goal to delegate to the lowest service delivery level as possible, the provision of all family planning methods, especially the injectable methods to be given by their extension health workers(Prata et al., 2011).

According to a study which was conducted in Kenya on women's attitudes towards receiving family planning services from community health workers ,it was noted that in order to effectively scale up family planning service provision to meet the current and future needs, an adequate number of trained health workers or VHTs should be available. However, the shortage of health workers hinders family planning service provision especially in rural areas (Namuunda & Mukiira, 2015).

Task shifting and sharing of family planning service provision with CHWs is a means of increasing injectable family planning service utilization without adding excessive burden to the already seriously strained health sector. Task shifting serves as a means to extend family planning services into communities where they are needed through the village health team members, hence improving coverage and geographic equity of family planning services (Namuunda & Mukiira, 2015).

Many developing countries have developed policies and programs to support task shifting and sharing of health care service provision with CHWs and the VHTs, including provision of injectable family planning services in rural areas, (Namuunda & Mukiira, 2015).

Experiences from some developing country shows that community based family planning services have been used successfully to deliver family planning methods including distribution of pills as well as injectable contraceptives (Namuunda & Mukiira, 2015).

In many countries this has been achieved by training and equipping community based health workers who provide various methods of family planning including injectable methods. For instance, Zambia implemented integrated community based family planning and reproductive health with nutrition, education and income generating activities with positive outcome in increasing contraceptive prevalence in rural areas, even though literature on uptake as well as methods used for family planning at community level in developing countries is available, literature on perceptions and attitudes of women towards the use of family planning services offered by CHWs is scarce(Namuunda & Mukiira, 2015).

Many women in Africa have hectic fifteen-hour work in a day in which they have to do housework, farming, marketing, and care for their families. It is very difficult for a woman who is busy like this to travel several miles to a health center for injectable family planning. If she makes the first visit, she might not be able to find the time for a second visit but can receive injection FP methods from the VHT (Hoke et al., 2012).

Men tend to be the major decision-makers in the area of family planning, so that after a woman has struggled to find the time to come to the clinic and be counseled on various contraceptive methods they may chose the methods but some women still wants to go and tell their husbands. A CBD program addresses the problems of distance and waiting time for just FP injections by taking the service near to the woman's home, so that she does not have to travel to the health center but the VHT to provide the injection to the women in their catchment areas. The CBD agent can counsel both husband and wife together. On the other hand, CBD programs provide modern contraceptive methods which are ideal substitutes for the traditional family planning method of abstinence, which is becoming less popular as societies modernize and become more urban (Hoke et al., 2012).

As evidenced by the training of VHTs in Iganga district by the APC/USAID-funded Advancing Community-based Access to Injectable Contraceptives in Uganda project, Well Share International conducted a district assessment on readiness of community-based access to injectable contraceptives and results showed that only 3 out of the 55 Health Centers in Iganga offer youth-friendly services including FP and less than 10 percent of Health Center staff are trained in youth friendly services. This means that youth access to family planning services is minimal from the health center but they can be provide injectable FP method by the VHTs as it is easy to visit the home of the VHTs than going to the health centers were many people see them (Kobusinge, 2012).

Although a number of CHWs indicated they did not know that volunteer work would be about injectable family planning when they agreed to be trained, over half believed that the new knowledge contributed to improvement to their personal lives and even most women appreciated the VHTs for the work they are doing and it has made easy to injectable methods of family planning compare to the time when they were going to health facility when women use to go and come back without getting the injections and they end up with unwanted and untimed pregnancies(Wamala et al., 2014).

Much as there is improvement in the recruitment of human resources for health and most of the gaps are filled up in some districts, there is still a problem in accessing FP services in most of the health facilities leading to high unmet need of FP and to reduce the high unmet need for family planning in Uganda, USAID consistently invests large sums in contraceptive commodity procurement and remains the largest donor in this area (Bertrand et al., 2015).

Distance, quality of service, waiting time and availability of health workers are keys in choice of receiving the injection FP from the VHTs than the health facility. Time spent before being attended to by the health worker is critical in effective delivery of health services as long waiting time discourages the mothers to seek family planning services from the health unit. Only 9 percent of women and 17percent of men reported that the health facility carried out outreach services on family planning in their villages and in other place people noted that no outreach was done by health workers, but by some Village Health Teams who are poorly facilitated(Bukuluki et al., 2015).

2.4 Challenges faced by the VHTs in provision of injectable family planning methods

Negative male attitudes towards FP have been shown to affect contraceptive use indirectly(Waled et al., 2016).In some cases, women whose partners are opposed or believed to be opposed to FP use contraception without disclosing to their partners or do not use contraception at all (Asingwire et al., 2016).

Even when men are not opposed to a woman's use of contraceptives, they often consider FP a woman's issue. Thus, changing male attitudes and dispelling myths and misconceptions amongst men is important to ensuring their support of FP. Another area of major concern is the reproductive health of young people, especially those who are sexually active are not allowed to use injectable family planning methods yet they still want to delay pregnancy (Asingwire et al., 2016).

Social and individual behavior to address myths, misconceptions and side effects improved acceptance and continued use of family planning to prevent unintended pregnancies. The low use of FP among people is partly attributed to the myths and misconceptions about FP and its side effects together with lack of information and access to services can be addressed by the services being offered by trained non-skilled personnel such as VHTs (Asingwire et al., 2016).

Away from the deficiencies on the side of health workers, especially mothers who seek FP services without checking first the pregnancy test and they are given the injection when they are

already, the VHTs are highly blamed and yet the VHTs are not provided with the pregnancy testing kit (Asingwire et al., 2016).

A study conducted in Karamoja indicated that the adult males in villages, still do not embrace modern methods; some of them have adopted strategies of avoiding their women who have given birth and are still breast feeding. They do this by going to stay in the kraal for a long time because if a woman gets any problem related to the drug and they ask for clarification through interaction with professionals who are always busy at the health facility (Hoke et al., 2012).

The alternative of community based providers such as VHTs has served about less than a tenth of young people overall. The few who have been reached by VHTs also had such interaction only once or a few times and as a result, their concerns and questions about FP remain inadequately handled and due to personal reasons, social problems or natural causes, some of the VHTs cease to be active or fallout altogether (Hoke et al., 2012).

Maintaining consistent commodity supplies was a challenge across settings by the VHTs. Problems rarely originated with VHTs, but mostly occurred when health facilities did not have supplies that VHTs needed and it is usually because of faulty forecasting, late requisitions or national shortages and in some bad roads especially when there is too much rain and the roads becomes flooded making it difficult for the VHT to reach the health facility for more supplies(Hoke et al., 2012).

Reasons why women are not using family planning methods that are available and accessible through the VHTs include because some people think that the VHTs have little knowledge about injectable methods and many men say they cannot entrust their wives in the hands of the VHTs. The reasons cited include opposition from male partners, side effects experienced by clients, myths and misconceptions about family planning among men and women, low FP continuation. Only about 25% of clients on average return to the VHTs on time for resupply or reinjection of a method (Kirunda et al., 2016).

Another study carried out in Pakistan to explore barriers faced by the female village health teams on provision of the injectable FP services in their communities found that the main reason was lack of drugs for managing the side effects of the injectable FP methods and some VHTs do not want to refer women with side effects and complications to various health facilities and those referred faces transport problem, especially on camp days (USAID/JHU, 2012).

The women who go to the health facility complain about long waiting hours for their treatment, some also reported inappropriate attitude of the staff, insufficient arrangement and payment for the procedure, resulting in the reluctance of clients going again yet these clients are the same people underrating the services provided by the VHTs,(USAID/JHU, 2012).

Some people in the community don't feel the community drug distributors and VHTs are skilled enough to provide the injection. Finally few clients refused the next injection because they were dissatisfied with the methods being provided by the community drug distributors and they refused the next injection and they preferred to go to the health facility (FHI, 2010).

In contrast, half of the VHTs report they are working more time since they started offering this service, and yet they are not given any token in addition, some say that providing injectable FP methods in addition to their other duties has caused problems. The biggest challenges faced by the VHTs cited were long distance which results in difficulty in travelling to the health center for more drugs, time constraints, and lack of transportation.(Katz et al., 2010).

Supervisors believe that CBD provision of DMPA appears to have contributed to the number of factors surrounding injectable FP methods provision influences the community drug distributors' workloads. For instance, the VHTs place,(Najjuma, 2015), spend long hours providing services, most of them are available at any time to provide the injections to the clients and they report that they spend an average of nearly 21 hours per week (range seven to 40 hours) providing family planning services. An additional burden is the travel time to the health center to receive family planning supplies they use their bicycle to travel to the health center and it takes an average of one to four hours to reach the center which is tiresome and some find difficulties making the trip to the health center at different times of the year; flooded roads is the most common problem (Kimbugwe et al., 2014).

Some people in the community look at the VHTs having no experience and lacking knowledge about FP. About 30% of women stop using a method due to side effects or because their husbands disapprove of injectable FP methods being provided by the VHTs and the VHTs also reported that most clients who drop out are within the first three months and these women are stopped by their husbands (Mlambo.C et al., 2013).

Since injectable methods provision began, the VHTs for the first time did not believe they received enough support with their new responsibility, only few about 37.5% of them reported receiving this support primarily by a nurse at the health center or a District Child Fund Zambia supervisor (Odiyo et al., 2011).

Both Child Fund Zambia supervisors and six of nine DHO supervisors reported that increased demand has impacted injectable FP stocks out. The community drug distributors confirmed that obtaining injectable FP supplies can be a problem and are not always available with them and even at the health facilities (ZAMBIA, 2011).

About half of the community drug distributors who had clients ready for second injections said sometimes they could not provide the next injection because they did not have any injection supplies as many women prefer to get their second injection through community drug distributors which leads to unplanned pregnancy and later women will fear to go for injection from the VHTs (ZAMBIA, 2011).

Other challenges faced by the VHTs when delivering health care messages included lack of political support and lack of enough resources such as educational materials (IEC), lack of transport means when following up clients in the community, lack of information about the sick or those discharged from the hospitals/health facilities and lack of drugs to take to them (Kimbugwe et al., 2014)

In addition to these challenges, poor motivation as the government has not allocated any funds to support their activities, lack of identification tools such as IDs or uniforms and the fact that they

have never received their certificates, frequent drug shortages, poor road network in the communities, political interference, lack of community awareness concerning VHTs and lack of male involvement. Thus this translated into work load for the active individuals since some of the VHTs have resigned from their work and only few are working. Majority of the VHT members were serving at-least 35 households against the set standard of 25 - 30,further making their work difficult and many of the VHTs confessed to be in charge of 100 or even more households yet these households are not clustered together but rather sparsely spaced and prolonging the distance (Kimbugwe, 2014).

As such, the VHT members are left to rely on their spirit of volunteerism which in turn affects their morale and efficiency while executing their duties. Because of lack of motivation, majority of these VHT members have ended up being inactive and yet they were very interested at the beginning. They reportedly experience poor interpersonal relationships especially with the politicians in the communities and some health workers, (Kimbugwe et al., 2014).

Some political leaders are not interested in their activities and those who are interested tend to interfere with them especially when it comes to issues like mobilizing community members. Health workers take them to be of a very low cadre in health care delivery. And having inadequate skills coupled with lack of refresher trainings was another big challenge encountered by the VHTs because they were supposed to undergo refresher trainings but it is not being done (Kimbugwe et al., 2014).

2.5 Challenges faced by the district health managers in supervising/ working with the VHTs in the provision of injectable family planning

Referring clients to midwives for counseling on Long term family planning methods is a problem with the VHTs as they think the community will doubt their work if they refer any client to the health centers (MOH, 2015).

Some VHTs do not document the nature of the FP counseling and injection they provide to clients and it becomes hard to them when it comes to writing a monthly report. Working with VHTs presents different challenges compared to working at the facility level. For example, VHTs are volunteers, most are semi-literate and have no previous data analysis or monitoring and evaluation experience (Kirunda et al., 2016).

Another study also indicated that the VHTs were not able to provide injectable family planning and counselling on a daily basis due to their busy schedules (Kirunda et al., 2016). Mothers were receiving injectable family planning services with no records made by the VHTs. The VHTs could not estimate the quantity of the injectable they have used or which are needed, thus, making it very difficult for the district health managers to assess performance in injectable FP service provision (PROJECT, 2016; USAID/JHU, 2012).

Village health team members are expected to provide injectable family planning counseling but they were giving different information on family planning and some important information were not included on the counseling charts which are being used by the VHTs. Mothers were receiving Family Planning services with no records taken. It was very difficult for teams to

assess, thus making it difficult to quantify the drugs needed by Kirunda (PROJECT, 2016; USAID/JHU, 2012).

A report of a study conducted in four African countries on Community-Based Distribution of Injectable Contraceptives indicated that the supervisors who are supervising the VHTs in providing the injectable family planning indicated that there were problems of safe disposal of medical waste, counseling on possible side effects and referrals of clients for management of serious side effects (FHI, 2010; Hoke et al., 2012).

Supervision was the chief mechanism by which service quality on injectable FP by the VHTs was monitored and performance standards were reinforced. Nonetheless, even these supervisors faced time and travel constraints that impeded their ability to maintain consistent contact with community-based distribution agents more frequently. The district health management teams in some cases, such as when flooding made roads impassable for them to reach the VHTs homes and to add more supplies of injectable FP methods. Sometimes there are no facilitations for the district health managers to reach the home of VHTs especially in terms of fuel (Hoke et al., 2012).

2.6 Strategies to overcome the challenges faced by the VHTs in the provision of Injectable FP methods

A study conducted in Senegal indicated that CHWs were based in health facilities and worked under the direct supervision of a skilled provider, usually a midwife so that they have enough skills in handling clients and the community has appreciated that the CHWs has knowledge . The MOH Senegal engaged developing a strategic plan to consolidate and promote community

health program which allows CHWs to provide basic health care including family planning services and some motivation inform of money is attached to this initiative (Mané et al., 2015).

The strategic orientation of political leaders on involvement of CHWs to provide reproductive health services confirmed the commitment of national authorities to support task sharing initiatives and although task sharing is not explicitly mentioned as a national priority in policy documents and political support is included in the document which allow the CHWs to be recognized as health workers at the village level (Mané et al., 2015).

Study done in Pakistan showed that men have negative attitude on VHTs providing FP services to their communities with reason that having many children especially boys is a source of great pride in Pakistan, as it heightens the status and prestige of a family within the community . This results in families in particular mothers -in-laws pressuring young married couples to produce many children and failure of the VHTs to manage side effects gives negative attitudes towards using FP services provided by the VHTs (Kimberley Wallaart et al., 2015).

Fear of side effects is another reason why people do not accept FP services from the VHTs for both husbands and wives and they fear that the uptake of contraceptives would harm a woman's womb formed an important obstacle in adopting such methods which makes it difficult for the VHTs to provide the service (Kimberley Wallaart et al., 2015).

In line with this, women lack decision-making power to decide on their own reproductive behavior making their husband to attack the VHTs for giving them FP service. There should be health education on importance of FP which does not only target women, but also to target men

to allow them change their attitude towards the VHTs and FP as well (Kimberley Wallaart et al., 2015)

Additionally, quotes of various storytellers showed that repeated contact with the same VHT helps take away fears associated with injectable FP methods. At least for some participants trust needs to be built slowly before participants really start to listen and open up to the VHTs.
Policymakers and program planners determine community health providers' practices and procedures based on the local context, taking into consideration the burden of disease, community priorities, available resources and capacity (USAID, 2017).

In India interest groups such as medical lobbies, women's health and rights activists, and parents' associations play are influential in deciding the extent of availability of contraceptive methods to the public and they put pressure on the Government to involve VHTs in the provision of emergency contraceptive pills and other methods of family planning methods and more VHTs where trained to increase on the few numbers (Khan1 & Bhatnagar, 2015, Vol. 35(4) 387–401).

In some countries, cultural practices restrict women's movement or their ability to make independent decisions and myths and misconception associated with FP makes women to use these drugs however CHWs overcome such barriers by bringing services to where women and their families work and live. Success of CHW programs is directly linked to continuous product availability at the community level and these drugs must be available with the CHWs throughout (Khan1 & Bhatnagar, 2015, Vol. 35(4) 387–401)

2.6 Conclusion

The purpose of this study was to identify the contribution of village health teams on the uptake of injectable family planning methods in Apac District. From the literatures there are challenges faced by the VHTs while providing injectable FP services within the community coupled with the poor perceptions of the community on VHTs and the quality of the injectable FP services provided by the VHTs.

In addition, it is significant to note that most of the studies on provision of health services including family planning by the VHTs were acknowledged. The study also established why unmet need of family planning is very high in Apac district 68% compared to the average national of 45% and the main factors affecting the uptake of injectable family planning services in Uganda and reasons for observed disparities in Apac district. Lastly strategies to overcome these challenges faced by the VHTs, most of them suggested that if they could be considered as CHEWS while others said they do voluntary work and it will be God to award them in future.

As the researcher has shown in the literature review, the uptake of injectable family planning is still very low in Africa and it is made worse that in Uganda most especially Apac as a District there is no official, accessible and citable study about the contributions made by the VHTs on the provision of injectable F.P services. This study will provide this useful information.

CHAPTER THREE

METHODOLOGY

This chapter describes the procedures that were followed in conducting the study.

3.1 Study design

A descriptive cross-sectional and non-interventional study design was used employing a mixed method of data collection where both qualitative and quantitative techniques and approaches were used. The mix study method was used concurrently. The qualitative method enhanced the collection of responses from the respondents on their perspective of the contribution of the VHTs in the provision of Injectable FP services.

This particular study design and methods were chosen due to their effectiveness in acquiring the needed information from the field. The structured questionnaires and in-depth interview guides were also administered for the purpose of getting right information from the expected respondents in the study area.

Descriptive survey research was intended to produce information about the contributions made by the VHTs in providing injectable FP services to the community that will interest stakeholders such as policy makers. Descriptive survey design is used in preliminary and exploratory studies to allow the researcher gather information, summarize, present and interpret it for the purpose of clarification. It is also used to generate and refine research questions for further studies.

3.2 Study area

Out of the twenty (20) health center IIs in Apac District, the study was carried out in only twelve (12) accredited government health center IIs although VHTs were trained from seventeen (17) facilities on injectable FP methods. The twelve health centre IIs included Ayago, Aganga, Kungu, Kidilani, Chegere, Atar, Biashara, Olelpek, Wansolo, Alworoceng, Alado and Atopi health center.

3.3 Study population

The study population was all the trained VHT members who were providing injectable family planning methods based at Health Center IIs in Apac District, the women of reproductive age, Health workers and the community members were considered in the study as key informants.

3.4 Study unit

The study unit was a member of the VHT who was trained in providing injectable FP methods, a woman of reproductive age and a health worker supervising the VHTs.

3.5The sample size determination

Sample size is the finite part of a statistical population whose properties are studied to gain information about the whole population. The sample size for this study was 156 respondents comprising of 53 VHTs out of the total of 60 that were trained, 11 health workers out of 12 from each facility, 56 women out of 60 expected to be in the study and 36 community members.

3.6.0Sampling technique

The researcher accessed the family planning unit in each of the twelve (12) health centers and randomly obtained members who formed the groups from which opinions were sought. To obtain the required number of five (5) VHT members per facility, all five (5) VHT members who were trained from each of those facilities were purposefully selected but only those who consented to participate in the study were included; one (1) health worker was also purposefully selected based on their consent and five (5) women were randomly selected on the first come basis and 3 community members from the 12 H/C II who are the opinion leaders in the area as key informants to participate in the study but only after receiving their consent. This method was selected because it is easy to use since the nature of the study required just a particular category of respondents.

3.6.1 Selection of the Study District

Apac District is one of the districts with the highest population in the country as well as having a fertility rate that is higher than that of the country of 7.2 children and unmet need of 62% from the data reviewed in the district and the population growth rate of 3.3 per year (National housing and population census 2014). Apac district is among the districts whose VHTs were trained on provision of injectable FP methods. Therefore, I selected it purposively because it is where injectable family planning methods were utilized after the training of VHT members.

3.6.2 Selection of Health Facilities for the Study

All the government health center IIs that VHTs are attached to were trained to offer Injectable FP methods were selected for this study.

3.7.0 Study Variables

All variables for this study were extracted from the four study objectives as discussed below:
The perceived quality of injectable FP methods provided by the VHTs. The variables are; Timely injections given and the indicator is reduced waiting time, another variable is the injection is risk free and its indicator is no injection abscess reported by the client, client centeredness were the clients reported that the VHTs are welcoming, accessible and reliable services indicated by VHTs always present to offer the injections and the last variable the affordable indicator is free injections provided by the VHTs tool for data collection is interview guide and key informant interview.

On the Socio-cultural factors on injectable FP method provided by VHTs, the variable is the perceptions of the community on injectable family planning provided by the VHTs, the indicator are reasons given by the clients partners on VHTs providing injectable FP methods, Knowledge of the community on injectable contraceptives, myths and misconceptions of the community.
The challenges faced by the VHTs while providing injectable FP methods, the indicators are negative attitude of male partners, side effects and lack of drugs to manage side effects, erratic supply of FP drugs, cultural norms/values, and long distance to health centers and work overload.

To establish challenges faced by the district health managers in supervising the VHTs while providing injectable FP services is the last objective and the variable are the challenges faced by the health workers in supervising VHTs in provision of injectable FP services indicated by Limited time to supervise VHTs, lack of documentation of procedures given, poor Report

writing skills, lack of harmonized counseling message, level of education of some VHT members, unsafe disposal of medical waste.

3.7.1 The Dependent Variable

The dependent variable was up take of injectable F.P being provided by the VHTs.

3.7.2 The independent variable

Provision of injectable FP methods by the VHTs in terms of the quality, perception of the community on VHTs offering Injectable F.P, and challenges of VHTs in Providing F.P services as described in the table 2 on the appendix.

3.8 Research Instruments

Primary data was collected using semi-structured questionnaires and Focus Group Discussion (FGD). These data collection tools' guides used are attached in the appendix section.

3.8.1Data collection and study instruments

Data were collected with the help of two research assistants who had completed at least diploma in midwifery and were conversant with the indigenous language in the study district (Luo). The research assistants were oriented on the research objectives, quality control, record taking and research ethics prior to the beginning of data collection process. They traveled to the villages at pre-arranged dates to conduct the study.

All interviews were digitally recorded and were checked manually for completeness and consistency. Experienced research assistants directly transcribed and translated the recordings from Luo to English. Based on the key questions and study objectives, a coding system was developed before the transcripts were examined. The initial step in the analysis was to read through all the transcripts several times while making notes in the transcript. The notes were reviewed by multiple readers and themes identified and coded, to ensure that all the key themes are captured. The research assistant and the lead investigator used an empirical approach to modify the pre-determined themes.

Interviews were held with the VHTs. This also allowed VHTs to give the challenges they face while providing injectable FP methods. Key informant interviews held with the health workers focused on the challenges they face while supervising the VHTs in provision of injectable FP methods in the district. Key informant interviews were also held with women to get the perception of the community about the provision of Injectable Family Planning methods by VHTs.

For all of these sources, Open-ended questions and responses to specific issues were used to allow for exploring new ideas and generating rich personal narrative. Each respondent was interviewed for between 45-60 minutes as they were given options to respond to the questions either in Luo or English depending on their preference. Every day, hand written notes were taken during the dialogues. These were reviewed and a detailed report written for each dialogue. The raw data were harmonized and revisited time and again to ensure accuracy and quality control. The audio taped in-depth interviews (in the local language) were transcribed and then translated

in English. All filled questionnaires were reviewed by the researcher and statistician for consistency and data quality Data was then entered using Epi info version 3.5.1.

3.9 Data analysis and presentation methods

After verifying and reviewing the coded and labeled responses, the researcher identified major themes. Open coding was carried out and the codes were grouped into categories in order for themes to be identified. Codes were grouped into categories and then themes and subthemes further identified. This was intended to identify similarities as well as differences in experiences and opinions across various categories of participants. Qualitative latent content analysis technique was used and the data was therefore condensed without losing quality. The research assistant and the lead investigator used an empirical approach to modify the pre-determined theme where inductive thematic analysis was used.

3.10 Quality control

To ensure quality, the tools were pre-tested on mini interview conducted using men and women at Nkozi Hospital to evaluate the relevance of each item in the guides to the research objectives and rate each item on the scale of very relevant (4), quite relevant (3), somewhat relevant (2) and not relevant (1) to ensure their validity and reliability and all the necessary changes were incorporated in the final tools.

Research assistants were recruited and trained in qualitative techniques. The research assistants were also oriented for two days on the research objectives, quality control, record taking and research ethics prior to the beginning of data collection process. Day one of the orientation involved face to face talk between the researcher and the research assistants and day two

involved field works to familiarize with the data collection tools. This was aimed at ensuring accuracy, consistency, uniformity and validity of the dialogues.

Validity refers to the appropriateness of the instrument or the extent to which research results can be accurately interpreted and generalized to other populations. To improve the validity of the questionnaire, the researcher tempered the tools to fit the study objectives. These catered for language clarity, relevance and comprehensiveness of the content and standard length of the questionnaire.

Validity of instruments was further ascertained by first of all discussing the questionnaire and check list drafts with the supervisor. The contents of the instrument were found worthy executing for the pilot run and thus the study. About 10% of the questionnaires were tested on the various respondents.

Reliability is defined as the level to which one depends on the results in the context of instruments used for measurement. According to Mugenda, (1999), Reliability; is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. To ensure reliability of the research instrument, a Cronbach alpha test was computed as a measure of scale reliability to determine the consistency. 30% of the questionnaires were used to measure scale reliability and consistency.

The instruments were retranslated to local Luo from English. The recruited data research assistants were trained for one day. Regular monitoring and supervision of the research assistants were done during the data collection period.

3.11 Ethical consideration

Before going to the field to collect data, the researcher first obtained an introductory letter from the Faculty of Health Sciences, Uganda Martyrs University which was taken to the participating health facilities where the researcher carried out the research through the office the DHO. Written consent was then sought from each participant before seeking for any information from them, assuring them of maximum confidentiality and respect by not putting their names on the questionnaires but giving codes for them to remain anonymous. However, the consent forms were kept away from the data collection tools under a key lock place since it has the names of the respondents but the interviews were also conducted in a private environment.

The principal researcher closely supervised the research assistants, reviewed each questionnaire collected and held daily debriefs after each fieldwork. Notes were taken during the dialogues which were reviewed and a detailed report written for each dialogue held.

3.12 Plans for Dissemination of Results

When the study was completed, the dissertation was to be submitted to the Faculty of Health Sciences, Uganda Martyrs University. Copies are to be disseminated to all the stakeholders who included the district authorities and the individual health facility for consideration of the recommendations made.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.0 Introduction

This chapter includes the presentation, analysis and discussion of the study findings regarding the contribution of Village Health Teams on the uptake of injectable family planning services. It contains the demographic characteristics of the respondents and more information on performance, socio-cultural beliefs of clients affecting utilization of Injectable FP method, areas for improvement for VHTs and challenges faced by VHTs while executing their duties. The findings are presented according to specific objectives. The research put into consideration the demographic characteristics of the respondents and these were considered relevant during data collection.

In relation to the findings from the FGD, pseudo names other than real names were used to ensure confidentiality of the respondents.

4.1 Socio-Demographic Characteristics of the Respondents

The researcher identified the respondents' socio-demographic characteristics in respect of gender, age, and marital status. This was carried out so as to appreciate the reliability and the accuracy of the research findings.

4.2 Distribution of Respondents according to Gender

The result from the study on gender indicated that 42.4% of the respondents were males, while, 57.6% were females out of the entire response rate. This meant that more women seek family planning services as compared to their male counterparts and this method is specifically for women. The respondents were observed about their sexes as in table 1 below.

Table 1: Distribution of Respondents by Gender

Sex	**Frequency**	**Percentage**
Women	79	51
Men	77	49
Total	**156**	**100**

Source: Primary Data (2016).

4.3 Distribution of Respondents by Age

The researcher was interested in finding out the age of participants in the study. This was important in that it helped in identifying the existing varying ages of respondents for deciding on the possible interventions. The respondents were asked about their ages and their responses were as in table 2 below.

Table 2: Distribution of Respondents by Age

Age	Frequency	Percentage
15-24	30	19.2
25-34	62	39.7
35-44	48	30.7
45 and above	16	10
Total	**156**	**100**

Source: Primary Data (2016)

The majority of the respondents were between 25-34 years (39.7%). It was found out that majority among the respondents were in their middle ages of reproduction while respondents aged 45 years and above had the least percentage of 16%. However respondent between 15-24 years were 30 (19.2%) although most of them were not yet married but they are providing FP services to the community without any problem.

4.4 Distribution of Respondents by Marital Status

We found out the status of marriage of the respondents decide on the possible interventions. Their responses were as in table 3 4 and 5 below.

Table 3: Distribution of Respondents by Marital Status (health workers N=11)

Marital status	Frequency	Percentage
Single	04	36.4
Married	05	45.5
Widowed	02	1.7
Total	11	100

Source: Primary Data (2016)

Table 4: Distribution of Respondents by Marital Status (Clients)

Marital	Frequency	Percentage
Single	21	37.5
Married	26	46.4
Widowed	09	7.5
Total	**56**	**100**

Source: Primary Data (2016)

Table 5: Distribution of Respondents by Marital Status (VHTs)

Marital	Frequency	Percentage
Single	07	13.2
Married	32	60.4
Widowed	14	26.4
Total	**53**	**100**

Source: Primary Data (2016)

Majority of respondents from three categories who participated in the study were married women and men. However, some women who are single could be because one might have separated with his or her dear one some time back and vowed not to re marry.

4.5 Evidence of quality of injectable FP services offered by VHTs.

This refers to the quality of injectable FP services offered by VHTs in terms of safety, effectiveness, timely, equitable and patient centeredness. This was important in that it helped in identifying how the VHTs are providing injectable FP services to the community. Respondents were asked about the quality of injectable FP services provided by the VHTs and the responses were as in table 6 below.

Table 6: Distribution of evidence of perceived quality of injectable FP services by VHTs (N=56)

Response	Frequency	Percentage
Safe	56	100
Timely	56	100
Effective	53	95
Patient centeredness	49	88
Affordable	49	88

Source: Primary Data (2016).

The study noted from the respondents that all the respondents 56(100%) said the quality of injectable FP services offered by the VHTs are safe and effective. In finding out why the

majority of the respondents said so, they said that the VHTs are easily approachable, friendly and they are always available when they are needed. According to the findings, the quality of safe injection by the VHTs seems to increase the number of clients who seek injectable FP methods from the VHTs as per the result since there is no injection abscess reported yet and the VHTs are always present to offer the services to the clients.

It was also noted from the study that 56(100%) of the respondent agreed that since the VHTs are within easy reach, they get their injection on time (timely) and 53(95%) believed that the services offered by the VHTs are effective. However, 49(88%) of the respondent agreed that VHTs are patient centeredness.

Similarly, findings from the focus group discussion, the respondents did mention that they fear health workers because they are rude. This to them affects the quality of care in the provision of modern family planning method at the facility as one respondent in the verbatim below reported that:

> *[…] I use to fear going to the health center and spend the whole day that is why I do not use family planning and I fear health workers because they are very rude.* (Aida)

On the contrary, some respondents reported that they did not get any injury or harmful side effects from the injections they got from the VHTs and to them the quality of care by the VHTs was good. They believed that the quality of care was good and that they are not going to stop seeking care from the VHTs.

> *[…] At least I have received five injections from the VHT but I have not experienced any problem so I know they are giving us good injections and I will not stop getting the injectable FP method from the VHT.* (Joan).

Further still, some respondents reported that the medicines administered by the VHTs were effective, provided in time and equitably. Others also pointed out that the VHTs are patient centered.

> *[…] These injections are safe as the drug come when packed together with everything so there no contaminations which occur in the injections which are packed separately from the needle and the needle is also very small*. (Rose).

Regarding the time taken to get the medicine, some respondents mentioned that they take very short time waiting for the injection as compared to the Health Facility. This to them makes them to go back and continue with their normal businesses

> *[…] Whenever I go for my injection the VHT attends to me immediately and I spend less than 20 minutes*. (Milly).

To respondents following the appointments coupled with the availability of the drugs as well as getting the injections in time is a major determinant for the effectiveness of the medicine. This is as per the verbatim below:

> *[…] I follow my appointment promptly since the drug is now available in our community so whenever I remember I always hurry that is why I have taken long without becoming pregnant.* (Lucy).

> *[…] The injectable FP is now at easy reach so I advice my fellow women to rest from producing every year and even if their husband do not want them to use family planning they can escape at any time and get the method*. (Hellen).

Some of the respondents pointed out that previously before the VHTs were allowed to give injectable FP method they use to borrow money for transport. While others appreciated the

government for such kind of delivery of introduction of making the VHTs to give the injection as in the verbatim below:

> *[…] I have rested from borrowing money for transport to go for FP in the health center, these days the VHTs are always with us and they are available whenever I want to get my injection.* (Mary).

> *[…] I really thank the Government for bringing this drug within our communities, nowadays I no longer go to the health center for family planning but before I could go for two day or even more for in injectable family planning methods.*(Agnes).

> *[…] One day a nurse shouted at me and told me to go and sleep in the kitchen for a night if I do not want to become pregnant and come back for injectable FP methods the following day because it is not emergency and she is tired to give me injection.* (Harriet).

However some women confirmed that even though their husband do not allow them to use injectable family planning offered by the VHTs, they will still continue using it as per the verbatim below:

> *[…] Even if my husband do not want me to use FP I will not stop getting the injection because I do not need any transport to go at the home of the VHT and sometimes I get it on my way to the bore hall.* (Maria).

4.7 Perception of the community on provision of Injectable FP services by the VHTs in the district

This refers to the perception of the community on provision of Injectable FP services by the VHTs. This was important in that it helped in identifying community issues that affect provision

of Injectable FP services. Respondents were asked about their perceptions about injectable FP provided by the VHTs and their responses were as in table 7 below.

Table 7: Perception of the community on provision of Injectable FP services by the VHTs in the district

Response	Frequency	Percentage
Saves time and money for transport	36	100
Women have enough time to do their domestic work	31	86.1
Women are now producing few children and they are easy to be cared for	27	75
Promoting prostitution among women	20	56
Caused barrenness	18	50
Producing abnormal/lame children	15	42
Reducing clan members	11	31

Source: Primary Data (2016).

The study noted from the respondents that the service provided by the VHTs saves time and money for transport that they would have used to travel to the health centers with 36(100%). On the other hand it was noted that since the VHTs are within the community, women will have enough time for doing their domestic work were the main perceptions of the community on Injectable FP method offered by the VHTs this was confirmed with 31 (86%).

In finding out why majority of the respondents said it saves time, most of them responded that women now have enough time to do the domestic work without going to the health centers which

sometimes make them to spend the whole day only for the injection. This is as per the verbatim below:

> […] *I support the work of the VHTs of giving the injections to the women in their communities as these women no longer go to the health center to get only the injection and it has saved them and their husband in either giving them money for transport or taking them to the hospital*. (James).

> *[…] I have decided to allow my wife get the injection from the VHTs since it is at easy reach and I don't have to give my wife transport money or take her to the hospital myself or pay a boda boda*. (Peter)

> *[…] These injection has helped me in many ways first I have rested from the burden of taking my wife to the hospital for FP and even we are still resting from, producing this girl is now four and half years*. (Simon).

Some of the respondents confirmed that VHTs have also saved time for women to go and follow long line only to receive the injectable family planning and they have rested from following long line in the hospital and they believe using injectable family planning allows a woman to rest and gain fully from the stress of frequent child births as per the verbatim below:

> *[…]These women are not wasting their time to go to the hospital and they are able to do their work and cook for their children on time. Even cleaning the home my wife maintains her home hygiene as she has enough time to do her work instead of spending the whole day in the hospital just for the injection which now provided by the VHT.* (Bosco).

> *[…] I want to produce only 4 children so I have told my wife to go and get the injection from the VHT so that we can send our children to good school*. (Alfred).

> *[…] At least this year she has not visited the hospital for family planning and she is not pregnant even, I am very happy and this boy is now 3 years and we still want to rest*. (Jacob).

However some respondents 20 (56%) of the respondents are not happy that since the VHTs are at the easy reach of the women it is making these women to move around with any man as they know they cannot become pregnant hence promoting prostitution among married women. This is as per the verbatim below:

> *[…] Using FP makes a woman to fall in love with any men who ask her because she will not become pregnant so I don't want my wife to join it.* (Paul).

The community has perception that if a woman is using family planning they will not produce many children hence reducing the number of the clan members with 11(31%), while others believe using family planning make women to produce lame or abnormal children as per the verbatim below:

> *[…] If she produces any lame child in my home, she will park her things and go to their home, doesn't she know FP causes lameness and abnormalities in children. Amtold she is receiving the injection from the local health worker by the name VHT.* (David).

> *[…] I do not support injection given to my wife by the VHTs; she even got abortion because she received that injection from a VHT so I think that child was even abnormal any way. (*John).

In addition some of the respondents wants their women to produce many children which is equal to the number of cows they paid as bride pride and if not there is always repeated domestic violence as to why their women are using injectable FP methods which being provided by the NHTs as explained in the verbatim below:

> *[…] Oh no not my wife I married her to produce the same number of cows I married her after all those cows are also producing so I want to have many children so that our clan become large but if she stars using FP the clan will reduce in number*. (Joseph).

Still on community perception about the injectable FP methods provided by the VHTs they are attacking the VHTs and some are beating/ chasing their daughters or wives away as why they are giving the injections to their children who are still at school and they are not yet married. Here the community believes FP is only used by the married couple only yet these young girls are sexually active as per the verbatim below:

> *[…] I have sent her away from my home she is still at school and received injection from the VHT does she want to become a prostitute*? (Winfred).

> *[…] I am worried if my wife starts getting the injection from the VHT she can fall in love with VHT because he give injection from his home, my wife should go the hospital.* (Micheal).

> *[…] Who has given you permission to get the injection do you think 7 children are enough that drug causes barrenness*. (Alex).

Mothers- in-law still has control over their son as confirmed by few who are against use of injectable family planning given by the VHTs and they think their daughters-in-law should produce the same number or even more children they produced. This was reported by few of the respondents in the verbatim below:

> *[…] Why does your wife wants to become barren? I found her getting the injection from VHT yet she has only two children, if I was using those drugs was I going to give birth to you, you are the 11th born but she has only 8 children*. (Josephine).

On the contrary some mothers-in-laws are encouraging their daughter-in laws to get the injectable FP from the VHTs even though their husbands are against it as per the verbatim below:

> *[…] My son does not want to dig, buy food, take his wife to the hospital and even pay the school fees so I have told her to get the injection without the knowledge of her husband.* (Margaret).

> *[…] At least with the injections are at easy reach I want my son and his wife to produce few children, there is no land for cultivation*. (Joan).

4.8 Challenges faced by VHTs in the provision of Injectable family planning services

This refers to challenges faced by VHTs in providing FP services. This was important in that it helped in identifying bottlenecks that affected provision of Injectable FP services. Respondents were asked about challenges they face while providing injectable FP to the women and their response were as in table 8 below:

Table 8: Distribution of challenges faced by VHTs in the provision of Injectable Family Planning Services (N=53).

Response	Frequency	Percentage
Lack of transport	53	100
No motivation by the government	53	100
Being under minded/rated by the H/Ws	53	100
In ability to manage side effects	51	96
Work load	50	94
Other assignments	44	83
Poor attitude of the community	40	75
Unwillingness by male partners	37	69
Lack of political support	35	66
Low educational level of clients which makes them to hold on the myth and misconception	30	57

Source: Primary Data (2016).

The study noted from the respondents that all the VHTs said lack of transport and no motivation by the government accounting to 53(53%) was their major problem; being under rated by the health workers also all the respondents agreed 53(100%).

Notably 51(96%) of the respondents believed they are not able to manage side effects although some were trained before by other IPs on family planning but the few VHTs who can manage the

side effects do not have the drugs to give to women with side effects which sometimes makes the women not to come back as per their appointments.

From the findings of study some respondents noted lack of political support 35(66%) coupled with Poor attitude of the community 40(75%) which in most cases prevent them from carrying out their duties as VHTs especially on family planning.

Since FP involve both men and women there is need for both parties to agree but some men have negative attitude towards FP with up to 37(69%) of being unwilling to support their wives to access the service from the VHTs.

As regards low levels of education of clients, respondent reported that their client hold to cultural myths about Injectable FP method because of their little or complete lack of scientific knowledge since most of them live in rural with 30(57%).

4.9Challenges faced by health workers in working/supervising VHTs in the provision of Injectable family planning services

This refers to challenges faced by the district health managers in supervising the VHTs providing injectable FP services to the community. This was important in that it helped in identifying bottlenecks that affected their supervision to the VHTs in provision of Injectable FP services. Respondents were asked about challenges they face while supervising the village Health Teams as they provide injectable FP services and their response were as in table 9 below.

Table 9: Distribution of challenges faced by Health workers in working/supervising VHTs in the provision of Injectable Family Planning Services (N=11).

Response	Frequency	Percentage
Lack of transport	11	100
Late submission of reports	11	100
Failure to submit reports	9	81.8
No documentation	11	100
Poor reception by the VHTs	07	64
Delay to be attended to by the VHTs	06	55

Source: Primary Data (2016).

The study noted from the respondents that most of them said lack of transport coupled with poor roads from the health centers to the homes of village health teams they supervise. Late submission of the reports or not even submitting the report completely makes the work of the health workers difficult as they need to order the injectable FP methods basing on the consumption rate, other problems includes failure of the VHTs to document any service they have offered and this was the response of all the respondents 11(100%) for each of them.

From the findings of study some respondents 7(64%)reports experiencing poor reception by the VHTs or sometimes VHTs do not attend to them when they go to their homes yet sometimes they have gone to support them or to add for them the stock.

Table 10 Strategies to overcome the challenges faced by the VHTs in the provision of Injectable FP methods.

Response	Frequency	Percentage
If the government could appoint the current VHTs as community health extension workers	53	100
Giving new bicycle or H/C to repair their bicycles and using boda boda	53	100
Refer women with side effects	53	100
IPs to give them monthly salary	47	89
District to support them to go for further training to avoid being under rated by the health workers	41	67
Policy and bylaws on man who do not want they women to use FP	35	66
Train more VHTs to reduce work load	35	66
This is a voluntary work and they will continue	30	57
Politicians to include them on the district budget	27	62
Low education level of clients which makes them to hold on the myth and misconception.	12	23

Source: Primary Data (2018).

From the findings of study all the respondents 53(100%) recommended that they should be considered and appointed as community health extension workers (CHEWs). However, only 23 (43%) had the required ordinary level of education which is the minimum requirement for one to be recruited as a CHEW.

Notably, 47 (89%) of the VHTs suggested that the implementing partners could give them token in form of salary on a monthly basis. However, 30(57%) of the VHTs said it is a voluntary work and they will continue with it. Other suggestions on how to overcome the challenges includes passing bylaw by the local council 35(66%) on men who do not want their women to use family planning, politicians to take those (VHTs) for tour that they attend every year and politicians to include them on the district budget among others.

Some of the VHTs felt that they were being under rated by the health workers. However, some VHTs suggested that there is need to support those who are able to continue with education to go back to school so that they continue with their work. On the issue of work load the VHTs argued that there is need to recruit and train more VHTs in order to relieve them from being over worked. Yet on the side of low education level of clients which makes them to hold on the myth and misconception 12(23%) of the VHTs proposed that there should be radio talk show to make the community understand the reality about injectable FP methods and to clear these myths and misconceptions.

CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

5.0: Introduction

This chapter discusses the findings of the field results and analysis, which were outlined in relation to the specific objectives in chapter one. As far as this chapter is concerned, it deals with results discussion, conclusion and recommendations based on the study objectives in reference to literature review. It also deliberates on specific recommendations for further studies in Apac district and about self-evaluation statement on the reliability of this study report.

The main objective of this study was to assess the contribution of VHTs in providing injectable family planning methods in Apac. Specifically, the study was to assess the performance and the quality of injectable FP services being provided by the Village Health Teams, to determine the perceptions of the community on the VHTs providing injectable FP services in the district, to identify the challenges faced by Village Health Teams and to identify the challenges faced by the district health managers in supervising/ working with the VHTs in providing injectable family planning methods in the district.

5.2 The perceived quality of FP injection services provided by the VHTs

From the results the quality of injections provided by the VHTs is perceived to be good with a large percentage of 70.1% of the respondents approving of the services. This indicates that involvement of the village health teams in provision of injectable family planning provision can

play an important role in reducing the high unmet need of family planning. This finding is in line with (Kaseba-, 2014).

This refers to the quality of injectable FP services offered by VHTs in terms of safety, effectiveness, timely, equitable and patient centeredness. This was important in that it helped in identifying how the VHTs are providing injectable FP services to the community and no injection abscess was reported in the period of the study.

Still from the study the respondents noted that VHTs attend to them immediately compare to health workers at the health facilities who have too many work and many patients to attend to coupled with following along line and handling emergencies first yet some client reach the facilities first but because FP is not seen as emergency so they are handled last. This finding is in line with (Namuunda & Mukiira, 2015) and (Asingwire et al., 2016)

The implication of using VHTs to provide injectable FP methods includes; relieve workload on the staff, reduce demand of health workers by the public and it also relieves pressure on Government to recruit health workers. However this is in disagreement with (Mbewe et al., 2011).

5.3 Perception of the community on injectable family planning services offered by the VHTs.

The perception of the community also indicated that the majority of the community members are benefiting from the injections being provided by the village health teams and many women have

accessed the VHTs home to receive their injections and it has reduced the walking of long distance to the health centers. This finding is in congruence with (Kabora 2016).

In finding out why majority of the respondents said it saves time, most of them responded that women now have enough time to do the domestic work without going to the health centers which sometimes make them to spend the whole day only for the injection. This finding is in line with (Wamala et al., 2014).

It was confirmed from the study that the VHTs are doing great job by keeping these injectable family planning at home so women are following their appointments and no defaulter has been observed for the time the VHTs have been giving the injections from their home. This is in agreement with (Hoke et al., 2012).

The community also appreciated the work of the VHTs and they are happy even those women whose partners were against FP now use without the knowledge of their partners as they can get their injections any time even when they are going to fetch water they just pass by the home of the VHT and it has helped them to keep their appointments. This is in agreement with (Katz et al., 2010).

However some of the community members believed that if a woman is using family planning, they become prostitute because they know they will not become pregnant so they go with any man and other members think FP causes barrenness if a woman uses it except natural methods

yet most of the women find it difficult to use natural FP, while other member think if a woman uses FP method they can produce lame or abnormal children. This is in agreement with (Kimberley Wallaart et al., 2015).

However some people confirmed that family planning leads to reduction of the clan members as the woman will produce very few yet they are married to multiply the clan. Therefore there is need to do a mass health education on injectable FP methods so that the community has enough knowledge on them and those who opposes FP methods might understand the dangers of producing children so frequently because the community think if a woman is using family planning will not produce completely and this finding is in line with Kimberley 2015.

It was also noted from the study that some of the parents are attacking VHTs for giving their daughters injections claiming that it will make them to start moving around with different men.

On the other hand, men believed that women should produce the same number of children with the same number of cows or even more than then number of cows they paid for dowry and they believe children especially boys are the pride of the home. This finding is in line with Kimberley 2015 (Kimberley Wallaart et al., 2015).

5.4 Challenges faced by the VHTs in providing injectable family planning services

Although the community is appreciative of what the VHTs are doing, the VHTs are faced with challenges such as transport which makes their work difficult to collect the drugs from the H/C. In finding out why majority of the respondents said so, they said that they have to travel to the health centers to get more supplies and take the report, this is coupled with poor roads which

sometimes becomes flooded making it especially when it rains it becomes difficult to ride on the rain. This is in congruence with (Hoke et al., 2012).

Other big problem is the transport means itself as some of them were not given the bicycles and even those who were given the bicycles they are too old and needs replacement, so the VHTs suggested that even those old bicycles should be repaired by the health facility they are attached to since it is the same bicycle which they use for immunization but if it breaks down they (VHTs) repair with their money.

There is no facilitation by the government and even the implementing partners give them little transport refund which cannot transport them from their homes to the district headquarters and taking them back home and most of the time the road become impassable especially during rainy season. This is in agreement with (Kimbugwe et al., 2014).

Although VHTs work within their communities, they spend most their time helping community members and other responsibilities assigned to them making them to spend more time at the facility instead of doing their work at home.

Poor attitude of health workers towards the VHTs demoralizes them to continue with their work so the health workers should appreciate the VHTs as they reduces the work load on the health workers and lack of political support came as an issue yet these VHTs are always within the community and helping the community members so their efforts should be recognized in any function and gathering in the communities

Other problems included being attacked by the parents of young girls who are not yet married and husband to some women, being over worked is another problem being experienced by the VHTs and this is in line with (Asingwire et al., 2016).

Therefore the work of the VHTs should be appreciated at all levels so that they will have the courage to continue with their work.

It was also noted that VHTs have too many work. Many IPs who go in the district target the VHTs first and involved them on various activities and other usual activities are also to be implemented by the VHTs such as immunization, community mobilization, involvement in indoors residual spraying so at the end of the VHTs are over whelmed with the work. This finding is in line with the study conducted by Kirunda in 2016 (Kirunda et al., 2016)

However some of the VHTs are still willing to continue with their work and they believe they were chosen by God and one day they will be rewarded for the work they are doing

5.5 Problems faced by the health managers in supervising/working with the VHTs in provision of injectable family planning methods

On the side of the health workers they reported some problems they encountered while supervising the VHTs and the major problem was transport means for travelling to the VHTs homes as most of the H/C IIs have no means of transport allocated and they have to wait for Primary Health Care funds which is released after three months yet they need to go to the home of these VHTs on a monthly basis or whenever the drugs reaches the health unit therefore, this problem can be solved by the District Health Officer by providing them with the transport means so that it is easy for health workers to supervise VHTs properly and timely. If there is transport

means, VHTs will be supervised and even during supervision health workers can add for them more injectable FP methods (drugs/supplies) which will build the morale of the VHTs since they will not be required to go to the health centers again for more drugs. During supervision the weaknesses of VHTs can be identified and addressed through continuous practicing and mentorship. The finding of lack of transport or fuel is in line with Hoke (Hoke et al., 2012).

Other problem health workers faces are no record keeping by the VHTs, poor documentation and incomplete documentation which makes it very difficult for them to make the monthly report and quantify the needed injectable FP methods. Therefore, the VHTs should be help on how to fill all the register being use and making proper documentation. This is in congruence with (Kirunda et al., 2016).

It was also noted from the study that the VHTs are not able to manage the side effects of the injectable FP methods. However some of the VHTs who were trained by the Marie Stopes knew how to manage the side effects but because they were not given those drugs for managing the side effects yet this is one of the reasons why women stop using injectable FP methods so they VHTs should also be given these drugs so that they can manage the minor side effects and refer those side effects they cannot manage.

Poor reception was another problem being faced by the health workers that when they visit the VHTs they are not welcomed well or sometimes the VHTs take time to attend to them yet they need to go back and attend to other clients remaining at the health facility and this is a two way complaints, VHTs are also complaining of being under rated/ minded by the health workers and

this can be minimized when a join meeting is held between the health workers and the VHTs since they are both working to achieve a common goal.

5.6 Strategies to overcome the challenges faced by the village health teams in provision of injectable family planning methods in the district

Most of the VHTs interviewed suggested that if they could be considered to become the community health extension health workers so that they continue with their work, while others said health center should repair their bicycles and give them new bicycles as the one they are using are very old and it is more expensive to maintain these bicycles while other VHTs proposed that they should use boda- boda when collecting the drugs and submitting the monthly report which is more expensive and not reliable. This is in agreement with the study by Khan and Bhatnagar (Khan1 & Bhatnagar, 2015, Vol. 35(4) 387–401).

On unwillingness of men of their women to use injectable FP methods VHTs said the district council should pass bylaws and these men are punish with a fine as well. Some VHTs suggested that for women with limited knowledge on injectable FP methods, health workers should be the one to tell them more about the rugs but they promised to tell them the truth to clear these women misconceptions and myths about injectable FP methods. This finding is in line with Asingwire 2016 (Asingwire et al., 2016).

Some of the VHTs felt that the IPs in the district should consider them for a monthly salary however little it may be as done to linkage facilitators attached to ART clinic in the health center providing ART services. However some of them said their work is a voluntary work and they are willing to continue serving the community either they are paid or not.

Those VHTs that do not meet the requirement of becoming the CHEWs proposed that if the district could sponsor them to go for further training for them to be given any opportunity which may come in future and this will also solve the problem of being under rated by the health workers but this might be difficult by the district as there is always limited fund for capacity building even those staff that are formally appointed are not supported financially when they are going for further studies.

On the side of work load VHTs suggested that government should train more VHTs to make their work easy and to give them time to do their family work and other responsibilities from home.

Lastly the VHTs suggested that the district councilors should include them on their budget and give them opportunity to travel with the councilors when they go for tour which is yearly so that they (VHTs) will have the opportunity to interact with the VHTs of the respective district visited by the district councilors.

Summary of the Findings

The study was guided by four research objectives among which included to assess the quality of injectable FP services provided by the VHTs.

According to the findings; the respondent said that the VHTs were giving safe injections and none of them had experienced any injection abscess. Table 4 indicates that up to 71% of respondents agree that VHTs were giving good injections.

The 2nd research objective dealt with the perceptions of the community on injectable FP services offered by the VHTs.

In determining the perceptions of the community on VHTs providing injectable FP, the study noted that most of the respondents appreciated the injections given by the VHTs that it saves both time and transport expense.

The 3rd objective dealt with challenges faced by VHTs as they execute their duties. The study noted that lack of facilitation, low levels of education and other assignments were the major challenges being encountered by VHTs. They said that much as they work within their communities, they spend most their time helping community members which affect their own ability to provide for themselves. In addition, VHTs reported that their work involves a lot of movement from the communities to the health facilities which also requires some form of facilitation. As regards low levels of education of clients of Injectable FP method consumers, they reported that their clients hold to cultural myths and misconceptions about Injectable FP method because a number of them have little or complete lack of scientific knowledge since most of them live in rural communities with low levels of education.

Nonpayment of a salary was also seen as a big challenge regardless of the small allowance given to them in form of transport refund. Sensitization of Communities by VHTs has faced stiff competition especially with emerging traditional medicine and self-medications.

In establishing challenges faced by the district health managers in supervising/ working with the VHTs in the provision of injectable FP methods, the study noted that lack of transport to travel to VHTs homes was the major challenge being encountered by the health workers. They said that

much as VHTs work from the homes, they should be supervised more often but they lack transport to visit their homes.

As regard reports writing and submission by the VHTs, health workers reported that the VHTs do not write reports and those who writes send it when it is too late.

On documentation the health workers also reports that the VHTs do not document the service they have offered to the clients yet at the end of the month they have to extract report from their registers which becomes very difficult since other information go missing.

The last objective on the strategies to overcome challenges almost all the VHTs suggested that they should be given appointment to work as the community extension health workers while some of the agreed to refer women with side effects to the health centers for better management and concerning the problem of transport these VHTs said that they should be given new bicycle while other said he health center should repair for them their bicycle and other said the health center should pay for the boda-boda they used while going to get more drugs.

Regarding men who do not want their women to use FP, VHTs said the district should pas by-law and these men have to be punished.

Limitations of the Study

Recall bias on the side of respondents was anticipated and to address that limitation, the research assistants were advised to probe further to get the data. Service delivery is usually a private matter that people rarely talk about publicly and therefore some respondent's would not be

willing to reveal certain information. To address that limitation, the respondents were assured of confidentiality and also a gender sensitive research team was built to ensure that female research assistants mostly interacted with women respondents.

I also acknowledged the sample biasness as the respondents who were considered for the study where only those receiving the injectable FP methods from the VHTs other than going in to the community.

5.6: Conclusions

From the above analyses, the quality of injections provided by the VHTs is in terms of safe injections as there was no report on injection abscess reported during the study.

Communities agree that Village Health Teams were involved in provision of Injectable FP services which is saving time for the women to go to the health and they are appreciative of the services provided by the VHTs. Lack of facilitation, low levels of education of Injectable FP method users and other assignments were the major challenges being encountered by VHTs.

The major challenge experience by the health workers is transport problem which hinder their movements the respective homes of the VHTs.

5.2 Recommendations

To the Ministry of Health

- I suggest the MOH to come on board to roll out the training to other parts of the countries where the VHTs were not trained on provision of injectable family planning methods by the village health teams for easy accessibility by the community.
- The Ministry of Health's department of Health Education and Health Promotion to provide the information, education and communication materials (IEC materials) which would be distributed within the communities and should be in the local languages so that those who cannot read in English find it easy to read.

To the implementing partners

- Donors in the district could consider giving some incentives to the VHTs.

To the DHO, office

- The VHTs that has the required qualifications to become CHEWS should be considered for the post.
- More training to the Village Health Teams to enhance their operations of health services in the district.
- During other activities like indoor residual spraying and immunization campaign VHTs could be used to motivate them.
- The DHTs should also be involved in supervising the VHTS.

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ANNEX 1

Data collection tools

Key Informant Interview Guide for VHTs

INFORMED CONSENT

I,……..of……health center/village has read the information in this form and I will be free to ask any questions. I do hereby give my consent to be included as a participant in the study of contributions made by VHTs in provision of injectable FP methods in Apac district.

My rights and responsibilities have been explained to me by the researcher, I am aware of the fact that I can opt out of the study at any time without having to give any reason, I am also aware that the researcher may terminate my participation in the study at any time, for any reason without my consent. I hereby give permission to the researcher to release the information obtained from me as a result of participation in this study to Uganda Martyrs University, Government/Private agencies and ethics committee.

By signing this consent form, I accept that the information given in this document has been clearly explained to me and apparently understood by me.

Signature……..... Date……

Name of interviewee……..

Name of Researcher……. Signature……

Date……..

APENDIX 1

A QUESTIONNAIRE TO THE DISTRICT HEALTH MANAGEMENT COMMITTEEMEMBERS

I am a student of Uganda Martyrs University carrying out a research on the contributions made by the trained VHT members in the provision of Injectable FP methods in Apac District. It is for the purpose of the award of a master's degree in Master of Public Health, Population and Reproductive Health of Uganda Martyrs University (UMU). This questionnaire is specifically for collecting data for the academic research. Your genuine contribution will be of great importance.

The information generated from this study if used may contribute towards improvement in Family Planning service in Apac district and the nation at large. The data you give shall be treated with utmost confidentiality.

Code number……

Date …….

Health Centre Name……..

Sex of Respondents

1. Male
2. Female

Age category of Respondents

1. 18 – 30
2. 31 -40

3. 41-45
4. 45 and above

Marital status

1. Single
2. Married
3. Widowed
4. Divorced

What is the quality of injectable FP provided by the Village Health Teams (VHTs) in terms of?

Tick appropriate	**Good**	**Fair**	**Bad**	**Not sure**
Safety				
Effective				
Timely				
Patient centeredness				
Affordable				

Section B: Perceptions of the community on injectable family planning provided by the VHTs

What do you feel about the injectable family planning provided by the VHTs?

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Section C: Challenges Faced By Village Health Teams

Please list five challenges faced by the VHTs in provision of injectable FP services.

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Section D: Challenges faced by the health workers

Mention five challenges you face while supervising/working with the VHTs in providing injectable FP methods.

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Section E: strategies to overcome challenges faced by the VHTs

Suggest ways to overcome the challenges you always face while providing injectable FP methods regarding these areas

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Table 2: Study Objectives, their Variables and Indicators

OBJECTIVE	VARIABLE	INDICATORS	METHOD OF MEASURE	TOOLS & SOURCE
To assess the quality of the injectable FP services provided by the VHTs	Timely	Reduced waiting time	Qualitative	Focus Group Discussion
	Risk free	No injection abscess reported		
	Client centered	VHTs are welcoming		
	Accessible Reliable services	Always present		
	Affordable .	Free injection.		
To establish the Socio-cultural factors on injectable FP method provided by VHTs	Perception of the community on VHTs that affect uptake of injectable FP method	• What male partners say about VHTs • Knowledge • Myths • Misconceptions	Qualitative	Interview guide
To identify the challenges faced by the VHTs providing injectable FP services	Challenges faced by the VHTs in providing injectable FP services	• Negative attitude of male partners • Side effects and lack of drugs to manage side effects • Erratic supply of FP drugs • Cultural norms/values • Long distance	Qualitative	Interview guide VHTs

		• Work overload • Unknown pregnancy status prior to giving Injectable FP drugs		
To establish challenges faced by the district health managers in supervising the VHTs while providing injectable FP services	Challenges faced by the health workers in supervising VHTs in provision of injectable FP services	• Limited time to supervise VHTs • Lack of documentation of procedures given • Poor Report writing skills • Lack of harmonized counseling message • Level of education of some VHT members • Unsafe disposal of medical waste	Quantitative	Key Informant
To identify the strategy to overcome challenges faced by the VHT members	Strategies to overcome the challenges faced by the VHTs	• To be employed as CHEWs • Give us transport • Sending them for more training • Resign from work • Political support • Training more VHTs • Passing by laws	Quantitative	Interview guide

APPENDIX II

BUDGET PROPOSAL

Budget items	**No of items**	**Unit cost**	**Total cost**
Lap top	1	900.000	900,000/=
Plain paper	3 reams	7.500	22,500/=
Ruled paper	1 ream	10.000	10,000/=
Printing			
Questionnaires	4 pages	1.000	4,000/=
Check lists	2 pages	1.000	2,000/=
Photocopying			
Questionnaires	340 pages	100	34,000/=
Check lists	73 copies	100	7,300/=
Transport			
Apac to University	4 trips	100.000	400,000/=
Trans port for data collection	20 trips	10.000/ day	200,000/=
Lunch			
While travelling to University	4 times	5.000	20,000/=
When collecting data	20 times	3.000	60,000/=

Others			
Photocopying services for 12 copies	1000 pages	100	100,000/=
Binding	10 copies	10.000 each	100,000/=
Airtime to distant Supervisors	3 cards	10.000	30,000/=
Miscellaneous			120,000/=
Total			2,009,500/=

APPENDIX III: TIME FRAME

Time	**Activity**
April 2016	Proposal submission
June 2016	Data collection
July 2016	Data collection
April 2017	Data analysis
May 2017	Draft report writing
July 2017	Final report submission

Uganda Martyrs University

making a difference

Faculty of Health Sciences

Email: enionzima@yahoo.com

11th July 2016

To: The Officer Responsible

Dear Sir/Madam

Re: INTRODUCING MS. LEJI CAROLINE FELISTUS

This is to introduce to you Ms. LEJI CAROLINE FELISTUS a bona fide student of Uganda Martyrs University. She is pursuing a course leading to the award of a degree in Master of Science-Population and Reproductive Health (MPH-PRH). She is currently on research for her dissertation on the topic:

CONTRIBUTIONS MADE BY THE VILLAGE HEALTH TEAM IN PROVISION OF INJECTABLE FAMILY PLANNING METHODS IN APAC DISTRICT

The topic and protocol have been approved by the relevant University authorities.

Any assistance rendered to her in this respect will be much appreciated by the University.

Yours Sincerely,

Nionzima Elizabeth 11/07/2016.

Programme Coordinator--MPH-PRH

For Faculty Approvals Committee

THE REPUBLIC OF UGANDA

APAC DISTRICT LOCAL GOVERNMENT

Department Of Health Services
P .O. Box 1, Apac.

In any correspondence on this
Matter please quote No; 20160712

Date; 12h July 2016

In charges
HC IIs & III
Apac DLG

RE: Introducing Ms Leji Caroline Felistus

This is to introduce to you Ms Leji Caroline F, a post graduate student of Uganda Martyrs University. She is currently on research for her dissertation on the topic "Contributions made by VHTs in provision of injectable family planning methods in Apac District". She wishes to conduct Key informant interviews, Focus group discussions, and documentary reviews at health facility and community levels. Please render her the necessary assistance to accomplish the exercise.

Yours truly,

DR. EMER MATHEW
DISTRICT HEALTH OFFICER/ APAC.

CC; The incharge Maruzi HSD.
" The incharge Kwania HSD.

AYABO HIC II
AKOKORO SUB COUNTY
DATE 26/07/2016

ALABO HIC II
IBUJE
DATE 28-7-2016

INCHARGE KUNGU HIC II
DATE 20/07/16
SIGN
MARUZI HSD. AKOKORO S/C

DATE 21/7/2016
SIGN

AC PRISONS HIC II
MARUZI HSD
DATE 27.07.016

THE REPUBLIC OF UGANDA

APAC DISTRICT LOCAL GOVERNMENT

Department Of Health Services
P .O. Box 1, Apac.

In any correspondence on this
Matter please quote No; 20160712

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INCHARGE BIASIIARA H/C II DATE 14-7-2016 SIGN MARUZI H/S DISTRICT APAC

WANSOLO H/C II DATE 16/7/16 SIGN MARUZI HSD

Yours truly,

DR. EMER MATHEW
DISTRICT HEALTH OFFICER/ APAC.

15/07/2016

INCHARGE CHEGERE H/C II DATE 18/7/2016

CC; The incharge Maruzi HSD.
" The incharge Kwania HSD.

file.

INCHARGE OLELEK H/C II DATE 22/7/2016 SIGN

INCHARGE KIDILANI HEALTH CENTRE II DATE 25/7/16

MAP OF APAC DISTRICT SHOWING SUB-COUNTIES