Community satisfaction with Village Health Teams' mobilization activities for HIV and Anti-Natal Care intervention in Masaka District

Kenneth Musinguzi Rugamba

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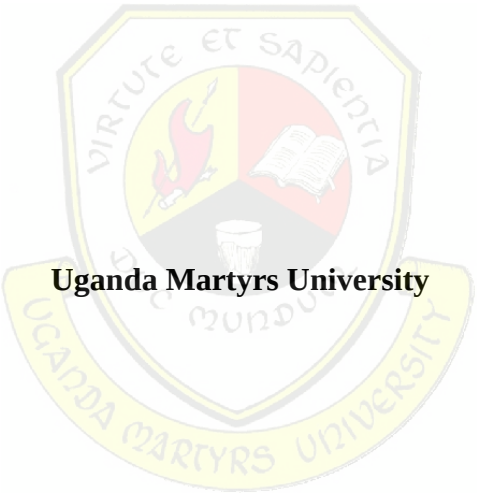

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Community satisfaction with Village Health team's mobilization activities for HIV and Anti-Natal Care interventions in Masaka District

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Dedication

This work is dedicated to Almighty God who enabled me to complete this course, my wife Julie, children; Kelly, Best and Pauline whose love, care and support inspired me to expedite my academic journey to great heights

Acknowledgement

I am greatly indebted for individuals and institutions whose encouragement, support and advice have enabled me to accomplish this work. Indeed it has been a result of combined efforts. I extend my sincere gratitude to all for inspiration.

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List of Abbreviations

ANC	Anti –natal Care
ART	Anti-retroviral Therapy
BRAC	Bangladesh Rural Advancement Committee
CHA	Community Health Agents
CHW	Community Health Workers
DHO	District Health Officer
DHT	District Health Team
FGD	Focused Group Discussion
HEW	Health Extension Workers
HSA	Health Surveillance Agent
HSSP	Health Sector Strategic Plan
HW	Health Workers
ICCM	integrated community case Management
KI	Key Informants
MOH	Ministry Of Health
NCDs	Non Communicable Diseases
NGO	Non –Governmental Organisation
NHM	Natural Helper Model
PREFA	Protecting Families against AIDS
STI	Sexually Transmitted Infections
HIV	Human Immune Deficiency Virus
TASO	The AIDS Support Organisation
TB	Tuberculosis
TBA	Traditional Birth Attendant
UBOS	Uganda Bureau of Statistics
UNICEF	United Nations Children's Emergency Fund
VCT	Voluntary Counselling and Testing
VHT	Village Health Team
W.H.O	World Health Organisation
EFMOH	Ethiopia Federal Ministry of Health
CDC	Centre for Diseases control and Prevention
UNDP	United Nations Development Program

Definition of the Key Terms

Village health Teams (VHT) members are community health workers (CHWs) chosen by their communities to promote health and wellbeing of their village members through mobilizing community members for health promotion and disease prevention, they treat simple childhood illness at home, check danger signs in children, report and refer very sick ones to health workers and keep village register updated (MOH 2009). In the study VHTs were defined as volunteer community members who are selected to serve and provide specific health services to community members through social mobilisation.

VHT health services are stipulated in the VHT strategy and operational guidelines of 2010. They included, home visiting, mobilizing communities for utilization of health services, health promotion and education, treatment of common childhood illness, follow up of pregnant mothers, referral and linkages of patients, distribution of health commodities, community information management and disease surveillance(MOH,2010). In this study the author concentrated on VHT mobilisation and assessed to what extent was household members satisfied, factors influencing satisfaction and people's perception about mobilization activities.

Community; a community is a place where people live and consists of different individuals with dynamic social relations. They are able to organise in small groups to achieve a common goal (Laverack, 2007). For this study, a community was defined as a communal place where people live, share relations, common values and work together to achieve healthy lives.

Community mobilisation; Community mobilization is a process for reaching out to different people in their communities to make partnerships aimed at focusing and addressing a specific issue identified by community members (Huberman& Davis, 2014). This study considered

community mobilization as a way of reaching to different people in communities to participate in health issue concerning their life.

Satisfaction is the difference between expectation and perceived performance, satisfaction is achieved when the level of service is better than expected and on the other hand dissatisfaction occurs when performance of service is worse than expected (Oliver, 1993). This definition is derived from expectancy disconfirmation theory which was used in the study. Therefore, this study considered community satisfaction to be referred to whena community member's expectation exceeds beyond the mobilization approach used by VHT.

Abstract

Introduction: In recent times of global health workers' shortage, community mobilization and empowerment is an important health promotion intervention for underserved population in rural areas. In Uganda, Village health Teams were introduced to bridge the gap between rural populations and formal health facilities for improved access and utilization of ANC and HIV services among others. Since then, the government and Non- governmental organisations have engaged VHTs in mobilizing communities to access and utilize ANC and HIV services from their nearest health facilities. This study assessed community satisfaction with VHTs' mobilisation activities for ANC and HIV services in Masaka District.

Methods: A cross sectional study using concurrent mixed method was employed; quantitative data were collected from 400respondents using structured questionnaire. Descriptive statistics were used to summarise data and Pearson's Correlation co-efficient index test and mean scores were applied to determine the association of VHT mobilization and community satisfaction with VHT's mobilization activities. Qualitative data was collected through interviewing five (5) Key informants. They included four VHTs' focal persons from two sub counties and one (1) District VHT coordinator. Two FGDs were conducted in Buwunga and Kyabakuza/Kimanya respectively.

Results: Among 400 respondents 69.8% were overall satisfied with VHTs mobilization activities. Pearson correlation co-efficient index R=0.701**(P=0.000)<0.05 indicated a high positive significant relationship between factors studied and satisfaction of VHTs mobilization activities for ANC and HIV services.

Conclusions: Overall, 69.8% were satisfied with VHTs mobilization activities for ANC and HIV services. The level of satisfaction would increase with enhanced factors. District officials and implementing partners should embrace VHTs in mobilization activities for ANC and HIV

CHAPTER ONE
GENERAL INTRODUCTION

1.0 Introduction

Community mobilization and empowerment for increased access and utilization of health services is a big concern worldwide (WHO, 2016). In developing countries, mobilization interventions were used to provide communities with information related to available health services. Through such interventions, individuals, groups and organizations capacity in planning, implementing and evaluation of health services would be built (Kulilmann et al, 2016). Furthermore, community mobilization helps community members to identify their health needs and be part of the solution. It is a key strategy for increasing demand for access and utilization for health services. Involving household members to participant in health programs enables VHTs to raise awareness of health, social and cultural issues that promote or prevent access to health information and utilization of health services. Through community participation, barriers to access to health information and services can be addressed. In turn, communities would be linked to nearby health facilities, hence fostering access and equity to health services especially ANC and HIV (ACQUIRE, 2011). In addition, community members were mobilised to fully participate in all activities that promoted their health and empowered in decision-making processes which would bring diverse stakeholders together(Blanchard et al, 2013). More so, community mobilization brings community members together for a common purpose that would be achieved through creating awareness and acquiring knowledge in health literacy and empowerment (Abramsky et al, 2012). However, there was still a need to understand whether community members were satisfied with VHTs mobilization activities used to inform people about ANC and HIV services in their areas(MOH,2010).Such mobilization approaches included; informal conversations, community meetings, one on one counselling, in places of worship (Churches and Mosques),

announcements at funerals, parties and market places, and even posters in schools(Kawungezi et al, 2015).

Furthermore, Uganda Ministry of Health and Non- governmental organisation adopted the use of community health workers (CHW) to mobilize communities to access and utilize health services (MOH, 2010). In Uganda, community health workers are known by different names such as Village Health Teams (VHTs), expert clients, peer mothers, drug distributor, field workers, volunteers and nursing aids (Namukwaya et al, 2015). Currently, Village health teams are commonly co-opted in Uganda to mobilize community members to embrace ANC and HIV services. They were trained and mentored in different aspects of community mobilization and health care which would enable them with skills of engaging household members to participant equally in decision making regarding access and utilization of the available ANC and HIV services within reach (MOH, 2015). In addition, they were also empowered with skills of referring and linking clients to the nearby health facilities, follow up community members with several health needs and report all strange diseases in communities. Indeed VHTs' efforts had shown some indicators for improvement of people's access to ANC and HIV services with increased health literacy(MOH, 2015).

Similarly, health extension workers (HEWs) in Ethiopia, were engaged in mobilising household members who were marginalised in accessing health services especially HIV prevention and Anti-natal during outreaches. Their involvement enabled community participation in health activities and empowering household members with knowing their health rights (Sibamo & Bertheto, 2015). Recently, research showed that community mobilization conducted by VHTs had a positive impact on HIV prevention programs especially when community members were involved from the inception to the end

(Lippmanet al, 2013). This is because when local people are involved, they are empowered to take control of health matters. Hence community engagement is vital for satisfaction (Muhumuzaet al, 2014). Therefore, the same study stressed that community members need to be involved in health activities throughout for planned outcomes to be realised.

In their study, Sibamo&Bertheto,(2015) argued that for health services to be utilized, community members should be satisfied. That means understanding satisfaction is important in VHTs mobilization activities for ANC and HIV services. Since VHTs have been engaged in mobilizing people to participate in HIV prevention activities for long, assessing communities' satisfaction with mobilization approaches used in ANC and HIV counselling and testing, would be useful in improving those services (Mwai et al, 2013).The social mobilization efforts by VHTs had been seen to complement the efforts of few existing health workers in mobilizing community members to access and utilize health services(Muhumuza et al, 2015). It is on this ground that the study assessed the level of community satisfaction, determined factors influencing satisfaction and explored perceptions of community members with Village Health Team's mobilisation activities for ANC and HIV services. Hence, the study would contribute to improved VHT's mobilization approaches, community engagement and demand for health services. It further empowers community members with knowledge and skills to prevent diseases and improve health at individuals, family and community level. Therefore, the community satisfaction study, intended to assess community satisfaction with VHT's mobilization activities for HIV prevention and ANC services in Masaka District. It would also act as the basis for demand creation and utilisation of HIV prevention and ANC service.

The first chapter introduced the topic of the study and its background. The available literature with emphasis on the study was reviewed and it shades some light the topic. The literature

drew insights from global perspective and other related studies that were studied. It also indicated the statement of the problem at hand that was investigated during the study period. Furthermore, objectives of the study to which the study was aligned to and research questions to be answered were clearly stated. The scope of the study elaborated the coverage interms of geographic and content; significance of the study justified the worthiness of carrying out the study in Masaka District. The study further addressed the question of why it was carried out and what were the implications of not conducting such a study as per the planned timeframe. The study was distinct and novel hence contributed to the body of knowledge. Key terms were also defined and positioned in their operational perspective. The theory on which the study was based was summarised and the conceptual framework drawn to show the relationship between the study objectives and research variables. Both theoretical and conceptual framework showed the theoretical positions on which the study was based. Furthermore, it showed the connection of the study with existing phenomenon, hence acting as the base of the study. It will contribute to the existing pool of knowledge in public health**.**

1.1 Background of the study

VHTs in other context are known as Community health workers (CHW)who globally are means of extending primary health care services to the communities (WHO, 2009). They have been working in many developing countries in Africa and other continents too. CHWs are named differently in their countries, for example in Brazil they are known as Community health Agents(CHA), in Bangladesh they are called ShasthyaShebikas (SS) and Extension health workers(HEWs) in Ethiopia(Fleury, 2011).

A Study conducted in Ethiopia, recommended the work of extension health workers (HEWs) who contributed greatly to the vibrant community health care system of their country through community mobilization (Karim et al 2013). It was suggested that health extension program

had significant effect on maternal and new born care practices. This resulted in improved health services in Ethiopia, which was regarded as the best African country in reducing child mortality for under-fives and maternal mortality. This was possible through mobilizing household members to know that they had a right to quality health services(Dynes et al, 2013).

In Brazil, a similar program for community health workers known as Sanida da familia or Family health program, trained many community health Agents (CHAs) who were also responsible for improving health care services at community level. It was achieved by empowering women who agreed on community level to embrace Anti-natal care and other health services. Indeed it is anticipated that more than 75% of people in Brazil depended on community health Agents for health care services (Fleury, 2011).

Similarly, in Bangladesh, community health workers (CHW) have been the foundation of primary health care since 1970s. The introduction of Bangladesh Rural Advancement Committees (BRAC) created a lasting impact on mortality rate for under five children and TB control in that country (Arifeen et al 2013). BRAC used low educated women who were trained with basic knowledge on disease prevention and treatment of common illness to engage with people in their communities. Through such engagements, community members were taught skills in disease prevention which was aimed at improving lives of people in that country(Arifeen et al 2013). The Community health workers' programs were sustained with small loans which were given in turns among CHWs. The loans motivated community health workers to be committed to work and felt their efforts were appreciated. This resulted in a very strong community program that was very effective in disease prevention (Mahood et al, 2010).

In Uganda, there was still a challenge where only 49% households were staying in a 5km range to a health facility compared to 80% of what was expected to be in easy access of health services(MOH, 2012). In addition, there is high burden of communicable diseases and increasing Non communicable diseases (NCDs) in the country (MOH, 2010). The real challenge at hand was how to extend basic care services to the entire population especially those in rural areas where access is limited. To respond to those challenges, the government through Ministry of Health introduced VHT strategy. The VHT guidelines were developed in accordance with Health Sector Strategic plan one (HSSPI) and implemented in accordance to HSSPII&III (MOH, 2010). Village Health Teams (VHT) are composed of four members per twenty five (25) households in each village, they actively mobilized rural communities to engage in primary health care interventions. The interventions are seeking Anti -natal care(ANC), safe delivery and breast feeding, management of uncomplicated childhood illnesses, promotion and health education, prevention and treatment of malaria, tuberculosis (TB), HIV/ AIDs, sexually transmitted infections (STI), and non-communicable diseases (MOH,2015).

Village Health Teams (VHT) were promoted as means of mobilizing communities to attain equity and accessibility of health services to the rural population that is marginalized. Consequently, it would promote universal access to health for all as it was stipulated in Alma Ata Declaration of 1978 on primary health care (WHO, 1986).

Furthermore, community health workers in developing countries have been co-opted to extend health care services in their communities, especially where there is a shortage of health workers. This was revealed by a study conducted by World Health Organisation in developing countries, where most health workers run for “greener pastures” in developed countries (WHO 2009). In addition, some studies conducted in Uganda and Ethiopia concurred with World Health Organisation and further investigated whether community

members were satisfied with the work of Community health works (Tumuhamye et al, 2013, Sibamo&Bertheto, 2015). The question of whether the community members are satisfied with VHTs' mobilization for health services was indeed important.

In Uganda, a study investigated client satisfaction with integrated community case management (ICCM) at community level. The study findings revealed high level of satisfaction among community members whose children were treated for childhood illness. The authors confirmed that their satisfaction was based on availability of drugs and the improved conditions of their children. However, the approaches used by VHTs to mobilize for such services were not assessed; and it was not established how community members were mobilized to take up ICCM services(Tumuhamye et al, 2013).In contrast, other studies investigated satisfaction with general health services, yet, the major focus of VHTs was to mobilize and empower communities to access and utilise health services (MOH, 2015, WHO, 2011). There is a paucity of studies in Uganda highlighting the level of community's satisfaction with VHTs mobilization activities. Besides, research on determinants of satisfaction is limited (MOH, 2015).

Community mobilization for health services is a major function of VHTs(MOH, 2010). They engage communities through social mobilisation and empowering individuals to take control of their lives. This is the cornerstone of health promotion that is derived from the Ottawa charter of 1986 (WHO, 1986). Health promotion programs have been implemented in communities based on effective mobilisation activities (Lankester, 2006). Therefore, in Uganda most health programs targeting communities rely on VHTs to mobilise community members to take up services (MOH, 2014). However, there is limited knowledge on whether community members are satisfied with the community mobilization activities and approaches (i.e., Word of mouth/informal conversation; community meetings; one on one basic counselling sessions and announcements in places of workshop; and speaking in places of

worship, at funerals, weddings, and Market places) used by VHTs to mobilise them to access and utilize health services—immunisation, antenatal care, family planning, sanitation and hygiene , HIV counselling and testing (MOH,2009).

To bridge this knowledge gap, there is need to investigate the level of community satisfaction with VHT's community mobilisation services. Such a study will also explore the factors that influence satisfaction and people's perceptions about VTH mobilization activities.

The results of the study will be used to improve the quality of community mobilisation services and hence contribute to increased demand for and utilization of health services in rural communities. The findings will be disseminated to the district, implementing partners and Ministry of health to improve programing with acceptable, affordable and sustainable community mobilisation approaches. Lastly, the study results will be used to inform VHTs that will empower the rural populations with their rights, build local networks and partnerships.

1.2 Statement of the problem

This study intended to look deeply on mobilization interventions used for ANC and HIV services. The usage of mobilization activities for ANC and HIV services was very low with poor access and utilization at household level in Uganda (WHO, 2014). It was established that household members were staying far away from health facilities and most were un informed of available ANC and HIV health services in their communities (Kawungezi et al, 2015). In addition, pregnant women had non- supportive husbands and were not empowered to make concise decisions to access and utilize ANC and HIV services. Still women in productive age group were vulnerable and did not enjoy their rights to access and utilize ANC services (Kawungezi et al, 2015, Kuhlman, et al 2016). In the view of promoting equity among women, pregnant women are expected to access, attend ANC services and deliver

with help of trained and skilled health workers. However, the involvement of VHTs at household level was still wanting with less ANC attendance at 37% and 57% assisted deliveries (UDHS,2011).

Furthermore, the Uganda AIDS indicator survey(UAIS) of 2011 showed that45%male and 66% of female have ever tested for HIV. Only 25% of men have been circumcised to prevent HIV infection. It further revealed that 52% of male in central region had tested for HIV.

These statistics show that mobilization of household members to access and utilize HIV services is still questionable. Therefore, a study to find out whether community members are satisfied with the VHTs mobilization for access and utilisation of available health services with in their communities was worthwhile. Moreover, many African governments and Non-government Organisations (NGOs) are currently struggling with how to improve community mobilization especially for household members in rural areas and hard to reach areas so that they can access and utilize health services (WHO, 2010, MOH, 2011).

Furthermore, in Uganda, more than 80% of the population live in the rural areas and more than 50% are not in reach of health facilities (MOH,2010). In view of addressing this problem, the government of Uganda through Ministry Of Health established village health team strategy to bridge the gap between their communities and formal health facilities. The VHTs would engage household members through mobilization and empowerment processes in order to access HIV, and ANC services with in their communities (MOH,2011).

Furthermore, studies have shown that many people are not aware of different health services provided at health facilities and further revealed that the work of VHTs in some districts in Uganda was also not known to community members (MOH, 2015). However, VHTs had mobilized community members to seek health services, the approaches used needed to be assessed and find out if they were appreciated by community members.

In Ethiopia, community members were mobilized and empowered by Extension Health works (EHW) to access and utilize health services. For example ANC, hygiene and sanitation, family health care and HIV prevention services (Simbo&Bertheto, 2015). In addition, Lunsford et al (2015) in their study of community satisfaction with Extension Health Workers (HEW), revealed high level of satisfaction with HEW's health services. However, the study did not investigate the mobilization approaches used.

Policies and strategies to improve community mobilization and empowerment of communities to access and utilize available health services are at the centre of national and international debate (WHO, 2014). This is in accordance with five service areas of Ottawa charter of 1986 on health promotion(WHO, 1986). Therefore, it was timely, for this study to assess community satisfaction with VHTs' mobilisation approaches for health services, explore factors influencing satisfaction and people's perceptions.

The overall goal of the study was to provide information on the effective community mobilization approaches and activities used to increase access and utilization of health services. The findings would contribute to health promotion through improved community mobilisation approaches and community empowerment; it was anticipated to influence policy on access and utilization of health services. The study findings were estimated to empower the communities to effectively demand and utilize health services with in their communities.

1.3 Purpose of the study

The purpose of this concurrent mixed methods study was to better understand a research problem by converging both quantitative (broad numeric trends) and qualitative (detailed views) data. In the study, a survey instrument was used to assess the relationship between VHT community mobilization (independent variable) and community satisfaction with VHT

mobilization activities (dependent variable). At the same time, the qualitative strand of the study was employed to explore community perceptions about the VHT mobilization activities and approaches. The determinants of community satisfaction with VHT mobilization activities and approaches (central phenomenon) was also assessed using qualitative interviews and focus group discussions with community leaders as key informants(KI) and community members who participated in focused group (FGD) at Buwunga and Kyabakuza/Kimanya sub counties.

1.4.0 Objectives of the study

1.4.1 Major objective

The major objective of the study was to assess community satisfaction with VHT's mobilisation activities among individuals who lived with VHTs and were residents for more than six months. This was aimed at empowering communities to create demand for access and utilization of HIV and ANC services in Masaka District.

1.4.2 Specific objectives

To assess the extent to which community members are satisfied with VHT mobilization activities for ANC and HIV services.

To determine factors influencing community satisfaction with VHT's mobilisation activities for HIV and ANC services in Masaka.

To explore community perceptions on VHTs' mobilization activities

1.5 Research questions

What extent are community members satisfied with VHT's mobilisation activities for HIV and ANC services in Masaka District?

What factors influenced community satisfaction with VHT's mobilisation activities for HIV and ANC services in Masaka District?

What are the community perceptions about VHT's mobilisation activities for HIV and ANC services in Masaka District?

1.6 Scope of the study

The study was conducted in Masaka District which is located 120km from Kampala in central Uganda, it lies in central region, bordering with districts of Kalungu in the East, Bukomasimbi in the North, Lwengo in the West and Rakai in South west and Kalagala South.

The district has nine (9) sub counties, 39 parishes and 356 villages. Masaka has a population of 296,649 people, 144,231 are male and 152,418 are female. Most people 192,820 (65%) live in rural areas and 103,829 in urban areas (UBOS, 2014). There are two(2) hospitals (Masaka and Kitovu), two(2) health centre IV(Kiyumba and Kyanamukaka), and ten(10) HCIIIs(Masaka Health sector report, 2015).

The district has 1400 VHTs with basic training and 1372 active. 36 VHTs are attached to health centre IVs &III while the rest are operating in the villages.Masaka has many Non-governmental organisations (NGOs)supporting VHTs to offer HIV/AIDS, and Anti natal services. They include UNICEF, Mildmay-uganda, Uganda Cares, PREFA, Child health and TASO (MOH, 2015).

1.7 Significance of the study to Public Health and Health Promotion.

This study explored the extent to which community mobilization process is carried out to satisfy or meet the need of users in their communities.

The study ascertained various approaches that VHTs used in their mobilization activities. The study particularly looked out for activities that were most appreciated by community

members in order to gain deeper understanding on the level of access and utilization of ANC and HIV services among household members and approaches used in mobilising their community members and the ones that were appreciated most in Masaka District. To public health practice, issues of accessibility to health services by "all" is a key principle in addressing equity in primary health care. Furthermore, the concept of utilization draws closer to the human rights based approaches which emphasized people's ability to have a say in nature of quality of health services they receive(UNDP,2011.). In addition, community member's capacity to decide what they want in terms of quality services is critical to understand fulfilment of communities need(Goodman et al, 2011). VHTs are representative of an institution(Ministry of Health), so they are obliged to fulfil rights and empower household members to access ANC and HIV services. This was a very critical concern to public health because every one body has equal right to heath. In addition right to health is fundamental for universal access to health services (UNPD, 2011).

The study findings would be beneficial in understanding the Anti-natal needs and HIV services of the most vulnerable population that are served by VHTs. More so the study would be very critical in addressing physical accessibility where household members have been struggling with long distance to health facilities. Even more, the study would be useful in addressing any gaps in information access especially where vulnerable and needy populations may have been left out or not considered for vital health promotion messages/information(Bakeera et al, 2009).

Still more, study findings were anticipated to be used to improve community mobilization activities for access and utilisation of ANC and HIV services. Such findings would be applied in public health/ health promotion programs to improve community mobilisation and empowerment. In addition, the study revealed mobilization gaps that government and implementing partners ought to improve through funding local interventions.

Furthermore, the finding would be used by community members, government and NGOs to align health services with community health needs. As a result, access and utilization of ANC and HIV services were anticipated to increase. Lastly, if similar research would be conducted in other contexts where VHTs are operating, it would influence the formulation of universal guidelines on VHT community mobilization activities.

1.8 Justification of the study

Masaka district is one of the districts with a robust VHT system as evidenced in the National VHT assessment study(2015). About one thousand four hundred (1400) VHT members who were trained in 2011 in community mobilization, over one thousand three hundred are still active, representing 98%(MOH, 2015), compared to other Districts in central region. To health promotion, this is an opportunity to obtain "first-hand" information from household members who directly benefit from VHT's mobilization activities. This in turn, their views were collected and will be used in decision making which will improve access for ANC and HIV services. Furthermore, engage and interact with household members to hear how they interact with VHTs, would help to understand how they have been implementing their activities at household level. But also from a community mobilization perceptive to understand how household members have been engaged and their fulfilment with VTHs services. Masaka is one of the few districts with such high number of VHTs still active. Therefore, undertaking a study to assess community satisfaction with VHTs' mobilization activities was worthwhile.

Therefore, it was timely to conduct a study aimed at assessing the level of community satisfaction with VHT's mobilisation approaches for ANC and HIV in both rural and urban settings of Masaka District. The factors influencing satisfaction and people's perceptions were also explored. Study findings will be shared with DHO, MOH and NGOs. The findings

will be used to improve community mobilization and empowerment during implementation of public health projects. It will further add to strategies needed to create demand for ANC and HIV services through community mobilisation.

1.9.0 Theoretic Framework

1.9.1 Social Ecological Model

The social ecological model is entrenched in an understanding of social determinants of health and health behaviours. The changes in health seeking behaviours are attributed to social, cultural and economic factors. The model is used to understand factors affecting health seeking behaviours and gives guidance for developing successful community programs (CDC, 2015).It is based on several levels of influence that include individual, interpersonal, organisational, community and public policy. All those levels are involved in community mobilization process.

It is understandable that public health and health promotion interventions are expected to be effective if they embrace ecological perspective.

On the other hand, there are many theories advanced to explain customer satisfaction, some are in health care and others in marketing discipline. Though there are such theories, satisfaction of clients in communities can still be studied? Among the many theories, consistency theory advanced that when expectations and actual performance do not match, the customers will feel some tension. Therefore, customers make adjustments in either their expectation or perceptions to reduce on such tension(Oliver, 1993).

1.9.2 Expectancy disconfirmation theory also explains customer satisfaction. The proponents urge that satisfaction levels are results of the difference between expectation and perceived performance(Oliver, 1993). It states that satisfaction is achieved when the level of

service is better than expected, dissatisfaction occurs when performance of service is worse than expected. Therefore, this theory has been widely used in studies of satisfaction. It is on this basis that this study too was crafted on same theory. The theoretic framework was the foundation of community satisfaction with VHT's mobilisation services in Masaka District.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Over the years, community health workers have been co-opted globally in many countries to offer community health services (WHO, 2011). In Uganda Village health teams(VHT) are the most famous community health workers who are currently volunteering to offer services in primary health care. They were introduced by the Ministry of Health to deal with the challenge of accessing health services in rural areas with marginalised population. This was after a study conducted by Ministry of Health showed unacceptably high morbidity and mortality rates mostly resulting from preventable diseases in communities (MOH, 2010). The same study revealed that75% of disease burden in Uganda was preventable through improved hygiene and sanitation, vaccination of killer diseases, good nutrition and increasing health awareness in communities (MOH, 2010). In addition, a study conducted in Ethiopia showed that communities need to be empowered in order to participate in health issues concerning their communities. It stressed that when community health workers engage household members, improved health outcome can be achieved through behavioural changes (Lunsford et al, 2015). Countries which are faced with inadequate health work force in Africa, have tried to avert that challenge by adopted community health workers to complement the few exhausted health workers. The strategy worked well in communities of most developing countries. Uganda is a typical example where doctor- patient ratio was un acceptably high at 1:24000(WHO, 2011).

Consequently, as a way of improving the situation in Uganda, Ministry of Health designed VHT program to promote access of health services at individual, family and community level. It would be achieved through community mobilization for members to participate and

practicing positive health seeking behaviours (MOH, 2010). As a result, community members would be empowered to seek ANC and HIV as integrated health services within their communities (MOH, 2015). To be acceptable and reach all communities, Ministry of Health(MOH) recommended that VHTs should be members of the community who are willing to volunteer and help others to improve on their health seeking behaviours (MOH, 2010). They were chosen through a popular vote by their village mates depending on their level of trustworthiness, commitment and willingness to engage in health and developmental issues (Taylor, 2009). Later those who were selected were trained by Ministry Of Health and other implementing partners for five to seven days within their districts. Their training focused on disease prevention, health promotion and education, community mapping, home visiting, community mobilisation, linkages and referrals (MOH, 2015). As the name suggests, Village Health Team (VHT) program is implemented in the village of all the 112 districts of Uganda where majority of the people are poor. Four VHTs members are attached per village and two attached to the nearby health facilities supervised by health workers (Taylor, 2009).

2.1 VHT mobilization activities

The concept of VHTs was delivered from Alma ate Declaration for health for all (WHO, 1978). In order to reach out to all community members with primary health care, countries found it necessary to involve lay people with in the communities to mobilize their colleagues for universal access of health services and to know their rights(MOH, 2010).

To put both male and female on board, gender balance was considered while selecting VHT members. This was because majority of men and women in rural areas are marginalised in health issues (MOH, 2010). More so, in Ethiopia, it was found that women are extremely left out in health programs yet the majority are exposed to many health hazards while pregnant. Therefore, Extension health workers (HEA) program empowered women to reach out to their

fellow women with in their communities (Ethiopia Federal Ministry of Health, 2011). However, a study in Uganda revealed that the selection criteria were biased in some communities where some groups of people were side lined. This generated mistrust and those who were selected to work as VHTs were questionable and others not acceptable in communities (Turinawe et al, 2015). The same study argued that selection of VHTs would have been based on Natural helpers' model(NHM). This was because the model encourages the use of naturally existing informal helping networks in communities, willing to serve their communities. It further states that leaders of those informal networks are recognised, trusted and loved by their fellow community members. Those virtues are basically important during community mobilization, if the intended goal is to be achieved and sustainable in communities. (Turinawe et al, 2015). Another study by Ministry of Health agreed with Turinawe et al (2015) that VHTs selection was not conducted according to given guidelines. It further revealed that VHTs role of mobilizing communities was met with resistances in some communities, and the intended goal of creating awareness to all household members was not achieved (MOH, 2015). Though it revealed that in Masaka District, VHTs have been engaging community members, reached out to people through community dialogues, pass on announcements in churches and even at public gatherings, there was still a big gap of accessing ANC and HIV services.

In addition a study in Ethiopia confirmed that extension health workers also applied similar approaches to mobilize people in their communities to take health services (Sibamo&Bertheto, 2015). In their study, they investigated the satisfaction of community members with urban health extension workers in southern Ethiopia. The findings showed that utilization of health services were related to community satisfaction. In fact, those communities were satisfied with health service, would continuously access and utilize the same services (Sibamo&Bertheto, 2015).

To effectively mobilize communities, VHT program was structured from village level to National level. Each Village has four VHT members who are supported by community members, local council and parishes' leaders in their mobilization for health activities (MOH, 2010). VHTs at village level are further supported by Health workers at health canter IIIs who over see their work in communities where they work. In fact, they supply them drugs for childhood illness and orient them on new health programs to be implemented in their communities. Furthermore, they receive education and communication (IEC) materials (posters, brochures and fliers), village registers and condoms to distribute to communities from the health facilities(WHO, 2009).

However, in comparison, VHT program in Uganda is unique from similar programs in other countries, In Ethiopia; Extension Health Workers were required to have formal education and must undergo a training course for nine months. After the training they are deployed to complement health service delivery in different communities where they mobilize community members and offer health services directly. These health services include; family planning, delivering mothers and treatment of common childhood illness (Lunsford et al, 2015). In addition, Health Extension Workers (HEWs) were also responsible for model families, home visiting, supplying of insect treated mosquito nets and HIV/ STI prevention messages to communities (Lunsford et al, 2015).

In Bangladesh, CHWs through their organisation called Bangladesh rural Advancement committee (BRAC), offered similar services in family planning, education on hygiene and sanitation, and engage in immunization activities and delivery of mothers. Still more, in their free time, they sold health products (basic medicine, sanitary pads and soap) which helped them to raise some money for their economic growth. While selling health products, they mobilize community members through giving information and were also motivated to keep on working (Afrifeen et al, 2013).

Many studies have agreed that community health workers were a very important resource in mobilizing communities for health care services and contribute greatly in accessing and utilizing primary health care. This was important in achieving health for all, as stipulated in Alma Ata declaration of 1978(Afrifeen et al, 2013, Lunsford et al, 2015). Therefore, the concept of community health workers was the same in many countries with slight difference in implementation framework. It aimed at mobilizing communities to increase health literacy, access and utilizing for health services through giving information to household members and referring those in need to accessible health facilities. This was consistent with AlmaAta Declaration on primary health care of 1978, which encouraged countries to have minimum health care package that was considered as the best way of offering health to communities with their full participation and involvement (WHO, 2010).

VHT Community mobilization activities require a robust and stringent policy to impact on access and utilization of health services in Uganda. Currently, there is no such policy in place, only using old guidelines that are not yielding much in terms of improving health services at community level(MOH, 2010).In other countries, their policies on community health workers (CHW) are strong, with emphasis on education level of senior four, being female and attending a training for nine months are well documented. Community health workers were incorporated into their health care structures with remuneration of monthly payments. For example in Ethiopia, community health workers are recognised as part of the health care system and the results had been enormous (Caglia, Kearn&Langer, 2014). Furthermore, it clearly stated that when they are selected, they undergo a vigorous training in hygiene and environmental health, family health services, disease prevention and control and health Education for one year. After graduation, they are deployed in their communities to improve on health services, for example in HIV programs, they are engaged in educating the population, psychosocial support to those who are affected by HIV, counselling for

individuals seeking HIV testing services, facilitating individual and group supports for HIV positive clients, ART adherence, tracing defaulters and referring complicated cases to health facilities (EFMOH, 2011).

In addition, Malawi developed a policy for Community health workers in 1995, when her health surveillance assistants were recognised by the Ministry of Health (MOH) as part of the health team. They integrated all the categories of many different community workers who included,VCT community counsellor, volunteers trained at health facilities, ABC volunteers and health surveillance assistant (HSAs) (Kok&Muula, 2013).They are engaged in mobilizing communities for health services; vaccination, growth monitoring, supervision of TBAs, sanitation and water source protection, disease surveillance, health and nutrition advices , provision of family planning devices and follow up of TB patients. On the other hand, in HIV programs, health surveillance assistants are deployed to give a hand in HIV prevention, offering voluntary counselling and testing, basic care for opportunistic infections, counselling on ART and septrin adherence and tracing defaulters on ART and treating uncomplicated childhood illness(Kate et al, 2013).

To affirm the need of community health workers, the World Health Organisation recognised the need for task shifting where tasks would be shifted from highly qualified. For example nurses were allowed to prescribe medicine in some simple cases and do nursing diagnosis. Some tasks were also shifting from professions to lay people who are trained and are interested in participating in health issues of their communities (WHO, 2009).This accelerated the move for involving Community Health Workers to extend health services through mobilization to their communities.

2.2 Community mobilization

Community mobilization is a process for reaching out to different people in the community to make partnerships aimed at focusing and addressing a specific issue identified by community members (Huberman& Davis, 2014). Other scholars define community mobilization as a capacity building process where community members in their groups or organisations, perform and evaluate activities aimed at improving their health, either in a group or on their own initiatives (Howard et al, 2007). The authors of VHT training manual also agreed with Howard et al, 2007 that community mobilization is a planned process of carrying out awareness, gathering support and participation of community members. It is achieved through capacity building, resource mobilization, managing information and service delivery (MOH, 2010).

Community members who are involved in monitoring and evaluating community programs are instrumental in improved performance of such programs that are acceptable and sustainable in communities (MOH, 2008). Community mobilization targets several categories of people who are in need of different health services; HIV prevention, ANC, immunisation, hygiene and sanitation, prevention of childhood illness (MOH, 2010). Furthermore, in Uganda VHTs are inevitable in all health related activities target people at community level (Muhumuza et al, 2015). They were instrumental in HIV prevention programs, through passing on information to community members to embrace HIV counselling and testing. In addition, they mobilised men to embrace safe medical circumcision (SMC) and mothers to enrol for EMTCT programs at nearest health facilities (MOH, 2014).

The SMC policy and other HIV prevention policies spelled out different approaches to be used by community health workers during mobilization, they included; Market days,

religious services, social gathering, political gathering, use of existing institutions like schools, health service delivery , house to house sensitization and local government meetings (MOH,2010). Successful community mobilization empowers people at grass root to collaborate with the top most who are decision makers. Community health workers continue to be involved in mobilizing people using different methods with appropriate approaches. The most used approaches used include; mobilising through community meetings, home visits, talks in place of worship (Namukwaya et al,2015).

Most public health interventions are designed with community mobilization approaches so that the primary beneficiary is reached (Huberman& Davis, 2014). The World Health Organisation has continued to recommend use of community mobilization to improve access and utilization of ANC services in rural settings. World Health Organisation works within the framework of Ottawa Charter on health promotion of 1986, the technical working group on maternal child health and adolescent though the current study, confirmed mobilization as one way of improving utilization of mother child health services in rural settings (WHO, 2014).

2.3 Community satisfaction.

Satisfaction can be explained as client perceived expectation and actual health services received, in fact it is the gap between clients expectation and actual service provided (MOH, 2008). Some studies have urged that if the gap is small, satisfaction is achieved and when the gap is bigger, clients tend to be dissatisfied with the health services (Lochoro, 2004, Copeland andscolle, 2000). Some theories have also attempted to explain satisfaction in health care. Fox and Storms, 1981 suggested that "satisfaction is desirable when there is alignment between patients' perception on what constitutes satisfaction in health care and their provider's views". They further proposed that clients are supposed to be aware of what constitutes good health services, hence acting as a yard stick to determine their expectation.

When someone has expectation of the services he/ she expect from a provider, there is a likely hood of attaining satisfaction or dissatisfaction with available services (Ofili,2014). Community members do have what they expect from VHTs who mobilize them to take up health services. From their expectation, their satisfaction is measured.

In addition, scholars had appreciated that satisfaction was easy to understand but hard to define. This resulted in different definitions on the same subject matter. However, other scholars agreed that satisfaction was a multiple dimensional concept (Health Board Executive, 2013). In communities, satisfaction was achieved by both the client who directly benefits from a given service or members of their household and distant relatives and friends. This meant clients and those who accompany them are part of the community, hence measuring community satisfaction especially with VHTs' mobilization for access and utilization of health services would be important. This is because those services well utilized would be maintained and quality improved and hence attracting community members to continuous utilization of those services (Sibamo&Bertheto, 2015, Ofili, 2014).

The ability of communities to demand and utilize health services was mostly affected by their level of satisfaction with the available services with in those communities. It was asserted by a study conducted in Ethiopia among community members aimed at assessing whether there was satisfaction with urban health extension program (UHEP). The same study revealed more information on how community members perceived the available health services in their locality. It would lead into better understanding on how to improve and maintain the quality of such health services (Sibamo&Berheto, 2015). Similarly, a study was conducted on patient's satisfaction in health facilities in Uganda and it revealed that understanding patients' satisfaction was core in improving quality of health care (MOH, 2008). In the same study, it was urged that "even the most technically competent care is meaningless if it does not satisfy the users". Hence improving community health services and quality of care was a major goal

of the health sector in Uganda (MOH, 2008).It was believed that studying community satisfaction would improve access and utilization of health services. This is because when people are not satisfied with a services, they simply do not use it (MOH,2008).Hence improved community mobilization and quality of community health services would result into cost effectiveness both at household level and National level (MOH, 2010).Therefore, studies assessing satisfaction are imperative in health promotion. Such studies had a significant role in empowering communities to demand for health services. When community members were interested in a particular service, it was more likely they would fully utilize it(Sibamo&Berheto, 2015). World over, health providers had been encouraged to consistently work with community members in designing health interventions for public interest and that is when they would be acceptable, sustainable and utilized (WHO, 2011). In satisfaction studies, scholars urged such practice would give community members feedback based on performance of such health intervention. This would narrow the gap of community members expectations and actual health services implemented (Olifi, 2014).In some countries, satisfaction studies have been used by health experts in designing client focused health services especially those intended to improve community health services and contribute to public health.

Furthermore, studying satisfaction at community and individual level promoted health and addressed most action points of the Ottawa Charter of 1986, "strengthening community action, reorienting health services, develop personnel skills, enable, mediate and advocate, create supportive environment and building health public policy" (WHO, 1986).Therefore, studies on community satisfaction empowers community members with ability to make effective health decision and attain their health rights**.**

In Uganda, a study on client satisfaction with integrated community case management (ICCM) conducted in Wakiso District, more information on use of VHTs in integrated

community case management (Tumuhamye et al, 2013). Ever since the VHT program started, there was scanty information on their work with in communities. More so very limited information on client satisfaction with ICCM program. They aimed at assessing client satisfaction with ICCM program in Wakiso District and that was the basis of their study. The study was across- sectional and it used quantitative methods with modified SERVQUAL tool. It was used and crafted to assess the satisfaction of care givers of children under five. During the study, there was high turn up of respondents (98.3%) and the majority were satisfied with ICCM's services offered by VHTs (Tumuhamye et al, 2013). The study used only quantitative methodology of inquire, hence need for in depth understanding of reasons for satisfaction. Still more it did not investigate service quality by providers since it was limited on demand side.

Ethiopia was one of the African countries with a robust, community health workers program known as health extension workers (HEWs). The program was well implemented across the country with health extension workers operating in small administrative units called Kebele (Ethiopia Federal Ministry of Health, 2011). In an attempt to reach out to urban dwellers, after recognizing improved health strides in rural settings, a sister program called urban health program (UHP) was introduced with an aim of extending services to urban dwellers (Ethiopia Federal Ministry of Health, 2011). Sibamo and Berhot in 2015 crafted a study to assess community satisfaction with services provided by Urban Health Extension professions in Hadiya Zone. Their study was relevant in health promotion, because community utilization of health services was directly affecting clients' satisfaction (Tumuhamwe et al, 2013. MOH, 2009). It was a cross- sectional study and they employed mixed method to get data from the respondents. lirket scale was used and it was appropriate for measuring levels of satisfaction with health services provided by HEWs. The study findings revealed majority of the respondent were satisfied with the services received from community health workers with in

their communities and community perceptions were also investigated in the same study (Sibamo&Berhot, 2015).

2.4 Factors influencing community satisfaction.

A study was conducted to determine client's satisfaction and their experience with health services in seven rural districts and one urban district of Kampala. The study was intended to measure the satisfaction of clients as an important indicator of Health systems strategic plan (HSSP II) (MOH, 2008). The use of qualitative approach was vital for data collection; exit interviews with clients, household respondents and focused group discussion for community members were also used. The authors, revealed number of important factors considered while measuring client satisfaction. Age was considerable factor because the older people are more satisfied with services since their expectations are few because they have been exposed to health services for some time. Client- provider relationship is another factor that can influence satisfaction and it was emphasised, when client provider relationship is good, Such as in case where clients choose their providers' they are more satisfied with services compared to when they do not (Crow et al, 2003 as quoted in MOH, 2008). This was common in Districts with VHT programs. People who participated in selecting VHT were satisfied with their services especially their involvement in community mobilization for health services (MOH, 2015).Information and technical competence was also highlighted as an important factor for satisfaction by a study conducted by Ministry of Health (MOH, 2015). It was further found that maintaining trust among clients and their service providers was a considerable factor. In addition, interaction of community health workers with people while giving health education talks, counselling household member sat community level was important (Muhumuza et al, 2015). The same study further stressed that community members believed in health providers who resided in their villages. This is because when community health workers who stay in villages members can easily mobilize for health services(MOH,

2015).Prior experience with health services was another factor measured by satisfaction studies, it was urged that, it exposes people to health services and actually they got to know what takes place in health facilities(Ofili, 2014). The author urged that effective communication was vital in mobilizing communities and that would increase uptake of health services and they are likely to be satisfied with health services (Lochoro, 2004). However, when community members expectations were high, it would lead to dissatisfaction of the similar health services (Kisia,Nelina& Otieno,2012).

2.5Community perceptions with VHT's mobilisation

Community perceptions about health services were important to be used to explore satisfaction, because it was related to the utilization of health care services (Haddad S, Fourner P, and Potvin L, 1998). In their study, intended to measure lay people's perceptions towards the quality of primary health care services in developing countries, perceptions and opinions were studied. Perceptions were measure on a scale with a focus on overall services. The factors considered included technical competence, effectiveness of care, personnel's attitude, availability and adequacy of resources, and accessibility of services (Kagwanja, MuthamiandNg'ang'a, 2014). In most cases, when people's perceptions were effectively considered, the utilization and health seeking behaviours for health services would improve (Sibamo&Bertheto, 2015). Hence community members in their communities would be more satisfied with the existing health services (Haddad S, Fourner P and Potvin L, 1998).

In their study Bucher et al, 2014 on stakeholders' perceptions of integrated community care management by CHWs, found that perceptions would enlighten program designers and implementers to involve community members from the planning stage to the end of the program.

2.6 Theoretical frame worker

There are many theories advanced to explain customer satisfaction, some are in health care and others in marketing discipline. Theories are important and act as a back borne to the study. Through such theories, satisfaction of clients in communities can be studied. Among the many theories, consistency theory advanced that when expectations and actual performance do not match the customers, will feel some tension. Customers therefore, make adjustments in either their expectation or perceptions to reduce on such tension (Oliver, 1980).

Cognitive Dissonance is another theory used to understand consumer satisfaction. It states that people have a motivational desire to reduce dissonance by changing their attitudes, beliefs and behaviours (Festinger, 1957). When clients in communities are offered health care service, their attitudes and perceptions depend on the reasons for taking up such services.

Adaptation theory, urges that one perceives stimuli only in relation to an adapted standard (Helson, 1964). Health care services have standards that are followed while offering them to community members; therefore, they will determine whether a client or customer will be satisfied of not especially if such standards are universally known.

Expectancy disconfirmation theory also explains customer satisfaction. The proponents urge that satisfaction levels are result of the difference between expectation and perceived performance (Oliver, 1980). It states that satisfaction is achieved when the level of service is better than expected, dissatisfaction occurs when performance of service is worse than expected. Satisfaction can be evaluated by considering clients experiences and emotions, it was asserted that users' satisfaction levels are as a results of difference between expected and perceived service performance and expectations as predicted in the future performance (Oliver, 1993).

Other scholars attempted to define satisfaction as a personal feeling of pleasure or disappointment resulting from company's products perceived performance in relation to his or her expectation (Kotter, 2000). It was further proposed that satisfaction is connected with "feelings of happiness, relief, excitement and delight" (Hoyer &Maclinis, 2001). However, in 2004, Hansen &Albinson urged that satisfaction is the overall client's attitude towards service provider. It is also expressed as an emotional reaction of what is anticipated and what actually is received in turn. In the expectancy disconfirmation model, Oliver 1993 agreed with many scholars and concluded that satisfaction studies attempts to understand the factors and processes of client's evaluation of their own expectations. Therefore, that if the performance exceeded expectation a positive disconfirmation occurs leading to satisfaction, and that if the performance fails to meet the expectation, a negative disconfirmation occurs leading to dissatisfaction. When the performance equal expectation, there is zero disconfirmation resulting into no effect on satisfaction (Oliver, 1993)

However, in their study, it was found that both disconfirmation and expectations had no effect on satisfaction (Oliver, 1993) and they concluded that satisfaction was determined by performance of durable goods.

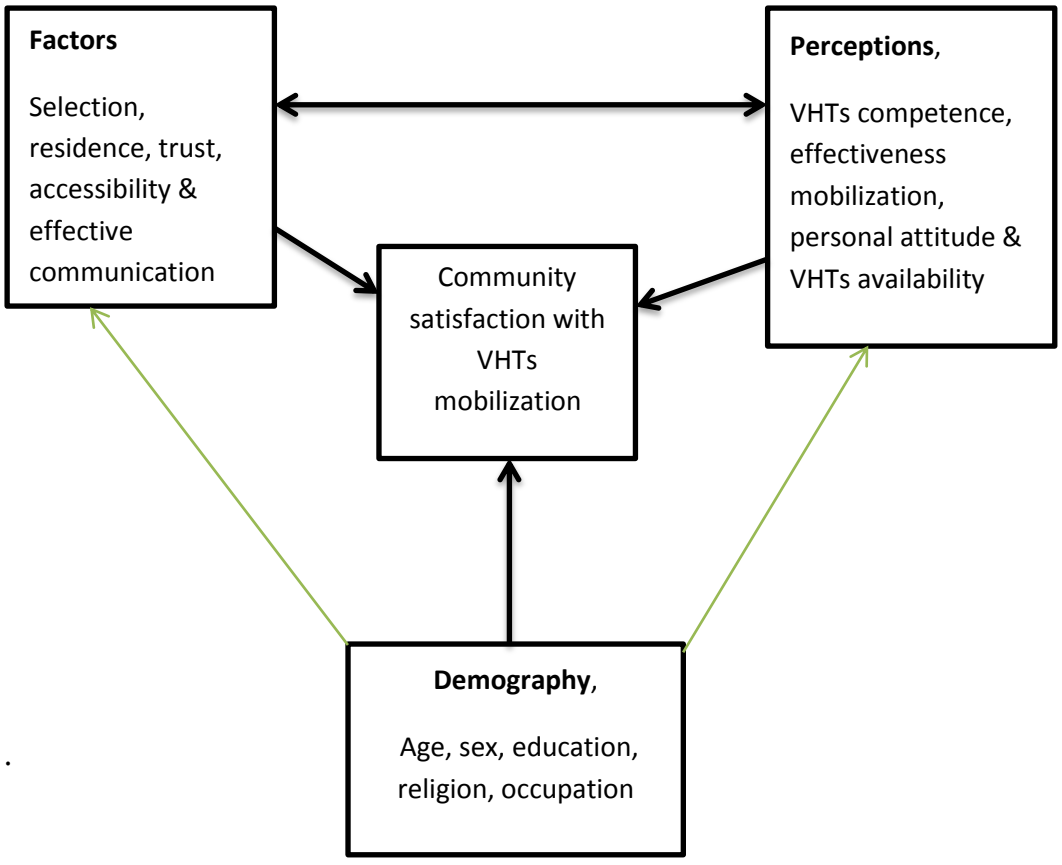
Therefore, expectancy disconfirmation theory has been widely used in studies of satisfaction and it is on this basis that this study too, will be crafted on the same theory. It is hoped the adopted theoretic framework will be the foundation of community satisfaction withVHT's mobilisation services in Masaka.

2.7 Conceptual Framework

The main variable was 'community satisfaction with VHT mobilisation'. It was influenced by various predictors that include VHTs selection, their residence, trust, accessibility and effective communication. Other predictors that influenced dependent variable included

community perceptions on VHTs competence, effective community mobilization, personnel attitude and VHTS availability. These predictors influenced the outcome as well as each other at times. Socio-demography had some slight influence on the general outcome. They were also considered for this study, they include; age, sex, residence, occupation and level of education.

Conceptual Framework



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CHAPTER THREE

METHODOLOGY

3.0 Introduction

The study employed a mixed method which was conducted concurrently. The purpose of the concurrent mixed method study was to better understand a research problem by converging both quantitative (broad numeric trends) and qualitative (detailed views) data. A survey instrument was used to assess the relationship between VHT community mobilization (independent variable) and community satisfaction with VHT mobilization approaches/activities (dependent variable). At the same time, the perceptions about the VHT mobilization strategies and determinants of community satisfaction with VHT mobilization approaches(central phenomenon) was explored using qualitative interviews and focus group discussions (FGD)with community leaders, health facility in charges, District VHT coordinator as key informants (KI). The community members participated in focused group discussion (FGD) at Buwunga sub-county and Kabakuza Division which were study sites.

The chapter presents the steps undertaken to address the research questions. It also describes the research design, area of study, study population, sampling producers, data collection and analysis procedures. Ethical considerations and study limitations are described as well.

3.1 Research Design

A cross-sectional study employing concurrent mixed method (qualitative and quantitative) was used to assess community satisfaction with VHT mobilization approaches. The data from both qualitative and quantitative was merged in order to come up with comprehensive analysis of the research problem (Creswell, 2014). Both forms of data were collected at the same time, analysed differently and later interpreted. The approach was less time consuming because both quantitative and qualitative data was collected at the same time. The proponents

of mixed study urge that both methods have bias and weakness that can be neutralized by collecting both forms of data that triangulated before interpretation (Creswell,2014).The two methods supplemented each other and confirmed the findings hence strengthened the outcome of the study. Questionnaires, interview guide and FGDs were used to collect both qualitative and quantitative data.

3.2 Area of study

The study was conducted in Masaka District located in Central Uganda, 120km from Kampala. The district has a population of 296,649, more than 50% (152,418) are female and 144,231 males with 286,042 estimated household (UBOS, 2014). Masaka District has nine (9) sub counties with one municipality that is made up of three divisions. Approximately 20% people reside in 5km radius from a health facility, 65% live in rural areas and 35% in urban setting (UBOS, 2014). Masaka District has 1400 VHTs, 1372 active and four per village where each is responsible for 25 households (MOH, 2015). Two sub counties of Buwunga and Kyabakuza/Kijabwemi were selected. Those two sub- counties are quite big, with many households and increased population. VHT in the two areas have worked hard to mobilise for health services.

3.3 Study population

The study population was comprised of community members who had been mobilised by VHTs to receive any of the two health services from a nearby health facility in their locality. It was estimated that health facilities in Masaka District received approximately 12000 of clients annually and about 40% had been mobilized by VHT (District Health Report, 2014). BuwungaSub County which was one of the rural study sites has a population of 42,367 people, 20.938 males and 21.429 females, with **9,907** estimated numbers of households (UBOS, 2014).Kimanya/kyabakuza was another study site in municipality with 34,632

people, 16,500 males and 18,132 females with**8,882**estimated numbers of households(UBOS, 2014).

3.4 Sampling procedures

A total of 400 respondents were interviewed in this study. Respondents were household members and in each household, one member was interviewed. These respondents were drawn from 16 randomly selected villages in two sub counties of Buwunga and Kyabakuza/Kimanya Division. A list of villages totalling to 296 were compiled from Uganda Bureau of Statistics 2014 census data (UBOS, 2014) to constitute a sampling frame. Using statistical Software Package (STATA version 11) .In each Village, 30 household respondents were interviewed, selected from every third house. Interviews were conducted with a member who was found at home during the visit after obtaining his/ her consent to participate in the study and was 18yrs and above. If the first household member failed to consent, the interviewer moved on to next house.

3.5 Sample size

The sample size was calculated using Kish leslie's formula which states**;**

$$\boldsymbol{N = P(1-P)Z2 / d2}$$

Where N= Number of respondents needed

P= Estimated proportion of households who were mobilized for HIV and ANC services.

Z= Z score corresponding to 95% critical interval

d = Maximum error the researcher was willing to allow at 0.05

Since there was no available study conducted on estimated number of household mobilized for HIV and ANC service, 50% was considered as worst scenario. Z-Score at 1.96 corresponding with 95% confidential interval.

N= (**0.5x0.5x(1.96)2**) =385

0.05*0.05

Using 10% non- response rate, the total sample size is 423

From the above formula, 423 households were considered. In each household, one questionnaire was administered to an individual found in a household (household head).

Two focused group discussion (FGDs) each consisting of seven (7) people was conducted per Sub County. The two FGDs, one was made up of males and the other females.

Five (5) Key informants (KI) were interviewed, two (2) per Sub County. They included; Health Centre III in charge and Health Assistant (HA).The District VHT coordinator was also interviewed. In total five (5) people were interviewed.

3.6.0 Sampling techniques

A systematic random sample for households was drawn from UBOS 2014 Census. A table of random numbers was used to locate the first sampling point; every 3rd household was selected to participant in the study. A computer power analysis program was used to determine how many participants are needed to have effective results from the study. Purposive sampling was employed to select respondents to be interviewed and those participating in FGDs.

3.6.1 Inclusion criteria

Individuals from randomly selected households in villages with VHTs, above 18 years and consented to take part in the study.

3.6.2 Exclusion criteria

Individuals who live in villages without VHTs, found sick and unable to consent did not participate in the study.

3.7.0 Data collection methods and instruments

Quantitative data was collected using a structured questionnaire. It was developed after reviewing VHT documents and guidelines in Uganda and other related studies done in other countries. The questionnaire was structured, developed in English and translated into local language (Luganda). It was then translated back into English to find out the consistency. It was pre-tested on 5% of planned participants and some modifications were made to come up with the final tools.

Qualitative data was collected during Interviews and FGDs conducted by the investigator and research assistants. Research assistants were trained in research protocol before they were deployed to collect data. Interview guidelines were used during interviews with KI and FGDs that was held with selected informants.

3.7.1 Quality control methods

3.7.2Reliability

The quantitative tool used was a modified likert scale. Research assistants were trained on how to use the tool, systematically recording and transcribing data. They were also supervised during data collection so that there was no missing data. In future, another researcher can use the same data to draw a similar conclusion.

3.7.3Validity

Likert scale is a common tool that was developed by Likert in 1932, since then it has been used in various studies with credible findings. Therefore, the same tool was used though

modified to suit the context of the study (Bell &Waters, 2014).The external validity depended on generalization of findings that were determined on the number of participants and context of the study setting.

3.7.4 Credibility of the findings

It was established by spending enough time with participants to check any alteration of data. In addition, participants' experiences were explored in detail during interviews and FGDs. Videotaping was also used for comparison with recorded data. The uncertain findings, explanation was thought from participants and cross checking with available sources of data from researchers' records, field notes and diaries (Rudestam& Newton, 2007).

3.7.5 Dependability

It was censured by training interviewers so that they systematically record and transcribe data. This was ensured through coding raw data in a way that another person can understand the themes and attain similar conclusions (Rudestam& Newton, 2007)

3.8.0 Data management and processing

3.8.1 Data Analysis

The quantitative data was entered and analysed with help of IBM SPSS 20, descriptive statistics and mean scores were used to summarise data. Inferential statistics were used to generalise findings from samples to the general population. Pearson coefficient test was applied to determine the association of VHT mobilization and community satisfaction. Qualitative data from interviews and FGD were coded, analysed manually and arranged into different themes so that it was triangulated with quantitative data.

3.8.2 Ethical considerations

Ethical approval of this study was obtained from Faculty of Health Science, ethical review committee of Uganda Martyrs University (UMU) on behalf of Uganda National Council for Science and Technology (UNCST). Permission was also sought from District authorities of Masaka District before the collection of data commenced. In addition, a written consent form was filled by respondents before they participated in the study. Privacy was maintained at all times while carrying out interviews and administering questionnaire. Confidentiality for data collected was ensured; it was possible by avoiding using respondent's name but rather use initials and numbers on questionnaire. Bias and fears of respondents were minimised during this study by presenting an introductory letter from CAO and DHO to respondents. Interviewers also introduced themselves and those who would be known to respondents, would not interview or administer questionnaire to them. Finally the study involved minimal unforeseen risks that were addressed as they unfold.

3.8.3 Limitations of the study

The study might not reflect the actual situation for satisfaction with VHT's mobilisation activities in communities thought out. This was because satisfaction tends to vary from time to time depending on other external factors (Oliver, 1993). The study concentrated on the demand side, thus provider (VHTs) side was not considered which might not give the true picture of VHT's mobilisation activities. Also the use of interviewer to administer a questionnaire might cause social desirability bias during data collection period.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF RESULTS

4.0 Introduction

This chapter presents the study findings as obtained from the field. The study was guided by three research objectives; to assess the extent to which community members were satisfied with VHT's mobilisation activities for HIV and ANC services in Masaka District; to determine factors influencing community satisfaction with VHT's mobilisation activities for HIV and ANC services in Masaka District. The third objective, explored community perceptions of VHTs' mobilisation approaches for HIV and ANC services in Masaka District;

The target sample for the quantitative strand of the study was423 respondents but 400 participated, resulting into 95% response rate. Data for the qualitative strand of the study were collected using two (2) FGDs and five(5) key informant Interviews were also conducted with District Health Officials and Facility Health In-Charges.

The findings and interpretations were presented in the following sub sections in this chapter being guided by the objectives.

4.1:0 Socio- demographic characteristics of respondents

Table1: Demographic characteristics of the respondents (N=400)

Demographic Characteristics		Frequency(f)	Percentage (%)
Sex of respondents	Male	135	33.8
	Female	265	66.3
Age of respondents	20-30	151	37.8
	31-40	124	31
	41-50	63	15.8
	>50	62	15.5
Marital status	Married	109	27.3
	Cohabiting	155	38.8
	Single	85	21.3
	Windowed	51	12.8
Religion of respondents	Catholic	179	44.8
	Protestant	99	24.8
	Moslem	78	19.5
	Pentecostal	44	11
Education of respondents	Primary	162	40.5
	Secondary	154	38.5
	Tertiary	48	12
	None	36	9
Occupation of respondents	Peasant	168	42
	Teacher	26	6.5
	Self employed	151	37.8
	Business	55	13.8

The majority of the respondents, 265 (66.3%) were female and most respondents 151(37.8%) were in age range of 20-30 years. More than half 264(66%) of the respondents were married and 179(44.8%) were Catholics. The 162(40.5%) of respondents had primary Education and most respondents 151(37.8%) were self-employed.The findings revealed that majority of the respondents who participated in the study were women. It further showed that majority of household members who participated in the study were married.

4.1:1Assessingto what extent are community members satisfied with VHTs mobilization activities for ANC and HIV services

The objective was seeking to find out the extent of satisfaction among the respondents of the study in Buwunga sub-county and Kyabakuza/kimaya Division in Masaka district respectively. It used different parameters to assess the satisfaction as stated below;

4.1.2: Awareness by household members about the presence of VHTs in their communities

In order to assess the satisfaction of household members with VHTs mobilization, it was important to first consider awareness of the respondents about the presence of the VHTs in the communities. This was important because satisfaction is influenced by people's expectations and what actually is experienced by the same people exposed to particular factors. In that regard, participants were asked to mention whether they knew the VHTs in their communities and it was revealed that majority 348(87%) of the respondents were aware of the VHTs in their Villages. This implied that VHTs were known to many community members whom they mobilize for different health services.

4.1.3: Determining community members who were mobilized by VHTs

This was assessed through asking participants to mention whether they had ever been mobilized to seek HIV and antenatal services. Majority 299/400 (74.8%) of respondents were mobilized by VHTs to seek health services. This means that the VHTs had mobilized a significant number of community members. However, 23.2% (101/400) of the members reported that they were not mobilized by VHTs for any health services. This finding was important to note, because VHTs are expected to mobilize all community members to access health services.It was further confirmed during interview with VHT focal person who said;

> Community mobilization to them is not easy, it has its hardships. According to their views, the fact that VHTs are volunteers, transport is high. To some extent it is a problem to them, in compiling report it is very hard. They have a reporting template which they are supposed to use to follow up pregnant mothers, how many have attended ANC, delivered and received care. But it is very hard due to transport challenges (**KI,Kyabakuza HCIV)**.

4.1.4: Awareness of the respondents on the VHTs' roles in community mobilization for HIV and ANC services

Participants were asked to mention whether they had been mobilized by VHTs to seek ANC and HIV services from the health facilities. Only 30/400 (8%) and 25/400 (7%) of

respondents indicated they were aware that VHTs mobilized community members for ANC and HIV counseling and testing respectively. This implied that community members could not distinguish the roles of VHTs. It was further confirmed during the FGDs, where members had been mobilised for one or more health programs though rarely had they been mobilised for HIV and ANC services. However it was noted that most times, VHTs are concerned with sanitation and hygiene in the households than anything else. It becomes a surprise to community members when VHTs discuss issues related to pregnancy. This was demonstrated by one of the participants who said;

> When a VHT visited my home, I was scared because I knew she was going to abuse me. I did not have a kitchen, my latrine was in bad condition and I was pregnant. To my surprise she counselled and gave me information and reasons why I should attend ANC. She further encouraged me to improve hygiene of my home in order to avoid diseases while i am pregnant. I was happy and promised to improve (**community member, FGD, Buwunga sub-county)**.

Regarding satisfaction of community members with the VHTs' mobilization, majority 18/25 (73.1%) of those who were aware that VHTs mobilize community members for HIV and counseling services were satisfied with their mobilization activities. Likewise, most of the respondents, 19/30 (63.3%) who were aware that VHTs mobilized community members for ANC were also satisfied with their mobilization. This shows that VHTs did not reach out to a significant number of community members while mobilizing for ANC and HIV services. However, the few who were reached were effectively mobilized by VHTs to access HIV and ANC services hence members were satisfied.

In addition, 23/30(76.6%) of respondents who were mobilized for ANC services were generally satisfied with VHTs mobilization activities and 14/25(56%) respondents who were

mobilized for HIV services were also generally satisfied with all VHTs mobilization activities.

The key informants and members of FGD were in agreement that majority of community members who were satisfied with VHTs mobilization activities. They added that there was increased number of household members accessing health services with information given by VHTs. One Key informant stated;

> "Though i am not at community level, but I also live in a village where there are VHTs and generally, VHTs do a good job. I think community members are satisfied by around 70% but not 100%. This is because community members are not easy" (KI, Masaka District).

This means that VHTs mobilized community members for different health services. Majority of respondents who were household members were satisfied with VHTs community mobilization activities and appreciated the work they are doing in their communities

4.1.5: Respondents' satisfaction with mobilization strategies used by VHTs for ANC and HIV services

Respondents who were aware about mobilization of community members by VHTs were asked about the strategies used in the mobilization. They were later interviewed about their satisfaction with the strategies used and the results are presented in table 2 below.

Table 2: strategies used to mobilise community members for ANC and HIV services (n=30)

Strategy	Frequency(f)	Percentage (%)
One on one counseling	5	16.7
Community meetings	6	20.3
Home visiting	16	53.5
Talks in place of worship	4	12. 3

The findings showed that majority 16(53.5%) of the respondents said home visiting was the most commonly used mobilization strategy in their communities. Key informants too believed that home visiting was the most common strategy used. Other methods were equally

used for mobilization as shown in table 2. It was also affirmed during focused group discussion, where members stated;

> VHTs reach to all homes within our villages, that is when they pass on the information properly and we feel respected and in return we embrace health service. In our villages, some VHTs talk to us after church services, they are given opportunity by our priest to pass on health information. That is how we get to know that there are drugs at our health facility, new diseases in our community like yellow fever, HIV counselling and testing by Uganda cares and when there are new doctors from Kampala to Masaka Hospital. They also give us information during our village meetings with LCs.(Member, FGD, Kyabakuza/Kimanya)

In addition, members noted that VHTs took advantage of social gatherings in their communities, for example parties, funeral and market days. That is when they pass on health related messages to community members. Even they also used talks in places of worship (Churches and mosques), village meetings and mega phone from the health centre. One person sits on a motorcycle with health assistant and they move in several villages while passing on information. This approach was used when the message is urgent, for example informing people for HIV counselling and testing outreach, receiving mosquito nets, child health days and world AIDs day etc. In addition, they put announcements in schools for children to pick information and take it to their parents for example announcement on safe male circumcision, cervical cancer screening and in case of any disease outbreak.

As regards community satisfaction with the strategies used, much as home visiting was the most commonly used strategy for mobilization, community members were equally satisfied with any of the methods used by VHTs. This depended on the circumstances under which the strategy was used such as the nature of health activity, the period and the urgency of the mobilization as highlighted above.

4.1.6 Respondents' satisfaction with referral and linkages of community members to health facilities for HIV and ANC services.

Participants who were aware that VHTs mobilize for HIV and ANC were asked to agree or disagree whether they were satisfied with referrals and linkages made byVHTs**.** Majority 22(72.8%) agreed that they were satisfied when VHTs referred and linked them to health facilities for ANC and HIV services. Members of the women FGDs acknowledged that VHTs visit them at their homes referred and linked those in need of ANC services and HIV testing. One member stated;

> When i was pregnant, omusawowakukyaro (VHT) visited me and explained to me reasons why i should seek ANC services. She even assured me that a midwife will treat me well. She informed me that at the time of delivery, my ANC card will help me. She cautioned me that when I am not attending ANC, health workers will not take care of me when am delivering. Our discussion at home was helpful. When i told my husband, he encouraged me to go for ANC and since then it became a routine. Now whenever am pregnant, i seek ANC services and deliver from the hospital. **Member, FGD, Buwunga Sub-county**

It was also agreed upon among members of FGD that VHT effectively communicated with community members. They were in agreement that VHTs talk to them at home and give information and also refer sick members to seek health services from the nearest health facilities. This implied that referral and linkage was an important component of community mobilization used by VHTs and it enhanced community members' satisfaction with VHTs mobilization for HIV and ANC services.

4.1.7 Demographic characteristic and overall satisfaction with VHTs' mobilisation activities for health services

A cross tabulation was run to establish the relationship between the demographic characteristics of respondents andoverall satisfaction with VHT mobilization for health

services in their communities. This was aimed at assessing community members generally whether they are satisfied with VHTs mobilization activities. The findings are presented in the table 3 below

Table 3 Demographic characteristic with overall satisfaction with VHT's mobilization activities

Demographic characteristics		Overall satisfaction with VHT's Mobilization activities				Total
		Yes		No		
		(f)	(%)	(f)	(%)	
Age of respondents	20-30	106	70	45	30	151
	31-40	87	70	37	30	124
	41-50	42	67	21	33	63
	>50	44	71	18	29	62
sex of respondents	male	100	74	35	26	135
	female	179	68	86	32	265
Marital status	married	82	75	27	25	109
	cohabiting	103	66	52	34	155
	single	60	71	25	29	85
	windowed	34	67	17	33	51
Religion of respondents	catholic	123	69	56	31	179
	protestant	67	68	32	32	99
	Muslims	64	82	14	18	78
	Pentecostal	25	57	19	43	44
Education of respondents	primary	116	72	46	28	162
	secondary	102	66	52	34	154
	tertiary	37	77	11	23	48
	none	24	67	12	33	36
Occupation of respondents	peasant	122	73	46	27	168
	Teacher	19	73	7	27	26
	self employed	107	71	44	29	151
	business	31	56	24	44	55

The majority of respondents above 50 years, 44(71%) reported that they were overall satisfied with VHTs mobilization activities in Masaka District. This suggested that age was an important consideration in measuring satisfaction.

Furthermore, a majority of male respondents 100(74%) indicated that they were satisfied with VHTs mobilization activities in Masaka District. This suggested that more men who were mobilized by VHTs were satisfied with their mobilization activities because men like social gathering like meetings, parties and attending church services where VHTs could have interacted with them.

In addition, a significant number of Muslims 64(82%) accepted that overall they were satisfied with VHTs mobilization activities in Masaka District. This means that most Muslim

appreciated the approaches used by VHTs to mobilize them for health services including HIV and ANC services. This was because Muslim wives stay at home more often, where they would have interacted with VHTs.

Majority 82(75%) of the married people were satisfied with VHTs mobilization activities. This means that being married contributed to individual's satisfaction with VHTs mobilization activities that targeted most household heads that are married in most cases.

4.1.8 Respondents overall satisfaction with VHTs mobilization activities for ANC and HIV services

Table 4. Indicators of community satisfaction (N=400)

Indicators	Scale	Frequency	Percentage (%)	Mean	SD
VHT are trained in community mobilization	Disagree	7	1.8	3.8225	0,66491
	neutral	109	27.3		
	agree	232	58		
	strongly agree	52	13		
VHT refer and link community members to health facilities	strongly disagree	1	0.3	3.8225	0.74993
	Disagree	20	5		
	neutral	88	22		
	agree	231	57.8		
	strongly agree	60	15		
VHTs mobilize people for HIV services	strongly disagree	8	2	3.885	0.95081
	Disagree	29	7.3		
	neutral	71	17.8		
	agree	185	46.3		
	strongly agree	107	26.8		
VHT mobilize women to attend ANC	strongly disagree	21	5.3	3.6675	0.0723
	Disagree	33	8.3		
	neutral	93	23.3		
	agree	164	41		
	strongly agree	89	22.3		
VHT mobilize for prevention and treatment of childhood illness	strongly disagree	2	0.5	4.1875	0.80247
	Disagree	16	4		
	neutral	38	9.5		
	agree	193	48.3		
	strongly agree	151	37.8		
VHTs communicate effectively with community members	strongly disagree	8	2	4.015	0.95239
	Disagree	32	8		
	neutral	34	8.5		
	agree	198	49.5		
	strongly agree	128	32		

Findings from table 4.2 above shows that most respondents 284(71%) agreed that VHTs were trained in community mobilization. Majority of respondents 291(72.8) also agreed VHTs referred and linked clients to nearest health facilities. Most respondents 292(73%) and 253(63%) also agreed that VHTs mobilize household members for HIV and ANC services respectively. A good number of respondents 326(81.5%) agreed that VHTs communicate to household members.

Overall satisfaction of majority respondents on a lirket scale was 279(69.8%).Meaning majority of respondents agreed with most of the indicators considered for satisfaction of VHTs mobilization activities for ANC and HIV services.

The above high percentages for indicators reflected thatcommunity members are satisfied with VHTs mobilization activities. The mean values on all items on satisfaction with VHTs mobilization showed highest mean as 4.1875 (VHT mobilization for prevention of childhood illness) and the lowest as 3.6675(VHT mobilization for ANC). In general the mean values suggested satisfaction with VHTs mobilization activities. The standard deviation showed the highest at 0.95239 (effective communication) and lowest at 0.0723(mobilisation for ANC). These standard Deviations in general were low, suggesting that respondents had similar views and perceptions on satisfaction for VHTs mobilization activities in Masaka District.

4:2:0 Determining factors influencing community satisfaction with VHTs mobilization for ANC and HIV services.

The objective was considering major factors influencing satisfaction with VHTs mobilization activities for ANC and HIV services. Five factors were considered on lirket scale for respondents to rate as strongly agree, agreed, neutral, disagree and strongly disagree. Both respondents who agreed and strongly agreed were aggregated together and considered to have agreed. Those who strongly disagreed and disagreed were also aggregated and considered to have disagreed.

4:2:1 Factors influencing community satisfaction with VHT mobilization

The factors influencing community satisfaction with VHTs mobilization were studied and the results are presented in the table 4 below.

Table 5: Factors influencing community satisfaction (N=400)

Factors for satisfaction	Scale	Frequency(f)	Percentage (%)	Mean	SD
VHT selection	SD	4	1	3.6425	0.89817
	D	30	7.5		
	N	144	36		
	A	149	37.3		
	SA	73	18.3		
VHT residence	SD	5	1.3	4.2675	0.68711
	N	40	10		
	A	198	49.5		
	SA	157	39.3		
VHT are trusted	SD	9	2.3	3.7675	1.0047
	D	50	12.5		
	N	53	13.3		
	A	201	50.3		
	SA	87	21.8		
VHTs accessibility	SD	14	3.5	3.8325	0.97304
	D	35	8.8		
	N	39	9.8		
	A	228	57		
	SA	84	21		
information giving of new health programs	SD	10	2.5	3.7900	0.97893
	D	44	11		
	N	50	12.5		
	A	212	53		
	SA	84	21		
VHTs effective Communication	SD	8	2	4.0150	0.95239
	D	32	8		
	N	34	8.5		
	A	198	49.5		
	SA	128	32		

Table 4 above, shows factors that were considered to influence community satisfaction with VHTs mobilization;

4.2.2 Village Health Teams selection

The findings revealed222 (55.6%) of the respondents agreed that VHTs were selected by community members. During the interview, one of the key informants also agreed that VHTs

were perceived as influential community health workers. Their selection attracted involvement of almost everyone in the village. The MOH guidelines stipulated that VHTs must be voted by their community members. Each Village selected four VHTs and each was responsible for about 25 households. Whenever there is a drop out of a VHT, Local council leaders were requested by VHT coordinator to identify a person from that village to .

> As per the guidelines in the Ministry of Health strategy, VHTs are selected by community members being guided by the criteria given to them. For them when they are given those criteria they identify the people who qualify to be selected. Whenever, there is a drop out like when someone dies or migrates to another place or someone is old. So we have been working with LCs and community members to identify others who are suitable. Community members like taking part in selecting VHTs. **KI, DHO office-Masaka**

It appeared community members were satisfied with VHTs selection. This was confirmed by participants in FGDs who said, VHTs who were selected by community members themselves, visit them in their homes and give them information about ANC, HIV testing and taking children for immunisation during an outreach in their villages. This means that VHTs selection is a strong factor in enhancing community satisfaction.

4.2.3 Residence of Village Health Teams

Furthermore, majority of respondents 355(88.7%), agreed that VHTs stayed in their villages. This factor was attributed to respondent's satisfaction because respondents said that VHTs who are close mobilize them more often for health services. In addition, participants in a female group expressed their appreciation for VHTs who stay in their villages and said they do great work. "VHTs in our villages are very helpful; they constantly remind us to go to a health facility if we are sick, when you are pregnant she will register you and even call you to remind you to attend ANC. Member",**(FGD, Buwunga sub –county)**. Therefore, a VHT

being resident was considered as a major factor that promoted satisfaction among community members.

4.2.4 Trust by Village Health teams

Still more, majority 288(72.1%) of the respondents agreed that VHTs are trusted by communities. It was further explored during the FGDs that VHTs talk to them at home and give information about new health programs targeting their village and they trust what they tell them. A member of focused group stated;

> They direct us well where to go in case of a new program or outreach for HIV testing. They also give us some posters for any new program that is coming to our village. They are good in giving us information in time and always tell us the truth. When they tell you, health workers will come for outreach and you take the child there, you find health workers there and it is good. Next time they tell you of HIV testing and counselling camp, you are sure it will be there (Member 2**, FGD, Buwunga Sub- County).**

We are satisfied with how they inform and involve us in health programs because most of them are trustworthy. The findings above suggest that trust was a strong element in influencing community satisfaction.

4.2.4 Accessibility for Village Health teams (VHT)

VHTs accessibility to community members was a strong factor too, majority 312(69%) of respondents agreed. This implied that VHT accessibility influenced satisfaction of VHTs mobilisation for HIV and ANC services.

4.2.5 Giving information

In addition, the majority of respondents 296 (74%) agreed that VHTs gave information to community members about the available health services in their locality. A participant who was interviewed stated that;

> As a district, we have realized VHTs are very important in mobilization. This is because reaching out to households is not easy. They reach each household and interact with members on issues concerning their health. , They give information on ANC and other related services. We had campaign and realized they had played a good job especially with campaigns for immunization, polio, measles and recently yellow fever (**KI a -DHO' office, Masaka District)**

The findings revealed that provision of information had an effect on community satisfaction with VHTs mobilization activities.

4.2.5 Effective communication

In the same direction, majority 326(81.5%) of the respondents agreed that VHTs effectively communicate with community members. One participant who was interview revealed that;

> VHTs communication would not be so bad. As you know challenges are there in life that we cannot avoid it. Like even health workers have challenges of talking to our clients, some shout at patients, ask patients money. So we tell VHTs that if they have a conflict with neighbour, the can tell another VHT to visit that home and do the work so that good communication is maintained. (**KI b-Kyabakuza HCII**)

This implied that effective communication contributed to community satisfaction with VHTs mobilization services

The high percentages reflected on factors considered in objective two, suggests that the studied factors influenced the satisfaction with VHTs mobilization. The findings were in agreement with the mean values. The highest mean was 4.2675(VHTs' residence) and the lowest was 3.6425(VHT selection), these mean values hence suggested there was agreement with all the factors studied. In general view of the level of agreement with studied factors in table above, they were aggregated into one main valuable factor as shown in the figure 1 below;

Figure 1: Factors influencing community satisfaction

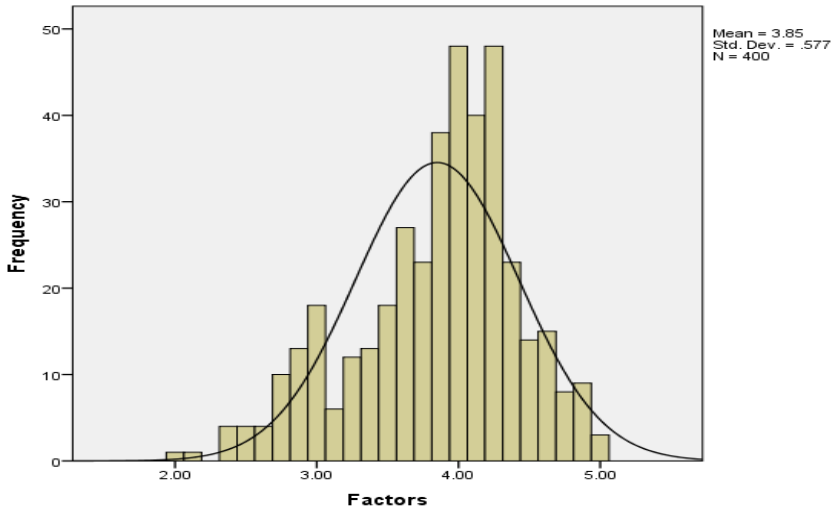

Figure 1: **Factors influencing community satisfaction**

Figure 1 above is histogram with normal distribution curve showing the majority of respondents were concentrated on right side of the curve. This suggested that the level of agreement among factors was high, with positive impact on community satisfaction.

On further analysis to further show how the five(5) major factors studied influenced community satisfaction, a Pearson's correlation was used as presented in table 5 below.

Table 6: Pearson's Correlation co-efficient index between factors influencing community satisfaction with VHTs mobilization

Pearson's co-efficient index		satisfaction	Factors
satisfaction	Pearson Correlation	1	.701**
	Sig. (2-tailed)		0
	N	400	400
Factors	Pearson Correlation	.701**	1
	Sig. (2-tailed)	0	
	N	400	400

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

Table 6 above, shows Pearson correlation co-efficient index between factors and satisfaction of VHTs mobilization. R= 0.701** with a significance P value =0.000 less than 0.05 the standard statistical Value that indicated there was a high positive significance relation between factors studied and the satisfaction with VHTs mobilization activities for health

services in Masaka District. As factors studied (selection of VHTs, being resident, trusted, accessibility, information giving and effective communication) improved, the level of satisfaction was also enhanced. Alternatively, as the factors decline, the level of satisfaction decreases too.

4.4.0 Exploring community perceptions on community satisfaction with VHTs mobilization activities for HIV and ANC services.

The objective ought to gather community members' insights, observations and opinions on community satisfaction with VHTs mobilization activities on HIV and ANC services in Masaka District. The answers were sought through qualitative inquiry using in-depth interviews and focus group Discussion (FGD)

4.4.1 VHTs competence for community mobilization

VHTs mobilization in communities required knowing how to mobilize people**.** Participant's perceptions on VHTs competence were explored. Their opinions were systematically analysed to make meaning. Most views expressed some level of competence. Participants showed that some VHTs who know how to mobilize and others do not do it well. They cite examples when they were mobilized but felt it was not conducted well.

> When I was pregnant for the first time I did not know when to go for check-up at hospital, when I asked our VHT she told me when i get time I go to any health facility. When I went to our nearest HCII, a nurse told me to go another health facility at our sub county where there was a midwife. I felt not helped and went back home. The VHT would have told me to go to a health facility at sub- County in first place. (**Member 1 FGD, Buwunga)**

This means VHTS were not competent enough to mobilize community for ANC HIV services in Masaka District though they might to be competent in mobilizing for other health services that were not explored.

4.4.2 Effectiveness in community mobilization

Community mobilization requires effectives to obtain substantial results. Therefore, the study explored participant's perception on effectiveness of VHTs community mobilization. From their views, VHTs were helpful in some programs and others not quite good. On HIV and ANC services, they expressed that mothers are not adequately mobilized and even those in need of HIV services. They noted a challenge of stigma and low men involvement that probably affects effective mobilization for access and utilization of health services.

> The challenge with pregnant mothers is that they do not want to be known that they are pregnant until it is seen. VHTs find it had to give them information on ANC when the pregnancy is still young, they keep hiding**(KI a -DHO's office-Maska District)**

This means VHTs mobilization for ANC was not adequate in communities and community members are less likely to be satisfied.

4.4.3 VHTs personnel attitude

Personnel attitude especially while doing community work needs to be observed. Therefore participants were asked to give their opinion on VHTs attitude while mobilizing community members to access and utilize ANC and HIV services. Participants gave a mixed reaction, some said majority of VHTs had a calm attitude, depending on the way they talked, responded to questions from the members and freely interacted with very one. However, few number of VHTs were reported to be rude, abusing clients and quarrelsome. A member who was interview said;

> Some VHTs are stubborn, they quarrel with members in the village, and there is a VHT member who is rude and we are thinking of replacing her. Though the community is not also easy, there is a lot of rumours and misinformation. But some VHTs are good, they have good attitude and are recommended by their community members(**KI, Buwunga sub-county**).

However, some community members were satisfied with VHTs mobilization activities; few members felt they were not doing the work right. They highlighted the issues of rudeness by some VHTs and those that only favoured their friends. Some community members undermined VHTs because some had no education and others had inadequate skills of mobilizing people. In addition, they were blamed for failing to be exemplary.

> It is not easy to satisfy community members, there some divisions brought in by politics and even rumours. Some members do not trust VHTs so they do not take them serious. They wonder if they are trained to treat their children and give right information on pregnancy (**KI Kyabakuza HCII).**

VHTs attitude was perceived with mixed reactions, some members question VHTs attitude in relation to community mobilization. It seemed improved personnel attitude was attributed to improved mobilisation for HIV and ANC services**.**

4.4.4 VHTs availability in communities

VHTs availability in their communities makes their community mobilization conducted across all members. The study explored participants thought, it was observed that VHTs are always at home but with many activities.

> VHTs are very busy with many activities, when your child is sick and run to their homes, you are told they have gone to the health centre or to visit other homes or mobilizing for Uganda cares, mothers for EMTCT or for meeting. They are hardly at home which makes it difficult to see them. They have a lot of work (**KI, Kyabakuza HCII).**

Their availability would give a very community member a chance to consult from them in case some information on ANC and HIV is needed. At times pregnant mothers need information on where to go for ANC services, where to receive family planning methods and even what facility can offer HIV counselling and testing and other related services. When mothers bounce at VHTs home, they become demoralised to seek ANC services.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

The purpose of this concurrent mixed methods study was to better understand how community satisfaction with VHT mobilization would affect access and utilization of health services in Masaka District. The chapter presents the discussion of research findings, conclusions and recommendation in relation with research objectives, it further discussed the implication of important results and expounded in line with the literature review.

5.1.0 Discussion

5.1.1 Community satisfaction with VHTs mobilization activities for ANC and HIV services.

Objective one sought to find out the extent to which community members are satisfied with VHTs mobilization for HIV and ANC service in Masaka District. The study analysed deeply the mobilization interventions used for ANC and HIV services. This is because involvement of mobilization activities for ANC and HIV services were still very low resulting into poor access and utilization of the same health services at household level in Uganda (WHO, 2014). It was established by previous study that household members were staying far away from health facilities and most of them were not informed of available ANC and HIV health services in their communities (Kawungezi et al, (2015). The findings of that study was in agreement with a study conducted by Ministry Of Health that found 48% households were staying in 5km radius from the health facility (MOH,2009). In addition, pregnant women had non- supportive husbands and were not empowered to make concise decisions to access and utilize ANC and HIV services. In response to above challenges, Ministry of Health promoted

VHT program that was supposed to mobilize household members to access the available health services (MOH, 2010)

Ever since the establishment of VHTs, they have continuously engaged household members to participate in ANC and HIV services in Masaka District. A study in Wakiso District revealed that children care takers who were mobilized by VHTs to undertake treatment of pneumonia, Dirrhoria and Malaria were satisfied with VHTs mobilization activities (Tumushabe et al, 2013).

Similarly this study established that household members in Masaka were satisfied with different mobilization approaches used by VHTs; home visiting, community meetings and announcements in places of worship. More so, Namukwaya et al (2015)in their study of increasing uptake of ANC attendance and Early Infant Diagnosis (EID) established that community members were happy with VHTs who mobilized them through home visiting, community meetings and one on one counselling. Such approaches would be used to engage women in productive age group who were vulnerable and did not enjoy their right to access and utilize ANC services (Kawungezi et al, 2015, Kuhlman, et al 2016). In the view of promoting equity among women, pregnant women are expected to access, attend ANC services and deliver with help of trained and skilled health workers.

In Uganda, more than 80% of the population live in the rural areas and more than 50% are not in reach of health facilities (MOH, 2010). In view to address this problem, the government of Uganda through Ministry Of Health established village health team strategy to bridge the gap between their communities and formal health facilities. This study was in agreement with MOH, it further established that VHTs referred and linked household members to nearest health facilities. Similar findings were revealed by other studies

conducted in Uganda (MOH, 2015, Tumuhamye et al, 2013). VHTs would engage household members through mobilization and empowerment processes in order to access HIV, and ANC services with in their communities (MOH, 2011).

Furthermore, the ability of communities to demand and utilize health services was mostly affected by their level of satisfaction with the available services with in those communities (Sibamo&Berheto, 2015). Similarly, a study was conducted on patient's satisfaction in health facilities in Uganda and it revealed that understanding patients' satisfaction was core in improving quality of health care. This was because when people are not satisfied with services, they simply do not use it (MOH, 2008). This study established that household members were satisfied with VHTs' mobilization activities for ANC and HIV services in Masaka District. The findings were consistent with another study that established that studying community satisfaction would improve access and utilization of health services. (MOH, 2008). In addition, scholars of satisfaction studies urged such practice would give community members feedback based on performance of such health intervention. This would narrow the gap of community members expectations and actual health services implemented (Olifi, 2014).Understanding how community appreciate VHTs mobilization activities would help health experts in designing client focused health intervention especially those intended to improve ANC and HIV services with emphasis to health promotion (WHO, 2011).

5.1.2Determining factors influencing community satisfaction

A number of important factors were considered while measuring client satisfaction. Age was a considerable factor because the older people are more satisfied with health services since their expectations are few. This is because they have been exposed to different health interventions for some time. Client- provider relationship was also another factor that influenced satisfaction. When client provider relationship is good, in case where clients choose their providers' they are more satisfied with services compared to when they do not (Crow et al, 2003 as quoted in MOH, 2008). Similar factors were established in Districts with VHT programs where People participated in VHT selection, they were satisfied with their involvement in community mobilization for health services (MOH, 2015). The same study found Information giving and technical competence were equally important factors for satisfaction. In another study conducted in western Uganda, it revealed that maintaining trust, interaction of VHTs with people while giving health education talks and counselling household members was imperative (Muhumuza et al, 2015).

This study had similar findings where VHT selection, trust, giving information and being resident and accessibility were explored. The selected VHTs would also easily convene village meetings with support of local councils to pass on information related to new programs. This meant that mobilization for ANC and HIV would be easily done and effective. All the factors were found applicable in Masaka District and enhanced satisfaction with VHT mobilization activities. Household members believed in health providers who resided in their villages. This is because when community health workers who stay in villages can easily mobilize for health services (MOH, 2015). On the other hand, prior experience with health services was another factor measured by satisfaction studies, it was urged that, it exposes people to health services and actually they got to know what takes place in health facilities(Ofili, 2014). The author urged that effective communication was vital in mobilizing

communities and that would increase uptake of health services and they are likely to be satisfied with health services (Lochoro, 2004). However, when community members expectations were high, it would lead to dissatisfaction of the similar health services (Kisia,Nelina& Otieno,2012).

5.1.3 Community perceptions with VHTs mobilization activities for HIV and ANC services.

Community perceptions were used to explore satisfaction in some studies which was related to the utilization of health care services (Haddad S, Fourner P, and Potvin L, 1998). The perceptions considered where measuring lay people's perceptions towards the quality of primary health care services in developing countries, included technical competence, effectiveness of care, personal attitude, availability and adequacy of resources, and accessibility of services (Kagwanja, Muthami and Ng'ang'a, 2014).

Consequently, when people's perceptions were effectively considered, the utilization and health seeking behaviours for health services would improve and resulting into satisfaction with existing Health services (Sibamo&Bertheto, 2015).

Relatedly, this study explored community perceptions on VHTs competence and effectiveness of their mobilization activities. It further considered personal attitude and availability of VHTs in communities. Such perceptions studies were in agreement with a study in Ethiopia which established that community health workers were competent in their work of mobilizing people to attain health services (Sibamo&Berheto, 2015). It was further expressed that VHTs were effective in mobilizing pregnant women to attend ANC and test for HIV. Similar findings were revealed in a study conducted in urban and rural health units in Uganda where use of community health workers were effective in mobilizing mothers to improve post natal attendance(Namukwaya et al, 2015). Other perceptions on personal

attitude and availability were revealed. In their study Bucher et al, (2014) on stakeholders' perceptions of integrated community care management by CHWs, found such perceptions would enlighten program designers and implementers on how to involve community members in health promotion program.

5.2 Conclusions

Community mobilization and empowerment with VHTs in Uganda have been undermined as a strategy for improving ANC and HIV services. However, both immediate and long term opportunities exist to improve the access and utilization of ANC and HIV services using VHTs mobilization.

Household members have been engaged to understand their rights and mobilized to fully access and utilize ANC and HIV services. In turn, communities had become aware that health is a fundamental right for everybody.

In addition, VHTs have continuously mobilized household members to improving their health seeking behaviours. More so communities appreciated VHTs mobilization activities for ANC and HIV services. Hence availing the opportunity to vulnerable and marginalised populations, to demand for quality health services in general and ANC and HIV services in particular.

Therefore, there is untapped potential in using VHTs to mobilize community members to access and utilize ANC and HIV services. Lack of fully integration of VHT strategy in community health programs illustrates a critical gap in health promotion, since VHTs are at the centre stage of Community mobilization, aimed at empowering marginalised population to access and utilize health services in rural areas.

Furthermore, experts and policy makers would take a lead in formulating local guidelines that would promote integration of community mobilization in all community health programs especially ANC and HIV.

All in all, to achieve great strides, District Health Team, Partners, health workers, community members and VHTs should work together to promote community mobilization since community members were satisfied with VHTs mobilization.

5.3.0 Recommendations

The study findings unveiled a number of gaps in community mobilization using VHTs. Thus in order to improve the accessibility and utilization of ANC and HIV using community mobilization, the study recommended**.**

5.3.1 Stakeholders at District and community level could embrace VHTs mobilization activities and take the opportunity to integrate VHTs in implementation of ANC and HIV services both at health facilities and in communities**.**

5.3.2 Program implementers and health workers together with community members could identify specific VHTs for a particular activity especially ANC and HIV activities. This will minimise overloading VHTs with a number of activities that are not well coordinated.

5.3.3 The roles of VHTs were not clearly stipulated and not well known to many community members as revealed by the study. Therefore, the community members should be involved in VHTs community review meetings so that VHTs roles are discussed. This would improve mobilization for ANC and HIV services.

5.3.4 Household members were satisfied with VHTs mobilization activities for ANC and HIV services generally. Therefore, the study recommended that VHTs could apply all

approaches (Home visiting, use of one on one counselling, focused discussion and talks in places of worship) while engaging community members.

5.3.5 The study recommended a referral path way that would be used by VHTs in referring and linking community members. The referral path way would clearly show where to refer and what services are available. This would quicken the process of referral and linkage for improved access and utilization of ANC and HIV services.

5.3.6 The District officials are encouraged to use the available opportunity, since members were satisfied with VHTs mobilization activities to engage all community members and create demand for ANC and HIV services. This would improve community member's access and utilization of health services.

5.3.7 The policy makers in the Ministry of Health could formulate policies that would integrate VHTs mobilization activities with ANC and HIV activities. So that, there is improved access and utilization of ANC and HIV services in communities.

5.3.8 The VHT strategy could be aligned to Natural helper model of health promotion. So that during VHTs selection by community members, the naturally existing informal group with people who are willing to help and are already trusted by community members could be considered. This would promote community involvement and sustainability.

5.5.9 The Ministry of Health could at least consider senior four level of education for one to be selected as VHT. So that VHTs are able to handle all the necessary documentation and use most of the mobilization approaches that target a big number of people. For example, use of Radios, TVs, brochures and internet.

5.3.9 The study recommended that VHTs training curricular should be improved with communication skills and increased duration to 2 weeks, the refresh training courses could be

periodic to update VHTs with current information in areas of ANC and HIV that is changing more often.

It was further recommended that study would be carried out to establish factors affecting services providers (supply side) the VHTs. Who mobilize community members for ANC and HIV services? The findings possibly would overcome the limitations of this study since it was restricted on demand side of community members.

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Appendix 1: Working schedule

Activities	Time frame													
	May 2016				June 2016				July 2016				August2016	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Pre testing tools														
Data collection														
Coding and data entry														
Data analysis														
Writing draft report														
Writing final report														
Submission														

Appendix 11: Budget

Proposed research budget				
Item	**Quantity**	**unit**	**Unit cost**	**total cost**
Preparations				
Travel	2	1	50000	100000
Stationary (ream of papers)	1	1	15000	15000
Translation of tools	2	1	100000	200000
photocopy of tools	1290	1	100	129000
Communication (Airtime)	1		50000	50000
subtotal				**494000**
Field work				
Travel to and from Masaka	3	2	50000	300000
Travel to site(RA)	2	30	10000	600000
Perdiem for research Assistant	2	30	50000	3000000
Travel for PI	1	4	50000	200000
Perdiem for principle investigator	1	4	50000	200000
Communication (Airtime)	3	1	100000	300000
SDA for Field guide	1	30	10000	300000
subtotal				**4900000**
Analysis				
Data entrant	1	10	20000	**200000**
Report writing				
Stationary (ream)	2	1	15000	30000
Photocopying draft reports	3	100	100	30000
photocopying final reports	5	100	100	50000
Binding	5	1	30000	150000
subtotal				**260000**
Grand total				**6030000**

Appendix 111; Questionnaire for Household Respondents

Good morning / afternoon?

My name is **Kenneth Musinguzi Rugamba** from faculty of Health Sciences of Uganda Martyr's University. We are assessing the level of satisfaction among community members who have been mobilised by VHTs to access and utilise health services (HIV, ANC and treatment of simple illness in children) in this community. The information you give will enable us to understand your knowledge of VHTs and how satisfied you are with the approaches used to mobilize community members. I promise to keep all the information confidential. Thank you for your cooperation.

This questionnaire/survey has three sections;

1. ***Socio- demographic characteristics of respondents***
2. ***Knowledge and practice of respondents on VHT services***
3. ***Level of community satisfaction with VHTs' mobilization activities***

Socio- demographic characteristics of respondents, Initials……

- ✓ Tick the appropriate answer

No	Questions	Response	Tick
1	Tell us your age,	20-30,	
		31-40,	
		41-50,	
		50>	
2	Respondents' sex	Male	
		Female	
3	Respondents, marital status	Married	
		Cohabiting	
		Single	
		Windowed	
4	Respondents religious affiliation	Catholic	
		Protestant	
		Moslem	

		Pentecostal	
5	Education level of respondent		
		Primary,	
		Secondly,	
		Tertiary	
		None	
6	Respondents' occupation	Peasant	
		Teacher,	
		Self-employed,	
		business	
	Others specify		

Section B. **Knowledge and practices of VHTs mobilisation approaches**

8) Do you know village health team (VHT) yes /No?,if yes Qn 9

9) What role do VHTs play in your community?

a) Mobilize for health services
b) Treat sick children
c) Follow up pregnant mothers for ANC
d) Tell people to go for HIV counselling and testing

10) Have you been mobilised by VHT Yes/ No.

11) Tell us which approach/approaches VHTs used as indicated below

a) Community meetings
b) One on one counselling
c) Home visit
d) Talks in places of worship
e) Others specify……..

Section C. **level of community satisfaction with VHTs mobilisation activities**

12 INSTRUCTIONS: This survey seeks your opinion on VHTs mobilization for health services. Please show the extent to which you think communities have been mobilized by VHTs to access and utilize health services. The statements below describe what VHTs do in their communities. Pick one of the five numbers next to each statement, if you strongly agree with the statement circle the number 5. If you strongly disagree circle number 1. If your expectations are not strong, circle one of the numbers in the middle. There is no right or wrong answer

		Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
A	Each village should have four VHTs	1	2	3	4	5
B	VHTs are selected by community members(factor)	1	2	3	4	5
C	VHTs are residents of their village of operation (factor)	1	2	3	4	5
D	VHTs are trained in community mobilization	1	2	3	4	5
E	VHTs refer and link community members to health facilities	1	2	3	4	5
F	VHTs mobilize people for HIV prevention and care services	1	2	3	4	5
G	VHTs mobilize women to attend ANC	1	2	3	4	5
H	VHTs mobilize for prevention and treatment of childhood illness	1	2	3	4	5
i	VHTs are trusted by their communities(factor)	1	2	3	4	5
j	VHTs are role models in communities(factor)	1	2	3	4	5
k	Homes of VHTs are models in communities(factor)	1	2	3	4	5
l	VHTs are accessible to community members	1	2	3	4	5

	(factor)					
m	VHTs give new information regarding new health programs(factor)	1	2	3	4	5
n	VHTs participate in resource mobilization	1	2	3	4	5
o	VHTs communicate effectively with others(factor)	1	2	3	4	5

13) Over all are you satisfied with VHTs' mobilisation for health services in your community? Yes/No…….

Appendix 1V: Interview guide for Key Informants (KI)

Good morning / Afternoon?

My name is **Kenneth Musinguzi Rugamba** from faculty of Health Sciences of Uganda Martyr's University. We are assessing factors influencing community satisfaction with VHTs mobilization for health services (HIV prevention and care, ANC and treatment of childhood illness). The information you give will enable us to understand the factors influencing satisfaction with in the community. I promise to keep all the information confidential.

Thank you for your cooperation

Demographic data

1. Name/ initials……
2. Age 20-30 31-40 41-50 51 >
3. Marital status Married, Cohabiting, windowed , single
4. Educational level Primary, secondary , tertiary University
5. Occupation, employed, self- employed, business, peasant, others specify……
6. Tell me your role in VHT program in your community
7. Please tell me some VHTs' activities you know in your community?
8. How many VHTs operate in your area?
9. How were VHTs in your community selected?
10. For how long have VHTs existed in your village?
11. What roles do VHTs play in your community?
12. What are your views on VHTs' community mobilization?
13. Tell us some of the health services do VHT mobilize people in your community to access and utilize
14. How do VHTs mobilize communities to access HIV prevention and ANC services?

    Through meetings, drumming, use of posters, one on one counselling, community based groups, public announcements in schools, place of worship, public gathering and public address system/ Kizindaro
15. What is your opinion about community members' satisfaction with VHTs mobilisation approaches?
16. Tell me some of the factors that influence their satisfaction
17. What are the perceptions of people in your community about VHTs mobilisation

18. What is your opinion on VHTs accessibility to community members?
19. How do you perceive their interpersonal relationship?
20. What is your perception about time VHTs spent in community
21. What is your perception about VHTs communication
22. In your opinion, what can be done to improve VHT mobilisation services in your community?

Appendix V: Focused Group Discussion (FGD)

Consent to Participate in Focus Group

You have been asked to participate in a focus group Discussion by **Kenneth Musinguzi Rugamba** from faculty of Health Sciences of Uganda Martyr's University. The purpose of the group is to try and understand perceptions and factors influencing community satisfaction with VHTs mobilization for health services (HIV prevention, ANC and treatment of childhood illness). The information learned in the focus group will be used to increase demand creation for access and utilization of health services.

You can choose whether or not to participate in the focus group and stop at any time. Although the focus group will be tape recorded, your responses will remain anonymous and no names will be mentioned in the report.

There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone. We hope you can be honest even when your responses may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

I understand this information and agree to participate fully under the conditions stated above:

Signed:_____

Date:_____

Questions

Engagement questions

1 Tell us what VHTs do in your Village?
2 What roles do VHTs play in your communities

Exploration questions

3 How do VHTs execute their duties
4 What health services do VHTs mobilize for in your opinion
5 What mobilization approaches do VHTs use in your communities

6 What factors influence community satisfaction with VHTs mobilization approaches

Exist Questions

7 How do you perceive VHTs competency on mobilization, interpersonal relationship, time spent, accessibility and way of communication.
8 What can be done for communities to appreciate VHT mobilization interventions?

Appendix IV: Informed consent document(English)

Research description

This is a study assessing community satisfaction with VHTs' mobilisation for three health services (HIV prevention and care, ANC and Hygiene and sanitation) in Masaka district. Its main aim is to investigate the level of community satisfaction with VHT's mobilisation services among community members in Masaka District. This will help to improve access and utilisation of those health services and strengthen community health systems. Information will be collected for a period of one month through questionnaire and interviewing key informants (KI) from selected areas of Masaka District.

Risks

There will be no foreseeable risks to you since the study only involves interviews.

Benefits

There will be no special benefits to you. However, the key informants will get the final report and be able to identify which areas they need to improve on according to recommendations.

Confidentiality

Privacy during interviewing and confidentiality of information are guaranteed. You will be interviewed separately from other clients. In case you know one of the researchers, you can be interviewed by someone else or withdraw from the study. You are not required to give your name so information cannot be traced back to you. The information collected will only be accessible to the research team.

Compensation

No compensation will be available for your time and any inconvenience but we are very grateful to you for taking part in this study.

Contacts

If you have any questions now please feel free to ask me. In case you have any later on, you can contact the principal investigator, Kenneth MusinguziRugamba, on the telephone number – **0702318560** or Email. **musinguken@yahoo.com**

If you have any issues pertaining to your rights and participation in the study, please contact the Chairperson of the Institutional Review Board, Uganda Martyr's University.

Voluntary Participation

Participating in this study is voluntary. You have the right to refuse to take part and can withdraw at any point without any penalty.

Participant:

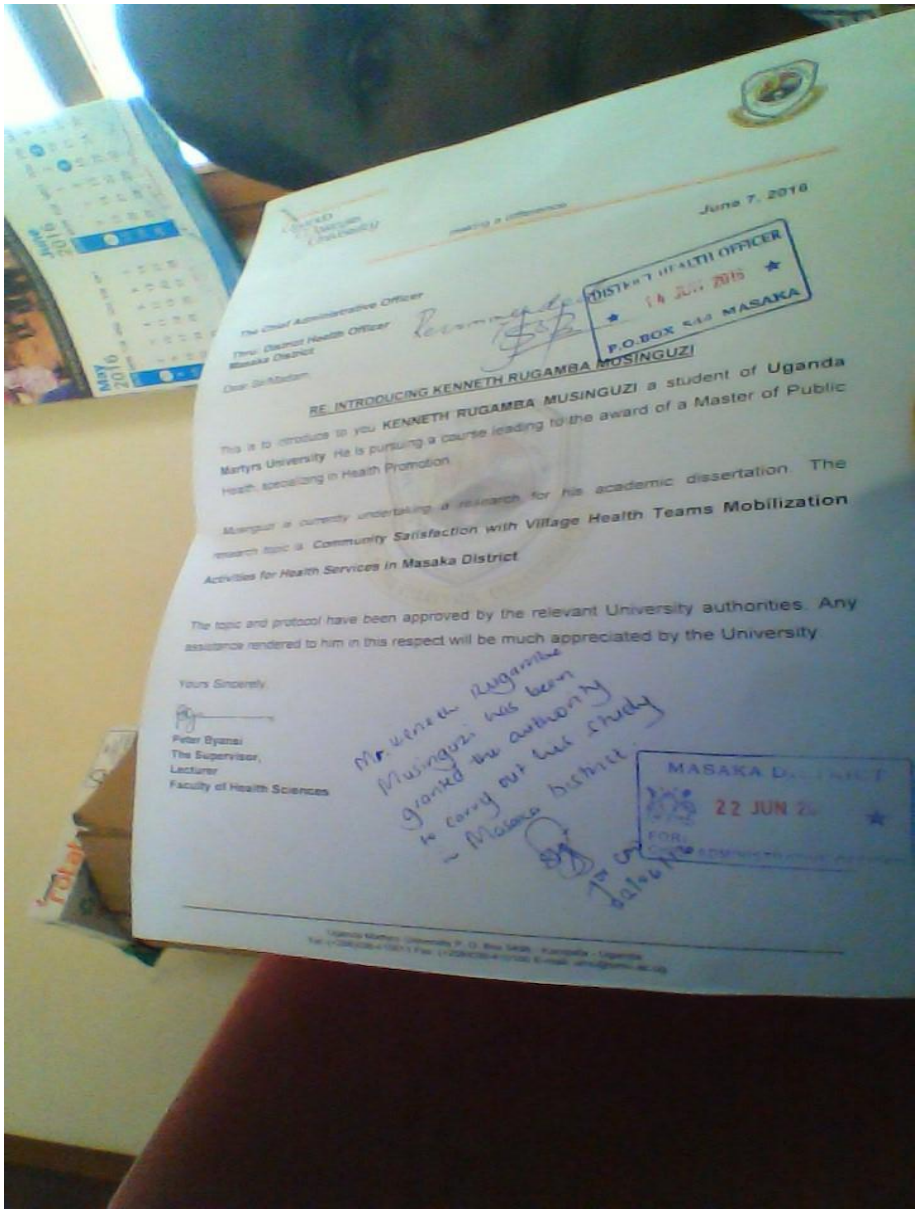
I understand all the conditions above and have agreed to take part in this study of my own free will.

(Signature / mark)……..

Researcher / research assistants' signature……

Any other witness…….

Appendix V1 Letter of introduction



June 7, 2016

The Chief Administrative Officer
Thru: District Health Officer
Masaka District

Dear Sir/Madam,

DISTRICT HEALTH OFFICER
14 JUN 2016
P.O.BOX 444 MASAKA

RE: INTRODUCING KENNETH RUGAMBA MUSINGUZI

This is to introduce to you **KENNETH RUGAMBA MUSINGUZI** a student of Uganda Martyrs University. He is pursuing a course leading to the award of a Master of Public Health, specializing in Health Promotion.

Musinguzi is currently undertaking a research for his academic dissertation. The research topic is ***Community Satisfaction with Village Health Teams Mobilization Activities for Health Services in Masaka District***

The topic and protocol have been approved by the relevant University authorities. Any assistance rendered to him in this respect will be much appreciated by the University.

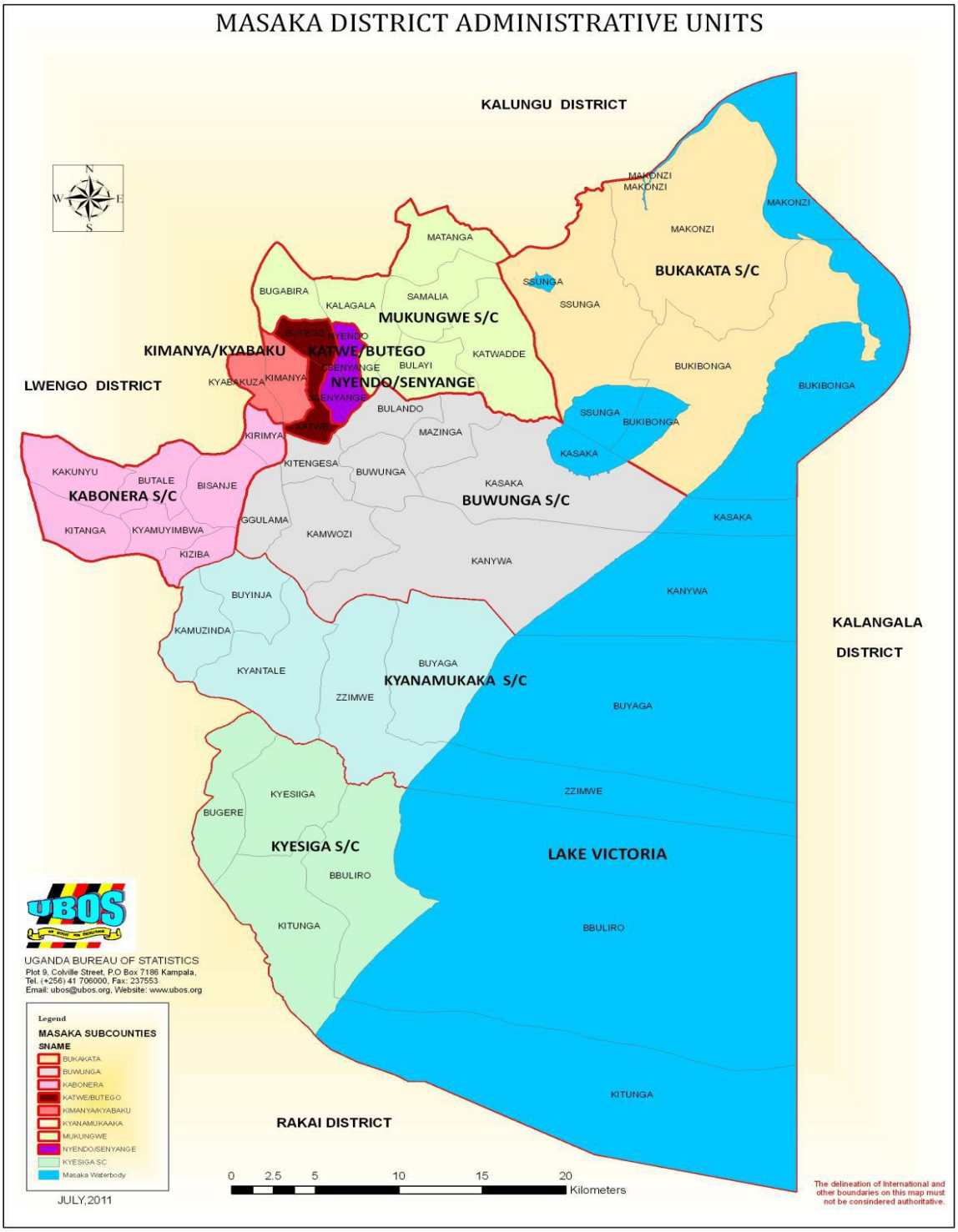
Yours Sincerely,

Peter Byansi
The Supervisor,
Lecturer
Faculty of Health Sciences

Mr. Kenneth Rugamba Musinguzi has been granted the authority to carry out the study - Masaka District

MASAKA DISTRICT
22 JUN 2016
FOR

Appendix: VII Map of Masaka District


MASAKA DISTRICT ADMINISTRATIVE UNITS
KALUNGU DISTRICT
LWENGO DISTRICT
KALANGALA DISTRICT
RAKAI DISTRICT
LAKE VICTORIA
BUKAKATA S/C
MUKUNGWE S/C
KIMANYA/KYABAKU
KATWE/BUTEGO
NYENDO/SENYANGE
KABONERA S/C
BUWUNGA S/C
KYANAMUKAKA S/C
KYESIGA S/C
MATANGA
BUGABIRA
KALAGALA
SAMALIA
SSUNGA
MAKONZI
KATWADDE
BULAYI
BUKIBONGA
KYABAKUZA
KIMANYA
BULANDO
MAZINGA
KIRIMYA
KITENGESA
BUWUNGA
KASAKA
KAKUNYU
BUTALE
BISANJE
KITANGA
KYAMUYIMBWA
KIZIBA
GGULAMA
KAMWOZI
KANYWA
BUYINJA
KAMUZINDA
KYANTALE
BUYAGA
ZZIMWE
KYESIIGA
BUGERE
BBULIRO
KITUNGA
UGANDA BUREAU OF STATISTICS
Plot 9, Colville Street, P.O Box 7186 Kampala,
Tel. (+256) 41 706000, Fax: 237553
Email: ubos@ubos.org, Website: www.ubos.org
Legend
MASAKA SUBCOUNTIES
SNAME
BUKAKATA
BUWUNGA
KABONERA
KATWE/BUTEGO
KIMANYA/KYABAKU
KYANAMUKAAKA
MUKUNGWE
NYENDO/SENYANGE
KYESIGA SC
Masaka Waterbody
JULY,2011
0 2.5 5 10 15 20
Kilometers
The delineation of International and other boundaries on this map must not be consindered authoritative.