

How to make the most of village health promoters

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In a rural area of Bangladesh the methods used by village health promoters and the time available to them for their intended tasks were inadequate. Poverty and illiteracy in the community exacerbated their difficulties. Ways of tackling these problems are discussed below.

During 1990 the first steps were taken to establish a health development project in Bangladesh's Ukhia subdistrict, with a predominantly rural population of approximately 122 000 people. Health and social services were minimal and high morbidity and mortality rates were associated with preventable diseases. The main aims were:

- to improve the curative, preventive and promotional aspects of the health system;
- to train 200–250 community health workers as village health promoters over a five-year period;
- to foster socioeconomic development by supporting income-generating projects.

Roles

In April 1994, almost two and a half years after the health development project began to be implemented, the performance was

assessed of the 28 male and 27 female village health promoters who had by then been trained. The priorities for action at this time were to distribute health cards and, in order to prevent diarrhoea and intestinal infections, to motivate families to install and use sanitary latrines and tubewell water. Each village health promoter was expected to provide health education by visiting 150 houses per month as well as health posts and schools. Certain houses in the community were also used as centres for health education. All the village health promoters spoke to both individuals and groups. Blackboards were used in schools and health posts by about a quarter of them, and a similar proportion used posters and leaflets.

It was intended that the village health promoters should provide comprehensive primary care, including:

- education on personal hygiene, the management of diarrhoea and the use of latrines;
- mother and child care;
- immunization;
- house registration and the distribution of health cards.

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Community leaders said that the village health promoters were widely accepted by the population. The activities of the village health promoters as reported by both themselves and the community leaders involved:

- visiting houses to distribute health cards and educate people about personal hygiene, sanitation and the prevention of communicable diseases;
- providing health care for mothers and children, including immunization;
- motivating families to buy and install slab latrines;
- vaccinating poultry.

Coverage

A sample of 300 households in the project area, 60 in each of five villages, was compared with a similar sample in a nearby control area. Mothers who had at least one child aged under 5 years were interviewed by women who had been trained for this work. The views of community leaders were sought in focus group discussions in four of the five selected villages on such matters as the kinds of activities performed by the village health promoters, the adequacy of the time they spent on health activities, and the needs and expectations of the communities. A structured questionnaire dealing with these and other matters was used in interviews with a total of 15 village health promoters in the same five villages and two additional ones.

In the project area it was found that 183 of the sample of 300 households had been visited by a health worker, 61% of the visits having been made by village health promoters. The failure to reach the target number of home visits by the village health promoters was evidently attribut-

able to the scattered distribution of the households, the lack of transport, and the difficulties of travel during the rainy season. In the control area only 136 households were visited by a health worker. Of the 40% or so of households in the project area which received health education on personal hygiene, sanitation and the use of tubewell water, some 60% were covered by village health promoters.

There were sanitary latrines in 53 of the households in the project area sample, and one-third of these had been constructed by families responding to encouragement given by village health promoters. Unfortunately, household latrines were little used by family members, especially children. Tubewell water was used for domestic purposes by a higher proportion of households in the project area than in the control area, but even so half the households in the project area lacked a water supply of this kind and continued to rely on polluted ponds, rivers and canals.

Only about 7% of the village health promoters gave practical demonstrations. Role-playing, storytelling and other effective methods were not employed. The time spent on health activities by village health promoters, which averaged 3.5 hours a day, was considered too short by half of

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them and by two-thirds of the community leaders. The principal difficulties and constraints affecting the village health promoters' work were said by both them

and the community leaders to be as follows.

- People were so poor and illiterate that they were unwilling to pay for health cards and were uninterested in health education.
- It was impossible to visit all the targeted households in the prescribed time because they were so scattered.

The efforts made did not, on the whole, succeed in inducing people to abandon unhealthy practices. The community leaders and village health promoters responded by suggesting:

- the creation of income-generating projects;

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- the establishment of health posts with essential equipment in villages lacking health facilities;
- the appointment of a female doctor to supervise female village health promoters and to help in the training and continuing education of village health promoters;
- the involvement of village health promoters in literacy work with both adults and children.

Towards increased effectiveness

Among the factors influencing the effectiveness of the village health promoters were the criteria used to select them, their

initial and in-service training, the planning and logistics of their work, and the degree of community participation in the project. Village health committees were involved in the planning and implementation, and in the supervision and evaluation of the these workers, who were confronted by constraints and difficulties comparable with those reported from other parts of the world. Full evaluation of the project would require a functioning health information system and the use of simple health indicators.

Because the people were extremely poor they did not regard health education as a priority. Major factors determining their poverty were the shortage of cultivable land, the high rate of illiteracy and the large sizes of families. Resources such as chalk, blackboards and posters were inadequate, and the well-tried teaching methods of role play, storytelling and demonstration were neglected by the village health promoters. The target of 150 home visits a month for each of them proved impossible to achieve because the communities were so scattered and there were no means of transportation. With a view to improving health promotion the steps outlined below are desirable.

- The number of houses to be visited by each village health promoter should be reduced from 150 to 90–100 a month, thus allowing more time to be spent on health education. Clearly, this requires increased numbers of village health promoters.
- Village health promoters should be encouraged to use more effective techniques, given the high rate of illiteracy in the population. Training in these techniques for health promoters is essential.

- The development of income-generating projects should be given urgent attention in conjunction with health and sanitation programmes. ■

Acknowledgements

The author wishes to express gratitude to the Ukhia health development project's steering committee and personnel for their help and encouragement. Special thanks go to all the village health promoters, the families who participated, and the village health committees.

Health in the community

Through research and direct support of countries, WHO actively promotes community involvement in health aimed at enabling people to take responsibility for decisions concerning their health and to make their health services more effective. Community involvement in health now seems to be widely accepted in most countries. It finds its expression in such ways as ensuring equitable and rational distribution of resources for health; mobilizing funds from local, national and international sources; and making good use of the knowledge and experience available within the community.

- *The world health report 1995 – Bridging the gaps.* Geneva, World Health Organization, 1995: 64.