THE VILLAGE HEALTH WORKER PROGRAMME IN PRIMARY HEALTH CARE IN THE MASERU HEALTH SERVICE AREA: A CASE STUDY

by

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CHAL	Christian Health Association of Lesotho
CHN	Community Health Nurse
CHW	Community Health Worker
DGHS	Director General of Health Services
HSA	Health Service Area
IMR	Infant Mortality Rate
LDTC	Lesotho Distance Teaching Centre
LFDS	Lesotho Flying Doctors Services
LPPA	Lesotho Planned Parenthood Association
MOH	Ministry of Health
NRSP	National Rural Sanitation Programme
ORS	Oral Rehydration Solution
PHAL	Private Health Association of Lesotho
PHC	Primary Health Care
PHN	Primary Health Nurse
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
UNFPA	United Nation's Family Planning Agency
VIP	Ventilated Improved Pit
VHC	Village Health Committee
VHP	Village Health Post
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organisation

CHAPTER ONE

FRAMEWORK OF THE STUDY

1.1 INTRODUCTION

Lesotho is a less developed country and has a poor health care structure. The introduction and implementation of developmental programmes such as the Village Health Worker (VHW) Programme are very important, because they help to improve the status of health in the country. Many people reside in the semi-urban and rural areas in the country, where there are few hospitals and clinics, unlike in the urban centres. The aim of the VHW Programme is mainly to deliver health care services at the village level, especially in the rural areas where many people are unemployed, old and poor. Many developing countries have used Village Health Workers as a catalyst for community involvement in health and for community development. It is recognised that this category of health workers may be able to provide a link between the formal health services and communities, because they speak the local language and are acquainted with cultural norms (Health Systems Trust, 1997:135).

The poor economy of Lesotho has a serious impact on the implementation of many programmes. This situation mostly affects the programmes that are implemented at community level where the majority of the people are usually poor. Since the onset of colonialism, that is, when Lesotho became a British protectorate, many men became migrant labourers working in South Africa (SA). Lesotho is reliant for a large proportion of her Gross National Product (GNP) on SA, which is provided by the Basotho men who work on SA mines (Dennill *et al,* 1995:47).

Proper nutrition is a problem facing most developing nations. In some countries the major problem is not only ignorance of what should be eaten, but also the insufficiency of what is to be eaten. In Lesotho, food has not yet become a serious problem, because of heavy dependence on the relatively strong South African economy. There is little denial among the general public in Lesotho of the fact that malnutrition in Lesotho is the result of a lack of education about what to eat and how to prepare it. As a result the Food and Nutrition Co-ordinating Office in Lesotho was set up to co-ordinate efforts of enhancing nutrition education among the Basotho and implementing nutrition programmes and policies (Makhetha, 1988:8). It is in this regard that the role of Village Health Workers is significant. One of their roles is to teach their communities, specifically the illiterate, about proper nutrition. They are supposed to raise the people's awareness of the importance of "health for all" in their villages, especially pregnant mothers and children (Lephoto, 1997).

Lesotho, like many Third World countries has a serious illiteracy problem. According to Lesotho Distance Teaching Centre (1997:2) in 1997, the literacy rates revealed that 55% of Basotho over the age of ten were barely literate in Sesotho, and that half of that number were not functionally literate. The results of a subsequent survey, also undertaken by LDTC, in 1985, showed a 62% literacy rate, while 46% "could read, write and calculate to satisfactory standards". This shows a 7% increase in basic literacy and a substantial growth of 23.5% in functional literacy, if the expression "could read, write and calculate to satisfactory standards" may be equated to functional literacy[1].

[1] A functionally literate person is the one who can engage in all those activities in which literacy is required for effective functioning of one's group and community and also for enabling one to continue to use reading, writing and calculation for one's interest and the community's interest.

1.2 STATEMENT OF THE PROBLEM

Good health for all is very important in any society. In order for a society to perform its duties in all spheres of life, be it education, economy, politics, and many development areas, it needs healthy people. In Lesotho, as in many other developing countries, the health status is poor and the health care structure is unbalanced, with the urban population favoured in terms of health facilities, compared with the majority rural impoverished population.

Since 1979 Lesotho has been implementing Primary Health Care as had been advocated by the World Health Organisation (WHO) at the Alma-Ata Conference in 1978. Here it was resolved that by the year 2000 there should be appropriate health services for all, regardless of age, gender, culture and status. One aspect of the introduction of PHC in Lesotho, was the implementation of the Village Health Worker Programme, which is funded by the Lesotho Government and the United Nations Children's Fund (UNICEF). This Programme entails providing voluntary workers with a basic training in order to supplement the poor health facilities. However, it seems that this Programme has experienced several problems. For example, some people consider the Programme to be Eurocentric and the perception is that it does not address the needs of developing countries. Moreover, the problem of illiteracy in disadvantaged communities, as in the rural areas of Lesotho, seems to adversely affect the development of programmes such as the one for VHWs. The main reason is that the training courses in the VHW Programme require people who are at least able to read and write their local language, which is not the case or very rare in the rural areas of the country.

Although PHC and the VHW Programme have been practised for quite a number of years, the life expectancy and Infant Mortality Rate (IMR) in Lesotho still seem to be a serious problem. For example, a recent report of the Ministry of Health (MOH) states that the IMR for Lesotho is between 110 and 120 per 1000 live births, while deaths occurring within the first 28 days (neonatal period) are calculated to be 54% of the IMR (Scott Hospital Annual Report 1996:9). This indicates that much needs to be done to improve the status of health in the country, especially in respect of the health of women and children which seems to be adversely affected by the present health care situation.

1.3 RESEARCH GOALS

The main aim of this study was to find out whether the introduction and implementation of the VHW Programme have improved health care provision and health status in the Maseru Health Service Area (HSA). More specifically the objectives were to find out whether VHWs are accepted in their communities, and to ascertain whether there are problems within the Programme, which could lead to poor delivery of services by the VHWs which impact negatively on health.

1.4 METHODOLOGY

This study dealt with the role relationships, norms, values and beliefs of the villagers in a health programme and took into account their behaviour in the field of medicine. As the study is medical sociological in nature, dealing with those aspects seems relevant. The sociology of medicine refers to the use of medical settings and health and illness in order to study such sociological phenomena as organisational structure, role relationships, attitudes and values of persons involved in medicine

(Allais & Mackay, 1995:6). Most importantly sociology of medicine is concerned with sociological problems in a medical setting, for example poor delivery of health care services to the community, similar to the case of the Village Health Worker Programme in the Maseru Health Service Area. Sociology of medicine therefore reflects the theoretical interests of sociology rather than the professional interests of medicine, unlike sociology in medicine, which is guided by the dominant values of professional medicine (Abercromie *et al,* in Allais & Mackay, 1995:6).

This study was done in two villages in the Maseru Health Service Area of Lesotho. The Maseru Health Service Area is the largest in the country and has many villages to manage in the Village Health Worker Programme. The Maseru HSA falls directly under Queen Elizabeth II hospital, which is the biggest and main referral hospital countrywide. The two villages, namely Ha Foso and Ha Thamae were chosen, because they are semi-urban areas and are similar to many other villages in the country. Lesotho is divided into ten districts, and each has a small town, except Maseru which is slightly bigger and considered to be the main city of the country (see map in appendix 6). It must be noted that in each district the towns only occupy a small area and the rest is either semi-urban or rural.

Information on the development and implementation of the VHW Programme, as well as on health provision and the health status in Lesotho, was obtained from a literature study, supplemented by interviews with the VHW Programme authorities of the MOH. To establish perceptions about the VHW Programme, and also to ascertain the nature of problems within the programme, a qualitative study was conducted and three categories of respondents were identified. Qualitative instruments, namely Focus Group Discussions (FGDs) were chosen,

because they were suitable for studying the research topic, which is explorative in nature. Moreover, qualitative instruments tend to be more open to using a range of evidence and discovery of new issues (Neuman, 1994:18). The open response format of FGDs produced and facilitated valuable data expressed by the respondents and the opportunity to observe a large amount of interaction and behaviour (Morgan, 1988:15).

The form of interaction in the FGDs enabled the researcher to probe for more information from the respondents. It was also easy for the researcher to clarify some of the questions to the respondents. The advantage of qualitative research is that the instruments employed are flexible, because they are not structured, unlike in quantitative research, where the researcher begins with a well-defined subject and conducts research to describe it accurately (Neuman, 1994:19).

In the empirical phase of the research, discussions were held with the MOH staff, specifically those who are responsible for training in the VHW Programme. The chiefs of the villages under study were also consulted by the researcher and permission to conduct a survey in their respective areas was sought. A general gathering (*Pitso* in Sesotho) was then called by the chiefs in their respective areas, to inform the people about the study to be undertaken. The people were asked to participate in the study and the VHWs explained to the villagers the aim of the study. In those general gatherings the problems the VHWs and the villagers already had before the survey, were addressed. Thus the survey in a way served as a platform to maintain peace in both villages, especially in Ha Thamae where the VHW Programme seemed to be unstable. With the consent of the chiefs, the researcher and respective respondents set dates for the Focus Group Discussion sessions.

The first category of respondents consisted of ten VHWs, five from each of the identified villages. The second group of twenty villagers was divided into four groups, thus two groups consisting of five respondents per village. The last group of respondents were five nurses from Queen Elizabeth II hospital who are responsible for training in the VHW Programme. Most of the questions asked in these discussions were similar, in that they required general knowledge about the VHW Programme such as, when they knew about the programme, the problems involved, what kind of solutions could they propose and their perception about the future of the programme in their villages. There were a few specific questions relating to the VHW Programme per group of respondents: The VHWs were asked how they generally felt about the VHW Programme, their training in the Programme and support from their Health Centres and villages. The questions that the nurses were asked were more about the training sessions in the VHW Programme, while the villagers were asked whether they were content with the services provided by the VHWs in the villages. Since the instruments for the study consisted of only open-ended questions, the responses were grouped together according to their differences and similarities. The FGD sessions gave an account of the following:

- The Village Health Worker Programme in Ha Thamae and Ha Foso
- The Village Health Worker Programme training in the Maseru Health Service Area
- The problems of the Village Health Worker Programme, which included poor incentives, medical kits and supervision and the dwindling Government contribution, as well as poor relationships with the chiefs and the impact of politics in the Programme
- Suggestions on improving the Village Health Worker Programme, which included improvement of incentives, upgrade services in the

Ministry of Health, maintain good relationships with the chiefs, address political issues and restructure the Programme in the villages

- An evaluation of the Village Health Worker Programme

Focus Group Discussions were conducted with all three groups. Finally, the respondents were given the research report to verify the results of the study.

1.5 RATIONALE OF THE STUDY

This study is important because it deals with the Village Health Programme, which is concerned with the life of the people at grassroots level. It is a fact that this category of people is usually ignored and to a certain extent undermined by the Government and other powerful institutions in the country in matters concerning their position in many areas of life. In this case there is a problem of delivery of poor health care services to the communities as outlined in the statement of the problem of this study. With the recommendations that are going to be proposed in this study, the researcher hopes that the Ministry of Health will make use of this information to upgrade the standard and services offered in the Village Health Worker Programme in collaboration with the communities involved. This collaboration may also improve the health status of the people in the villages, by making use of appropriate health programmes. Moreover, studies of this nature are very rare in Lesotho, so this one might contribute to the Ministry of Health library especially on the Village Health Worker Programme, which is covered by only a few outdated reports.

1.6 DEFINITION OF CONCEPTS

For the purpose of this study Primary Health Care (PHC), Community Health Worker (CHW), Village Health Worker (VHW), Traditional Birth Attendant (TBA), Biomedicine, Ethnomedicine and Holistic Approach will be discussed.

1.6.1 Primary Health Care

It is very difficult to explain PHC in only one phrase. The main reason for this is that in modern health care it is used in different contexts. Although various organisations and people have defined PHC, it must be noted that the meaning they perceive is almost similar. According to the WHO (in Coughlan, 1995:9) PHC is "essentially health care based on scientifically sound and socially acceptable methods and on technology made universally accessible to individuals and families in the community through their participation at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination". PHC is therefore the basic level of care provided equally to everyone, and addresses the most common problems in the community by providing preventive, curative and rehabilitative services to maximise health and well-being (Pillay, 1992:606).

The main focus of the PHC approach, namely to permit all citizens to lead a socially and economically productive life, has to be achieved by the attainment, and not the imposition of health, through the commitment by both people and Government (WHO in Gaigher, 1992:34). It must be noted that unlike general health care PHC, is defined in a far broader way, thus from previously being the absence of disease, health is now

defined as a state of physical and social well-being (Buch, 1989:34). PHC is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work. It constitutes the first element of a continuing health care process (Kalaka, 1997). Appendix 7 illustrates the levels involved in PHC.

The Alma-Ata Declaration of 1978 explains that PHC can be seen as a new development in health, as well as one that builds on the developments and lessons from the past. PHC is therefore an attempt to broaden the base of health and health care and to move away from the solely curative approach. It is also about social justice, and thus part of the movement to eradicate inequalities within and between countries, groups or social strata and individuals (UNICEF & WHO, 1983:83). Above all, PHC attempts to involve individuals and the community in health care programmes and projects, which are meant to improve the general health status of the people at village level.

1.6.2 Community Health Workers

The WHO explains that at the first level of contact between individuals and the health care system, community health workers acting as a team provides Primary Health Care. This team should be organised in such a way that it suits the life style and economic conditions of the country concerned. The type of health workers will vary by country and community according to the needs and resources available for satisfying them. Thus, they may include in different societies people with limited education who have been given elementary training in health care, "barefoot doctors", medical assistants, practical and professionally trained nurses and general medical practitioners, as well as traditional

practitioners (UNICEF & WHO, 1983:62). Accordingly, a community health worker is anybody involved in health care practice in the village, town or city.

Mostly, however, a CHW is non-professional, elected by the community, who lives in the neighbourhood that she serves and responds to the needs of her community (Molapo, 1998). Hence the Government of Lesotho and the United Nations Children's Fund contend that a CHW should be effective in the areas of motivation and mobilisation for health promotion (Government of Lesotho & UNICEF, 1997:62). In the case of Lesotho the community health worker can either be a Village Health Worker, Traditional Birth Attendant or a Traditional Healer. All these people, no matter their specialities, are called community health workers, because they serve their communities in health-related issues.

A CHW is referred to as a village, grassroots, auxiliary, or volunteer health worker and the duties, training and organisational attachment varies considerably. The CHW's main objectives are to prevent disease and promote health in her community with the active participation of the people themselves. The CHW also tries to stimulate development through the active fostering of group action. This formation of networks of groups and individuals enables communities to use local knowledge and skills and to become less dependent on external sources. The CHW encourages the development of self-esteem, leadership, decision-making and democratic skills. In summary, she uses health and health-related issues to stimulate community development (Ijsselmuiden in Gaigher, 1992:37).

1.6.3 Village Health Workers

Since more than ninety percent of VHWs in Lesotho are females, the researcher will use "she" in the text to refer to the VHW. A VHW is a mature person, male or female, who has the ability to work alone, but liases with other workers. She should be a permanent resident of the village. A VHW is selected for training by her particular community with the approval of local authorities. Each community selects their VHWs from among its members using its own criteria (Chideme, 1986:25). After training she becomes a member of the team of community health workers who promote good health within the community (UNICEF & PHAL, 1983:2).

In the case of Lesotho the VHW is elected because she has self-reliance, initiative and responsibility concerning PHC (Kucholl, 1985:55). Since the majority of VHWs in Lesotho are females, there is a need to encourage and recruit more males to become VHWs. However, the majority of males in the country are migrant workers in South African mines. It is a fact that the communities are likely to work more harmoniously with people they regard as mature, and can be relied upon to keep secrets. Thus the VHW should be a responsible person and command respect from the community (Makhetha, 1988:1).

1.6.4 Traditional Birth Attendant

According to the WHO (in Makatjane & Molapo, 1992:17), a TBA is a person who assists the mother and the unborn baby during the process of delivery. This person is said to have acquired her skills of delivering babies by herself or by working with other TBAs. A Traditional Birth Attendant is usually a female who is a full-time village resident,

recognised and respected by the community for the work she has been doing in caring for the expectant mothers, providing assistance during labour and delivery. In some instances a TBA is also a VHW, and therefore carries out both responsibilities. The other requirements of the TBA are the capability to read and write Sesotho, as well as to have a good health status (UNICEF & PHAL, 1996:4).

1.6.5 Biomedicine

Biomedicine is based on biological principles. Biomedical understanding encourages us to see the body as a set of anatomical parts and physiological systems. That is, biomedicine focuses solely on the individual's physiological state (Allais & Mackay, 1995:48). Health is therefore defined simply as the absence of disease or physiological malfunction; it is not a positive state, but the absence of a negative state; here if you're not sick, you're well (Weiss & Lonnquist, 1997:106). In biomedicine illness is explained as a temporary or permanent derangement of the body. This disturbance is in turn seen as a complex series of physiological processes. Consequently, medical diagnosis and therapy aim to discover the specific pathological processes or abnormalities responsible for an illness, and to modify or correct these by chemical or physical means (Allais & Mackay, 1995:93).

Moon & Gillespie (1995:83) also argue that "...biomedicine is a more specialised practise of medicine, disease-oriented, concerned with pathology". In terms of the medical model, the more specialised the practise the more reductionistic is the view of medicine (Rosengren, 1980:96). Thus the medical focus is both literally and figuratively on organic matters (Allais & Mackay, 1995:48). The level of technology used

by biomedicine is very high and its status is acquired through formal education.

1.6.6 Ethnomedicine

The term ethnomedicine represents different culture-bound methods of healing based on an ancient belief system in traditional societies. Ethnomedicine can either be secular or religious depending on the culture of the traditional healer and his/her patients (Van Den Hazel, 1984:3). This type of medicine is very common in rural areas of the Less Developed Countries, where people still strongly believe in traditional practices and very are reluctant to attend modern hospitals which do not accept payment in kind, like some of the traditional practitioners.

Traditional medical systems have existed and still do in most countries, including highly industrialised ones. In the past, these systems have often been ignored, or even banned outright. Yet, they frequently serve a considerably larger part of the population than the formal health care system. Traditional practitioners form an integral part of the community, in contrast to doctors who frequently come from the country's elite. They speak the same language, have the same background and are fully integrated with the cultural beliefs of the community they serve (Kielmann *et al,* 1991:141-142).

Traditional practitioners are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health care system, the indigenous practitioners can become important allies in organising efforts to improve the health of the community. Some communities may select them as community

health workers. It is, therefore worthwhile exploring the possibilities of engaging them in Primary Health Care and of training them accordingly (UNICEF & WHO, 1983:63).

1.6.7 Holistic Approach

The holistic approach assumes that the body and the soul are not separated in the process of curing and preventing disease. It is believed that both the body and soul are dependent on each other and if one is affected, automatically the other one will be affected. Therefore, PHC should not only concentrate on physical aspects, but also on the psychological ones because in traditional societies, as in the rural areas of Lesotho, illness tends to be regarded as a misfortune that involves the whole person. It is often through the combined effort of the community that the individual is healed (Owen, 1977:52). Moon & Gillespie (1995:68) also explain that the holistic approach is concerned with finding ways of dealing with sickness and disease through gaining greater understanding of individuals, the contexts in which they live, their social and mental states, and their own beliefs. This supports the theme by Illich that the holistic approach is "the need for spiritual and personal dimensions in coping with illness and disease" (Moon & Gillespie, 1995:75).

1.7 THE PROBLEMS OF THE STUDY

There are several problems that the researcher encountered in this study. The main problem of the study was **the inability to get information from the Ministry of Health,** where researchers would expect to get some information on health related issues. The structure was outdated, especially the library. There were no recent books of any kind in the library. Moreover, there was not even a single annual health

report where programmes like the VHW Programme featured. According to the Primary Health Care Evaluation Report of 1998, in almost 50% of the Health Centres where the Village Health Worker Programme is administered, there are no records on the services delivered, or the records available are not kept properly (Sagbohan, 1998:viii). It was only through personal communication with the VHW Programme staff in the Ministry of Health, who are the nurses conducting training and supervision of the Village Health Workers at Health Centres, that information about the VHW Programme was acquired.

The unstable political situation in Lesotho has affected the VHW Programme a great deal. Some of the people, who were known to have participated in the VHW Programme since its implementation by the UNICEF and the GOL, have been transferred to other ministries, and it was difficult to find them. The person from the MOH who was most helpful in this study was Mrs Lephoto, who is the pioneer of the VHW Programme, even though she was extremely busy and out of the office most of the time. Without any form of documentation she gave general information about the Programme, including its history, structure, successes and problems. She also expressed her concern about the present situation of the Programme and its future.

The whole process of organising the FGD sessions **was time consuming.** The fact that the researcher had to undertake procedural steps before conducting interviews, such as asking permission from the chiefs who were always busy was rather hectic. Moreover, to attend those *Pitso's* where problems, which were not relevant to the study, were discussed, was tedious. Another serious problem was that **the majority of respondents, especially the villagers were old,** on average all over fifty years of age and illiterate and took time to understand most of the

questions, which required the researcher to repeat a question at least three times.

The male respondents in both villages seemed not to have any interest in the VHW Programme and **were reluctant to participate in the FGD sessions.** Their reason was that "*Ke ntho ea basali,*" which refers to the Programme as being a women's issue. In Lesotho 83% of migrants are males aged between 20 and 59 years. In the age group 20 and 59 for the resident population, 64% are women. This situation itself explains the reason why in numerous activities, including development, health and education, women are represented in far larger numbers than are men (Makhetha, 1988:6). The male respondents argued that most of the activities involved in the VHW Programme require more women's knowledge and skills than men's, such as monitoring children's growth rate and pregnancy. It was also clear that some villagers **could not differentiate the VHWs from ordinary Traditional Birth Attendants** and were unable to answer some of the questions.

Although the UNICEF, WHO and CHAL libraries helped the researcher regarding **the literature review,** problems were still encountered. **Firstly**, most of the reports from these libraries were similar in content, except for the fact that they had been compiled by different organisations. **Secondly**, the reports with regard to the VHW Programme were not recent, which may have been due to the fact that, for the past three years, there had been serious political changes, which had impeded the progress of the Programme. Thus, some of the VHW Programme authorities who had been involved at its inception, were transferred to other ministries, because they were not of the ruling political party. **Lastly,** being the first recent study to be conducted on the VHW Programme in Lesotho, there was not sufficient information to compare

with or determine other researchers' opinions regarding its implementation and performance in the country. Some members from the CHAL explained that they were having serious problems with the VHW Programme, because from 1997 UNICEF, which plays a very important role in the health programmes' support, had its budget cut to almost half of what it was in 1996. Moreover, they complained that the Government's contribution towards the programme was very limited and problematic because the funds are always budgeted for but never delivered. This could also be the reason for the poor publication rate of the health reports.

1.8 THE STRUCTURE OF THE STUDY

Chapter One

This chapter has given the framework of the study and included the statement of the problem, the research goals, research methodology, rationale of the study, definition of concepts, the structure of the study and the problems of the study.

Chapter Two

Chapter two is on the Village Health Worker Programme in Primary Health Care and gives a general overview of the VHW Programme in Primary Health Care, considering community participation, the influence of traditional structures and paradoxes involved in the programme. Problems and solutions in the VHW Programmes will also be discussed. The Siavonga VHW Programme in Zambia will be used as a case study.

Chapter Three

This chapter deals with the development of the Primary Health Care and the Village Health Worker Programme in Lesotho and focuses on some interviews with authorities from the Ministry of Health relating to the study and a review of the relevant literature on the health care system. The influence of Primary Health Care on the status of health will be discussed. This chapter also explains the contribution of the United Nations Children's Fund and Christian Health Association of Lesotho in the Village Health Worker Programme. The relationship between the Village Health Workers and traditional practitioners in the villages is also taken into account.

Chapter Four

This chapter explains the Village Health Worker Programme in the Maseru Health Service Area and presents data analysis, interprets the major findings of the study and gives a comparison between the Village Health Worker Programme in the Maseru Health Service Area and other developing countries in Southern Africa.

Chapter Five

The fifth chapter is the final of this study and gives an evaluation of the Village Health Worker Programme in the Maseru Health Service Area, a summary and the recommendations of the study.

1.9 CONCLUSION

Although at present there are problems within the VHW Programme in Lesotho, it is important to emphasise that the contribution of the VHWs to the delivery of health care services is very crucial. In view of the fact that the majority of people reside in the rural areas where health care facilities are poor, the VHWs play a facilitating role, because they are always available in their villages. The next chapter will discuss the Village Health Worker Programme in Primary Health Care.

CHAPTER TWO

THE VILLAGE HEALTH WORKER PROGRAMME IN PRIMARY HEALTH CARE

2.1 INTRODUCTION

The member states of the World Health Organisation have committed themselves to creating conditions which will enable everyone to enjoy a healthy life by the year 2 000. They have also accepted Primary Health Care as the key approach for achieving this social directive. This acceptance of the PHC approach implies that member states have agreed that the individual is responsible for his or her own health (WHO, 1986:1).

Ever since the WHO conference in 1978, PHC has been viewed as the answer to the pressing health care needs of the Third World countries. Debates have developed as to the nature of PHC, but most agree that PHC involves a move away from high-technology biomedicine delivered to the privileged few, to a range of health care practices that are accessible to the majority of people and are broadly aimed at improving health, rather than curing disease. An important element of PHC is that it is delivered by teams of health workers, rather than a few highly trained professionals and that such teams should rely heavily on the contribution of nursing staff and "auxiliaries" such as Village Health Workers (Segar, 1994:46).

The employment of VHWs may be regarded as a very important component in PHC, especially in developmental programmes such as the VHW Programme, because they are playing a positive health promotion

role in providing first line medical help, advising fellow villagers on personal hygiene and advocating preventive measures.

In this chapter a general overview of the VHW Programme will be given, taking the following into account: The selection, training, supervision, remuneration and functions of VHWs. The influence of traditional structures and the community as a whole will be looked at. The paradoxes, problems and solutions involved in the VHW Programme will also be considered. The Siavonga VHW Programme in Zambia will be used as a case study.

2.2 THE VILLAGE HEALTH WORKER PROGRAMME

The VHWs have always been part of communities in many countries, but were undermined by the health departments, which are organised and controlled by professional medical doctors/nurses. Werner (in Davey *et al,* 1995:285) explains that in Latin America, for example, the health departments have tried to stamp out the work force of non-professional healers, yet they have had trouble coming up with viable alternatives. Their western-style, city-bred and city-trained medical doctors not only proved uneconomical in terms of cost effectiveness, they flatly refused to serve in the rural areas. The first official attempt at a solution was, of course, to produce more modern doctors. In Mexico the National University began to recruit 5 000 new medical students per year (and still does so). The result was a surplus of poorly trained doctors who stayed in the cities. The next attempt was through compulsory social service. Graduating medical students were required (unless they bought their way off) to spend a year in a rural health centre before receiving their licenses. The young doctors were unprepared either by training or disposition to cope with the health needs in the rural area. With

discouraging frequency they became resentful, irresponsible or blatantly corrupt. Next came the era of mobile clinics. They, too, failed miserably. They created dependency and expectations without providing continuity of service. The net result was the undermining of the people's capacity for self-care. It was becoming increasingly clear that the provision of health care in the rural areas could never be accomplished by professionals alone, hence the introduction of the Village Health Worker Programme.

The Village Health Worker Programme is almost similar in many countries. This situation is influenced by the fact that the VHWs are at the bottom of the hierarchical health care structure in any country, that is, they are mainly functional at the lowest level in the health care system. Despite the similarity in many countries, there are still many differences relating to its structure, depending on several factors. **Firstly,** the level of the country's economy influences the status and functions of the VHWs to a large extent. For example, the VHWs are more important in Less Developed Countries (LDCs) than in developed ones, because the former are usually stricken by severe poverty, unemployment and high rates of illiteracy. People in the LDCs unlike in developed countries are therefore unable to attend local clinics and hospitals, which in most cases require a certain amount of money.

Secondly, the interest and cooperation of the community involved have a vital role in the efficiency and effectiveness of developmental programmes. The VHW Programme could be easily implemented in areas where the people are likely to participate. For example, in some countries, like Zambia, the VHWs operate from the Village Health Posts (VHPs), which are constructed buildings by the community on a self-help basis, with a Village Health Committee (VHC) and the community itself to carry out PHC activities (WHO *et al,* 1995:5). It is important to note that

the VHPs are places that are not used as full time health facilities, but are visited regularly by teams of health workers from nearby clinics. They are very crucial for bringing health care services closer to the people who need them most (ANC, 1994:62). However, in countries like Zimbabwe, the VHWs operate from their homes, because there are no VHPs (WHO *et al,* 1995:11). **Finally,** the status of health and the health care system in the country contribute to a large extent to promoting and implementing the VHW Programme.

In implementing the Village Health Worker Programme and strengthening community support, it was seen that grassroots level planning and management are of crucial importance. Especially significant was the strengthening of the VHWs in terms of their benefits, recruitment, deployment, activities, remuneration, management and evaluation. This was vital, as the experiences of communities all over the world have shown that the VHWs are the effective link through which the health services can provide better and more efficient coverage, the community can become more responsible for its development, and the health authorities can improve their responsiveness and accountability to the community (WHO, 1986:1).

2.2.1 Selection of the Village Health Workers

Criteria for the selection of the VHWs vary from country to country depending on the specific health needs in that area. However, the following are common criteria:

- The VHWs should be **chosen by members of the community** whom they serve and should therefore belong to that community and have the same culture, religion, beliefs, customs and socio-economic

background. Most important is that a VHW who is selected by the general community (or representatives of various segments of the community) tends to be more acceptable to the community than the one nominated by the village leader (Smith, 1992:117).

- People with a **desire to serve their community** should be selected, as they must be prepared to work on a voluntary basis, although sometimes they are remunerated depending on the country or community.

- In some cases a basic education is required to ensure that the candidate (VHW) can **at least read and write** (Fourie, 1988:26).

The Village Health Committees (VHCs) represent all the villages within a constituency and are also selected, mainly to support the VHWs in their duties. The composition of these committees should change according to the size of the village. Where a Village Development Committee (VDC) exits, the VHC should become a sub-committee of the VDC (Sagbohan, 1998:13). However, there are some countries where the VHCs are non-existent like in South Africa (Setlogelo, 1998),(a). Although the VHW Programme is not gender discriminatory, many health reports reveal that the majority of VHWs are adult women, married and literate (WHO *et al*, 1995:11).

2.2.2 Remuneration of the Village Health Workers

The remuneration of VHWs is one of the most problematic areas in the VHW Programme. However, countries have different approaches regarding the remuneration of VHWs. In many countries VHWs do not

receive a salary as such, but rather an incentive to reward them for their efforts and to motivate them to continue.

In Namibia for example, the VHWs are strictly volunteers. Thus it is in the best interest of the communities to remunerate the VHWs in any way they like, be it in cash or kind. In Zimbabwe the Government provides VHWs with a uniform and a monthly salary (WHO *et al,* 1995:11). Remuneration can also be in the form of collective benefits instead of money, as is the case in the Cala district of Transkei where remuneration is in the form of fencing loans, gardening tools and adequate water supplies (Fourie, 1988:26). The Government is therefore not obliged in any way to pay salaries to VHWs.

It must be noted that whatever method is used, VHWs continue to receive most of their income from their farming and other work. So village health work should not be viewed as a full-time job but rather as a part-time, voluntary service to the community, for which payment should not be expected (Molapo, 1998).

Although the all the parties seem to be necessary in planning and organising the VHW Programme, the remuneration issue is rather a sensitive issue. In order to solve the remuneration problem, health care authorities, who usually come from the main hospitals in any country, should discuss the remuneration issue with the VHWs, preferably not in the presence of the community leaders or other influencing bodies in the villages, in order to obtain a true picture of their feelings (Smith, 1992:118).

2.2.3 Training, supervision and support of the Village Health Workers

Training sessions for VHWs are usually organised at Health Centres by the nurses and other people responsible for the VHW Programme in various countries. The syllabus aims to train the VHWs to cope with elementary PHC in their villages. For this reason the training is community-orientated. Moreover, training is focused on promotion of health and prevention of disease (Mentz, 1989:4). Although the syllabus is almost similar in many countries, the duration of the training sessions differs, ranging from days, to weeks and months.

In Zambia for example, VHWs are trained for six weeks, while in Zimbabwe they are trained for two months (WHO *et al,* 1995:5 & 11). Most countries that are involved in the VHW Programme emphasise that it would be relatively easy to review the content of the VHWs' training through an interview with the trainers and trainees. However, it is more important to assess the effectiveness and appropriateness of the training, as well as the quality of performance of the VHWs. For example, does the VHW have sufficient knowledge and competence to deal with the prevailing health problems of the village? What practical training has the VHW had especially those who would be dealing with delivery cases? When and from whom? (Smith, 1992:117).

Doctors and nurses can best carry out the **supervision** of VHWs. Nurses are particularly suited to supervise the VHWs, however they must be prepared to take on this additional responsibility as problems may arise if the professional clinic nurse views the VHW as a nurse. This was shown in a study in Ciskei, where 36,4% of the processional clinic nurse respondents viewed the VHW as a nurse (Fourie, 1988:26).

The VHWs' perception of the quality of **support** received, forms an important dimension in the VHW Programme. Support should include not only working facilities and remuneration, but also supervisory support, both from the health centre and the community, and demonstrable interest by the community in carrying out the VHW Programme. The following issues should be clarified: does the health centre staff maintain a cordial and close liaison with the VHW? Has it been prompt in taking action to help find solutions to problems encountered by the VHW? Is the community actively involved in carrying out health-related activities in the area? (Smith, 1992:117).

The nature of public health care is essentially multidisciplinary and inter-sectoral, and to be effective, requires coordinated activities of all involved. Many members of the professional health team do not, however, have a clear understanding of the concept of teamwork and multidisciplinary/intersectoral cooperation in the provision of health care. In Lesotho as in other countries, "much has been written about the importance of including an orientation towards team work and intersectoral cooperation in the training and supervision programmes of health care workers, but in reality very little has been done to ensure that it is achieved" (Glatthaar, 1995:162).

Glatthaar (1995:162) further asserts that it is generally accepted that there is an urgent need to adjust the training and supervision approaches of public health care workers from a discipline-based approach to a community-based multidisciplinary approach. It is also agreed that the training and supervision of all members of the health care team should place a much greater emphasis on the multidisciplinary team concept. It is nevertheless true that the existing curricula of health professionals seldom include such an approach.

2.2.4 Roles and functions of the Village Health Workers

Village Health Workers are essentially facilitators, their role being to help their communities in health-related issues to reach the right decisions at the right time. Their role is instrumental and increases immunisation coverage and raises awareness of personal hygiene and strategies for better health care. Quite often people take the situation in which they find themselves as given. Under such circumstances outside help is needed, even if just to overcome this state of inertia. People in such a situation need to be stimulated to discuss their predicament. They should be assisted to realise that something can and should be done to improve this situation. Most important is to make them see that they themselves can do a great deal to improve their situation. In this case the VHWs become the catalysts (Kaya in Liokoro, 1995:145).

More specifically the roles and functions of the VHWs are as follows (Fourie, 1988:26):

- The VHWs refer patients, do home visits and deliver oral contraceptives to women after their initial examination at the health centre.
- Good record keeping forms an essential part of their daily tasks.
- The VHWs perform preventive and promotive tasks, which include follow-up of patients, motivation of people to visit clinics and dissemination of health information.
- They keep registers for birth and deaths, identify malnutrition of children and educate the mothers. They also ensure the immunisation of children younger than five years through home visits.

- VHWs assist the health authorities with the food and nutrition monitoring system, as they can collect data and teach the villagers about nutrition.

Most VHWs are trained to perform preventive and promotive health care duties, however, in some places this may be extended to include curative services as well (Lephoto, 1997).

2.3 COMMUNITY PARTICIPATION IN THE VILLAGE HEALTH WORKER PROGRAMME

It is a fundamental principle of the Primary Health Care Approach that there be maximal possible community participation in the planning, provision, control and monitoring of health services. For such community participation to be effective, it is not enough that the managers of the services simply be held to be formally accountable to an elected body. Community development and empowerment are essential to the promotion and maintenance of the health of the communities, and vibrant community-based organisations must be accommodated within the district health structures if true community participation and involvement is to be realised (Owen, 1995:24).

The success of the VHW Programme does not only depend on the VHWs but also on community support. For people to participate meaningfully in what concerns their lives, commitment becomes eminent. Self-help, such as building Health Care Posts, therefore becomes one of the crucial aspects of community participation. Community participation also enhances the interests of the people in the programmes undertaken in their areas and instills a certain amount of responsibility from the community. When people help themselves, join together to deal with their

similar problems, whether this concerns health or the neighbourhood, they feel empowered, as they are able to control some aspects of their lives. This self-help induced empowerment may have a significant political relevance, because as people are enabled to deal with some aspects of their lives on a competent level, the skill and positive feelings they acquire may contagiously spread and empower them to deal with other aspects of their lives (Liokoro, 1995:146). Therefore, the community must be made aware that appropriate health care delivery is not only about delivery of goods to passive citizens, but it is about active involvement.

In order to implement any programme effectively, beneficiaries have to be involved in one way or another. Community participation can take place through formal structures (Legislated Governance Structures) and informal structures (Village Health Committees/Workers). For these structures to perform effectively, their establishment should be guided by the principles of legitimacy and representivity (Setlogelo, 1998:1),(b). Effective community participation as envisaged in the Primary Health Care Approach means that democratically elected community structures, integrated with representatives of the different sectors and stake-holders involved in health and community development, have the power to decide on health issues (ANC, 1994:21).

Verwey (1993:66-67) outlines the benefits of meaningful community involvement/participation.

- The true needs of the community as perceived by the community are addressed.
- The legitimacy of the programme is increased, as there is greater acceptance by the community.

- People have greater control over their own environment. This form of participation will enable communities to identify their own health needs and at the same time assume responsibility for their own health care campaigns. Empowerment encourages devolution of power from the Government to the communities, which in turn will minimise the community's dependency on outside resources.
- The greater acceptance of programmes such as the one for VHW will provide greater momentum for change in health and other sectors in the community.
- The use of VHWs will result in a partnership being developed with the broader community.

2.4 THE INFLUENCE OF TRADITIONAL STRUCTURES IN THE VILLAGE HEALTH WORKER PROGRAMME

It is very important to highlight that every country, irrespective of its socio-economic status, has endogenous forms of structures. In Africa for example, most of the people still believe in traditional practices, and developmental programmes that are implemented, usually encounter problems if they do not cooperate with the traditional authorities. In a Gazankulu case study in South Africa it was mentioned that the VHW has to report to the tribal office every morning or, where there is no tribal office to report to, the local headman when she starts working. Likewise she has to report to the tribal office or headman when going home in the evening. This is to ensure that the VHW may be easily traced when needed, as when the community health nurse or one of the local doctors is visiting the village (Mentz, 1989:5). In Latin America also various groups have been involved in promoting VHWs for decades. To a large extent, villagers still rely, as they always have, on their traditional health

structures, herb doctors, bonesetters, traditional midwives and spiritual healers (Werner in Davey *et al*, 1995:285).

Apart from the traditional structures, there are also a number of institutions in every country determined and influenced by different factors such as illiteracy, health status, unemployment and others. These institutions which include the health care systems, have their own rules and logic, power relations and procedures for reward, all of which influence the health perception for the individual and the family, as well as the overall health situation in any given community. The WHO (1986:5) explains Mali's experience of using one traditional institution called "Le Ton"[2] to implement PHC at the village level. "Le Ton" is responsible for choosing the VHW and for making resources available for her remuneration. It was pointed out that such institutions are more readily understood by community members who hence are more willing to work with them. In contrast, externally inspired institutions do not enjoy the same confidence and adherence, nor are they as permanent. In fact, they do not build up the same capacity for self-reliance.

2.5 THE PARADOXES INVOLVED IN THE VILLAGE HEALTH WORKER PROGRAMME

People argue for the merits of the VHWs on different grounds. Some would say that the most important reasons for their work are cost containment and appropriateness. The majority of problems in rural areas are either readily preventable, or can be dealt with by people with far less costly training than doctors or nurses. However, the term appropriateness is viewed differently by various people. Some argue that VHWs, coming from the same community, understanding local health

[2] Le ton is a local institution where men and women organise the traditional events.

practices and causes of ill-health, and speaking the same language (in more than just a literal sense) are best placed to understand the barriers between the people and the formal health system and to do health education. Then there are those who see the organisation of VHWs as a platform for working towards other, non-health goals. They see village health as an entry point for integrated rural development and especially for the organisation of women (Lund, 1993:60).

Lund (1993:61-67) further asserts that no matter whether the VHWs are paid or not, or do curative or preventive care, they face similar paradoxes in their programmes. These are the paradoxes of prevention, of professionalisation, of participation and of policy.

- **The paradox of prevention**

When the idea of VHWs is being introduced to other professional health personnel, the rationale is often given that the VHWs will be able to assist the nursing sister, and lighten her load. But VHWs are introduced into a context of limited health resources and a poor health care system. To the extent that the VHW does her work well, she creates more work for the health personnel. Her efforts at early detection of health problems mean that she brings more patients to the clinic for the nurse to deal with.

- **The paradox of professionalism**

It is a popular idea that VHWs are ideal as they are from the community, are accountable to the community, and therefore they can get people to take more responsibility for their own health. In the very act of choosing some people to go for training as health workers, however, the VHWs are

professionalised in the eyes of local people, who therefore are likely to say that health care is something that other people (VHWs) do. In this way a broad band of local people may become less likely to participate in health education, or health campaigns.

- **The paradox of participation**

Another popular idea is that the community should participate in the election of the VHWs, as they themselves know who the most appropriate people would be for the task. However, in most developing countries, local elections get rigged and controlled by those in positions of power and there is little real participation in a free and fair way.

- **The paradox of policy**

National initiatives to forge a policy surrounding the VHWs, in order to ensure that they have a place in the health care system of the future, is surely a good thing, and very necessary in order to get the role of VHWs firmly on the agenda. However, the policy comes from the progressive health sector, and turns out to be top down, regressive and disempowering the VHWs.

2.6 PROBLEMS OF THE VILLAGE HEALTH WORKER PROGRAMMES

Although Village Health Worker Programmes have been implemented in many countries, serious problems are experienced, which affect the delivery of health care services at the village level..

The first problem is **the availability and accessibility of VHWs.** One of the essential requirements in the VHW Programme is that the VHWs must be available twenty-four hours a day. This is one way of making health care services accessible to the community, but it often limits the time the VHWs have to rest. This increases the likelihood of their suffering from burnout. Working and living in the same area also makes it difficult to distance themselves from their work. Thus, while the routines of the VHWs are an essential requirement, this could also result in the failure of their performance (Binidell & Miller, 1992:26).

The second problem relates to **the VHWs' links with other parts of the health services and their logistic support.** The VHWs' general limited basic education and short period of preparation require continuing on-the-spot training and the full support of the whole health care service system. Existing health services have seldom provided training and support, nor have whole-heartedly accepted the concept of VHWs. Thus unless front-line workers have the backing of the rest of the health system, the rural populations may well reject a service that is clearly insufficient by itself (Djukanovic & Mach, 1975:19).

The third problem pertains to **poor communication.** Because VHWs work in remote areas without well-developed communication and transport, it is difficult to ensure that they have the proper equipment and that patients can be easily referred to other levels of care. The remoteness of their posts also makes it more difficult to supervise and evaluate their work (Molapo, 1998).

Factors responsible for poor functioning of the VHWs can be categorised as follows (WHO *et al,* 1995:7-8): **Community factors, personal factors** and **service factors.**

2.6.1 Community factors leading to the poor functioning of the Village Health Workers

Community support is very crucial to motivate the VHWs. Communities fail to support the VHWs because of the following:

- The low socio-economic status of the community, so that they fail to remunerate the VHW financially. Poor community organisation by the VHCs.
- Poor community support given to the VHCs due to factional disagreement, failure to reach consensus during meetings, hence failure of possible concrete supportive activities.
- Poor community support for the VHWs due to unmet community expectation, for example, high expectations from the VHW whose training does not allow her to provide popular forms of treatment like giving injections.
- The community's preference for other types of health care.
- Lack of confidence in the VHW resulting in low utilisation of health posts/homes of the VHW.

2.6.2 Personal factors influencing the performance of the Village Health Workers

Although the VHWs are aware of the benefits offered in the VHW Programme, most of them fail to perform within a given situation. The factors behind this are:

- High personal expectations by the VHW in terms of promotion and high remuneration prospects.
- Other (and/or better) job opportunities.

- Economic pressures due to her spending time on community health activities without or with poor benefits.
- Low educational level does not allow the VHW to advance in the field of medicine, for example to become a professional nurse.

2.6.3 Service factors leading to poor functioning of the Village Health Workers

Poor delivery of health care services by the Ministry of Health affects the performance of the Village Health Workers. The following influence the situation:

- Failure of supervisory health staff to involve communities' decision-making with respect to setting tasks of VHWs and priorities for tasks of VHC members and developing criteria for selection of VHWs.
- Poor training of VHCs and VHWs (short duration of training, inadequate content).
- Inadequate provision of necessary drugs and equipment.
- Poor supportive and irregular supervision of VHWs leading to loss of hope and feeling neglected.
- Lack of incentives for VHWs and VHC.

2.7 SOLUTIONS TO THE PROBLEMS IN VILLAGE HEALTH WORKER PROGRAMMES

Some people maintain that the problems within the VHW Programmes are due to the fact that the VHWs are at the bottom of the health care structure where they are controlled and exploited by other levels above them. In order to solve the problems in the VHW Programme, the present health care structure must be changed, where the VHWs must be on top

and the doctors at the bottom in the health hierarchy. Thus "health care will only become equitable when the skills pyramid has been tipped up, so that the primary worker takes the lead, and so that the doctor is on tap and not on top" (Werner in Davey *et al,* 1995: 292). Appendix 8 shows the structure of the Village Health Worker Programme in many countries.

The main arguement for the Village Health Workers to take the lead in the VHW Programme is that their skills are more varied. Whereas the doctors can limit their responsibilities to diagnosis and treatment of individual cases, the health worker's concern is not only for individuals, but also with the whole community. They must not only answer to the people's needs, but they must also help them look ahead, and work together to overcome oppression and to stop sickness before it starts. Their responsibilities are to share rather than hoard their knowledge, not only because informed self-care is more health conducing than ignorance and dependence, but because the principle of sharing is basic to the well-being of humans (Werner in Davey *et al,* 1995:291).

2.8 THE VILLAGE HEALTH WORKER PROGRAMME IN SIAVONGA IN ZAMBIA: A CASE STUDY[3]

This case study is included in the study as an example of the Village Health Worker Programme in another country in Southern Africa. The main reason is that Lesotho is a Less Developed Country like most of the countries in Southern Africa, and tends to have many things in common such as poor economy, health status and many others.

[3] This case study is taken from WHO *et al* (1995:5-65)

2.8.1 Background information

Zambia, with an area of 752, 600 sq. km and a population of 8.09 million (1990 census), has a national average population density of 10.8 per square kilometer. Unlike many of its neighbours (e.g. Malawi, Mozambique, and Tanzania, where 80% of the population is rural-based) only 58% of Zambia's population stays in rural areas. The size of the country and vast migration to urban areas, such as Lusaka and the Copperbelt, have created a situation where the regional population growth rate is 3.2%. While copper mining has been the mainstay of the economy, it is now being diversified. The drop in the copper price on international markets during the mid 1970's, has had a devastating impact on the economy and consequently on the available resources for PHC.

Administratively the country is divided into nine provinces, which are further sub-divided into sixty-one districts. Siavonga is a sub-district of Gwembe, which is one of the six districts in the southern province of Zambia. Siavonga is situated along Lake Kariba, covers an area of 4 600-sq. km, shares borders with Mazabuka, Choma Gwembe Central and has an international border with Zimbabwe to the south. It has a population of 42 416.

2.8.2 The structure of the Village Health Worker Programme

The structure of the VHW Programme in Siavonga is as follows: there is one central government hospital, one mission hospital, four rural health centres and twenty-seven health care posts where the VHWs operate in their respective villages. Appendix 9 illustrates this situation.

In Siavonga there are also Village Health Committees (VHCs) which are meant to support the VHWs and play a coordinating role on health issues in the village. Thus its role is to oversee disease prevention issues, organise immunisation days, make a work plan and monitor the performance of the VHWs, collect remuneration from community members, organise cleaning campaigns and health education sessions and organise transport for the very sick people whom the VHWs have referred to the next level health facility. To empower the VHC members to function maximally, training is sometimes provided to this cadre. However, in Siavonga there has never been this form of training.

2.8.3 Selection, training and remuneration of the Village Health Workers

In Siavonga the VHWs are local persons, females or males, chosen by their respective villages. The VHWs are trained by professional health care workers at district health centres for a period of six weeks to enable them to perform their tasks. The course content includes treatment of malaria, diarrhoea, simple infections, cuts and sores, eye infection, prevention and control of cholera and dysentery in a village setting, proper recording of patient register and regular compilation of monthly reports. During training, practical procedures are emphasised. In Siavonga the remuneration package of the VHWs is organised in such a way that they are employed as managers in local agricultural cooperatives run by missions to earn a monthly salary of K500[1]. However, there are some VHWs who are not employed in the local cooperatives and therefore rely solely on community support for a monthly salary.

[1] Kwacha is the currency in Zambia

2.8.4 Problems of the Village Health Worker Programme in Siavonga

The problems of the Village Health Worker Programme in Siavonga revolve around the Village Health Posts, which are sometimes structured poorly. This situation therefore affects the performance of the Village Health Workers negatively.

2.8.4 (a) Support of the Village Health Posts and Village Health Workers from the Health Centres

In Siavonga the Government-supported VHPs are supervised by the MOH, while the mission supported VHPs are supervised by the nurses from the mission hospital. However, supervision is done in different ways without any formal guidelines and no reporting is done as a follow-up to such supervision. Furthermore, it is not clear who is responsible for such supervision. Inadequacy of supervision is a problem aired by the VHWs. Support of VHPs in terms of ensuring adequacy of supplies is not good. Bicycles, which had been promised to ease transport problems of VHWs, are not supplied. The supply of drug kits is irregular and when it is given it is not based on demand. Mission-supported VHPs are lucky in having additional drugs supplied by the mission, but again without evidence of such supply being based on need. Despite the frequent contact between nurses of the mission hospitals and VHWs in mission supported VHPs, there is no supervisory policy on which to base such visits.

2.8.4 (b) Performance and reasons for drop-outs of Village Health Workers in the programme

It is the performance of the VHWs that contributes most to the effectiveness of the VHPs, yet their performance is closely related to that

of VHCs, which are mainly established to assist and support the VHWs. In Siavonga the VHWs serve isolated and sometimes big communities. The VHWs in these VHPs write monthly reports and are knowledgeable on prevention of disease, but restricted when implementing the programme's policies, which actually demotivates their performance. The main factors leading to the VHWs' drop-out are inadequate community support, and personal factors such as poor benefits and poor relations between the VHWs and the community.

2.8.5 Suggestions to improve the Village Health Worker Programme in Siavonga

To revive non-functioning VHPs, the District Health Management Team (DHMT) proposed that the following procedures be adapted:

- The VHCs should be formed through election and the inactive VHCs should be replaced.
- The new VHWs should be given training by the DHMT.
- Drugs should be given to the VHPs and regular supervision should be guaranteed.
- During training and supervision of VHWs, the keeping of records (patient registers and monthly reports) need to be emphasised.
- Whenever the Government (MOH) supplies materials such as bicycles, drugs, stationery and others, they should hand them over to the VHC and not to the VHWs.
- The delivery of drugs to the VHPs should be rationalised. Instead of providing standard drug kits, it would be better to supply drugs according to the needs of the population served. This requires better insight into actual expenditure of drugs at each health post.

2.9 CONCLUSION

Although there are problems in the VHW Programme in many countries the VHWs play an outstanding role in the improvement of health especially at household level. Many of the remote rural villages cannot be reached easily by the health service delivery system. In these communities the VHWs contribute to the raising of the health status of the local communities, especially with regard to personal and environmental hygiene. Thus if the VHWs are properly trained, they can make a valuable contribution in the general health status of the people in the villages. The next chapter explains the development of Primary Health Care and the Village Health Worker Programme in Lesotho.

CHAPTER THREE

THE DEVELOPMENT OF PRIMARY HEALTH CARE AND THE VILLAGE HEALTH WORKER PROGRAMME IN LESOTHO

3.1 INTRODUCTION

The health care structure in Lesotho is similar to those in many developing countries where health care services are unfairly distributed, thus marginalising poor communities in terms of the provision of health care facilities. These communities are in the semi-urban and rural areas in the case of Lesotho. Primary Health Care is very important in any country, because it tries to address the needs and wants of almost every person in health-related issues. The main aim of PHC as propounded in the Alma-Ata conference in 1978, is to bring health services to every individual, regardless of whether the country is developed and rich or underdeveloped and poor. The contribution of PHC in Lesotho has been quite significant, especially in health developmental programmes. In this chapter, a profile of the health care system will be given, while the health status of the population, the development of PHC and the VHW Programme in Lesotho will be discussed. The Alma-Ata Declaration will also be considered. The contribution of the Ministry of Health, United Nations Children's Fund and the Christian Health Association of Lesotho will be taken into account. Finally, the relationship between the VHWs and the traditional practitioners in the villages will be looked at.

3.2 THE ALMA-ATA DECLARATION

The Declaration at Alma-Ata is very important, because it acts as a foundation for PHC implementation in any country, especially in

programmes, which try to improve health status at the lowest level of the community. The Declaration proposed that everybody throughout the world should be given an opportunity to have health care at a cost that is affordable and comfortable, such as using available resources like certain traditional herbs. According to the World Health Organisation (in Dennill *et al* 1995:4-5), the Declaration consists of ten elements which are as follows:

1) Health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. It is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

2) The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

3) The economic and social development, based on a New Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

4) The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

5) The main social target of governments, international organisations and the whole world community in the decades ahead should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

6) PHC is defined as the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development to the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

7) Primary Health Care:

- reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

- addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

- includes at least: education concerning prevailing health problems and the methods of preventing and controlling the promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning, immunisation against the major infectious diseases; prevention and control of locally endemic disease; appropriate treatment of common diseases and injuries; and provision of essential drugs;

- involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors, and demands the co-ordinated efforts of all those sectors;

- requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate;

- should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those mostly in need;

- Relies, at local and referral levels, on health workers, including physicians, nurses, mid-wives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

8) All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

9) All countries should co-operate in a partnership and service to ensure primary health care for all people, since the attainment of health by people in any one country directly concerns and benefits every other country.

10) An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

There have been substantial global health gains since Alma-Ata. The Infant Mortality Rate has declined by almost fifty per cent in many

developing countries since 1980 and life expectancy at birth has increased profoundly, with many developing countries now having life expectancies in excess of sixty-five years. Many of these gains were achieved through implementation of vertical programmes like the Expanded Programme on Immunisation or diarrhoeal disease control, within the direct control of the health services (Yach, 1996:3). In Lesotho, the above-mentioned programmes are incorporated into the Village Health Worker Programme.

3.3 THE HEALTH CARE SYSTEM IN LESOTHO

One of the first things to mention about the health care system in Lesotho is that no national health insurance exists. Except for Tuberculosis (TB) patients who receive free treatment in Government hospitals, people have to pay for health care. In fact, the idea of health care insurance is not so well known among the general population, and only a few of the affluent take out health coverage with private insurance companies (Shale, 1996:7).

The Lesotho health care system is characterised by the high number of Community Health Workers operating in the country and by the increasingly decentralised approach taken to health care. However, lack of capacity at central level has meant that the health care system has not always been able to spend its budget appropriately and this has inevitably led to deterioration in the service offered to people. "This is particularly evident in the decreasing number of people using health centres, which may be partly due to the cost to the individual of health care" (Gill, 1994:ii).

Kucholl (1985:04) provides the following historical information about the structure of health care in Lesotho: Since the nineteenth century, two systems of medical practice have existed in Lesotho, namely traditional healers and doctors trained in Western medicine. Missionary doctors first introduced modern medicine, but from 1875 onwards there has also been a Government health service. Today the health services fall under the Ministry of Health, which is responsible for hospitals in nine of the district headquarters/towns. Health services provided by missions fall under the Private Health Association of Lesotho, now known as the Christian Health Association of Lesotho.

Since the Methodist Hospital in Semonkong closed in late 1995, there are now eight mission hospitals providing health services mainly outside the main urban areas. In addition, there are over one hundred health centres or clinics situated mainly in rural areas, to facilitate the health services delivery from the main hospitals. The majority of these health centres belong to the Ministry of Health or to CHAL, but a significant number are also the responsibility of the Red Cross and the Lesotho Planned Parenthood Association (LPPA). In addition to those services, there are a number of doctors and nurses in private practice with surgeries in different parts of Lesotho, but mainly in lowland towns. In the early eighties the Health Service Areas were also instituted and went into operation. According to the Scott Hospital annual report (1996:5) the purpose of creating Health Service Areas, was to decentralise health services in order to facilitate the planning, implementing and co-ordination of health activities at all levels.

At present the country is divided into eighteen Health Service Areas for health administrative purposes (appendix 10 shows the HSAs map). The HSAs were created around nine government hospitals and nine CHAL

hospitals. Each HSA includes one or more clinics (health centres) providing outpatient care services and deliveries serviced by a nurse clinician with support from the Village Health Workers and Traditional Birth Attendants (Shale, 1996:8). The HSAs also supervise all Health Centres in their areas, are responsible for the training of all non-stipendiary staff, the implementation of PHC and all government policies, and the provision of basic hospital services (Sechaba Consultants, 1993:44).

3.4 THE DEVELOPMENT OF PRIMARY HEALTH CARE IN LESOTHO

The Alma-Ata Declaration was basically a result of the recognition by nations that there must be a change in the perception of health. It involved a change in emphasis from the biomedical practices of health to the social and economic context of health. The basis of PHC was laid down as a concept of essential health care made accessible at a cost a country and community can afford (Kalaka, 1997). WHO *et al* (1995:1) give the following as five basic principles of PHC: the promotion of equity, community participation, appropriate technology, focus on prevention and an intersectoral approach to public health problems.

Many countries, including Lesotho, have set up PHC programmes to implement these principles. These programmes include activities such as maternal and child health, family planning and nutrition, provision of essential drugs, provision of safe drinking water and sanitation, immunisation, health promotion and elementary curative care (Lephoto, 1997). It is important to emphasise that the idea behind the 1978 PHC Conference in the USSR (Alma-Ata) was to bridge the gap between the "haves" and the "have nots", so as to achieve a more equitable distribution of health resources, and to attain a level of health for all

citizens of the world that would permit them to lead socially and economically productive lives (WHO in Jacobs, 1996:3). In an international context the idea is to close the gap between the developed and underdeveloped countries. In the case of Lesotho the idea is to bridge the gap between and rural and urban dwellers.

Primary Health Care has existed in Lesotho even before the International Conference at Alma-Ata took place. A Village Health Worker Workshop was held prior to this conference in 1977 and in the same year external assistance was organised, so that the MOH and the whole health care delivery system could be reorganised and decentralised in order to implement PHC. Regarding PHC implementation, new types of health workers were trained (e.g. nurse clinicians and VHWs), new teaching and working guides were written and tested, while the Health Centre Operation Manual and "*Bophelo bo botle ho bohle: buka ea basebeletsi tsa bophelo metseng,*" which means "good health for all; a workbook for VHWs," was published (Kucholl, 1985:7).

After the conference, there was an increased interest in improving and expanding Primary Health Care services in the often under-served rural areas of Lesotho. A commitment to PHC was considered as a means whereby basic health care services could be provided in a country short of both financial resources and highly trained humanpower. Because of the success of the conference, the Government of Lesotho, through the Ministry of Health and Social Welfare, decided in the same year to hold a Seminar/Workshop on PHC in Lesotho. The seminar was to be part of a three-step process, which was to lead to the formulation of a National PHC Programme. The first step, the seminar, was intended to inform participants of the principles of PHC and to formulate guiding principles for a national programme. The workshop, the second step, was to develop

the principles formulated in the seminar. The third step was to establish an Action Committee which would consolidate the principles and potential plans into a coherent, integrated National Primary Health Care Programme for implementation (Ministry of Health and Social Welfare, 1978:1).

In 1979, the Ministry of Health adopted the Alma-Ata Declaration on PHC as a framework and strategy to improve the physical, mental and social well-being of every Mosotho. The idea was to address health problems in the community providing promotive, preventive, curative and rehabilitative services. Community participation in health issues was to be promoted through Village Health Workers. Finally, PHC was to ensure that health care services were geographically and economically accessible to the people (Lekhotla & Liphafa, 1995:04).

In Lesotho, the Government has made a commitment to strengthen PHC services, primarily for its rural citizens. As a result, considerable effort has gone into planning the reorganisation of the health care delivery system (Lephoto, 1997). PHC includes the maintenance of health, prevention of disease and treatment of illness when it occurs. Therefore, such care is provided by a person who is the first (primary) person to provide health care for the well-being of another person, namely the Village Health Worker (Makhetha 1988:9).

The structure of PHC comprises the Department of Health Care in the MOH, district hospitals that also serve as the headquarters of a district health service area, the Health Centre and the Village Health Worker in the village. The MOH has organised the health services into eighteen Health Service Areas, complemented by the Lesotho Flying Doctor's Services (LFDS). Each HSA is headed by the HSA hospital whose

functions among others, is to provide support and supervision to HCs within the HSA, both governmental and private (Lekhotla & Liphafa, 1995:4). Appendix 11 shows the structure of PHC in Lesotho.

3.4.1 Health policies and strategies

When the Government of Lesotho officially accepted the Primary Health Care Strategy of Alma-Ata in 1979, it set about implementing it in three five-year plans. The health sector operates independently and has a three-tier referral system, namely the village level with a network of over 5 000 volunteer health workers, the Health Centres with health teams serving 6 000 to 10 000 people and finally, the Health Service Areas with teams operating from referral hospitals (Sechaba Consultants, 1993:40). The private sector and Non-Governmental Organisations are responsible for about 50% of the health care. Policy is determined and health development monitored at national level. At the village level, the communities are given responsibility for their own health and health development and they elect their own Village Health Worker Committees. These committees are established by law, which was promulgated in 1981. Membership usually includes traditional leaders and healers. As resources are limited, priority is given to providing new services to rural areas, which have received little or no service before (Dennill *et al*, 1995:48).

3.4.2 Health status in Lesotho

The health status in Lesotho has been influenced to a large extent by the implementation of PHC. Several health projects and programmes in the country have been undertaken by the Government and other organisations to promote PHC. The Village Health Worker Programme is

an example of such a programme to promote PHC at the community level. Patterns and trends in health status in Lesotho reflect the transition that many developing countries are experiencing, with a decrease in mortality and morbidity due to infectious and parasitic diseases, whilst chronic diseases begin to increase (Sechaba Consultants, 1993:83).

At present Lesotho is undergoing an epidemiological transition. Diseases of under-development and development co-exist. The demographic situation is a basic determinant of the epidemiological situation in the country. Childhood diseases of importance in morbidity and mortality include acute respiratory infections, diarrhoea and malnutrition-related conditions, including nutrient deficiencies. In adulthood, Tuberculosis and sexually transmitted diseases are clearly the leading causes of morbidity and mortality. HIV/AIDS is an emerging problem of serious magnitude with social and economic implications. Cardio-vascular diseases and diabetes have emerged as serious conditions, whose magnitudes have not been sufficiently assessed as yet. No doubt as the population ages, these conditions will contribute more to the disease burden in the country (Ministry of Health and Social Welfare, 1993:4).

Although sheer destitution is rare in Lesotho, most children grow up in relative poverty. The poor economy of the country necessitated the migrant labour system and that has meant that nearly sixty percent of households are either headed by a woman or managed by a woman for much of the time. Children in Lesotho are fortunate in that the country has none of the tropical diseases common to other parts of Africa. The main cause of morbidity amongst children is therefore acute respiratory infections and malnutrition, which are monitored by the VHWs. Injuries are also a major cause of mortality, particularly among five to fourteen

years olds. The various programmes run by the Ministry of Health and Social Welfare, such as the VHW Programme have largely been successful at combating these diseases. Admissions to hospitals for acute respiratory infections have declined and there is evidence that the use of oral rehydration therapy undertaken by the VHWs in the communities has increased. Most of the immunisable diseases have declined substantially, with the exception of Tuberculosis, which may be connected to an AIDS epidemic (Gill, 1994:iii).

Due to the absence of tropical diseases many of the health problems women face are related to pregnancy. In 1994, the maternal mortality rate was 282 per 100 000 live births and it seems likely that hypertension is a major contributor to this figure. Other causes of mortality in addition to hypertension, are sexually transmitted diseases and trauma. The high rate of violence in the Basotho society contributes to these conditions and also probably contributes to the growth in nervous disorders and mental problems. As AIDS becomes more prevalent, the number of women with TB is also on the increase. Although AIDS is now firmly established in Lesotho, there is little evidence so far that it has entered people's consciousness and that behaviour is changing. The distribution of condoms has risen, but not to anything like the levels that would be needed to have an impact on the disease. The use of other contraceptives encouraged by the VHWs in the communities have also risen and indicates some desire for people to have smaller families, but the contraceptive prevalence rate is still only somewhere between 17% and 27% (Gill, 1994:iii).

3.4.3 Improvements in health

Sechaba Constants (1993:69) provides the following information on improvements in health in Lesotho: the prevalence of certain diseases, particularly childhood ones, has shown a significant drop over the last few years. Polio has dropped from 228/100,000 in 1979 to 23/100,000 in 1989. Diphtheria and tetanus are very rare and cases of measles have decreased. In the years 1981-1985 there were normally about 5 000 to 7 000 cases of measles a year; these dropped to an all time low in 1988 with some 1 200 cases reported. This decline is undoubtedly due to immunisation. In 1990, 68.7% of children were fully immunised. There was a slight difference between the rural and urban areas, with 75.1% being immunised in the urban areas and 66.5% in the rural areas, reflecting differences in mother's education and access to immunisation services. Thus immunisation has seen a steady rise in Lesotho.

In terms of deaths from diarrhoeal diseases in children supervised by the VHWs in the communities, there have also been dramatic improvements. Before 1986 the case fatality rate was around 7% of admissions to health facilities. By 1990 this had dropped to 4.3%, most likely attributable to the opening of Oral Rehydration Therapy Units in District Hospitals and the promotion of home based Oral Rehydration Therapy. This has ensured a steady decline in the number of children admitted with dehydration to health facilities. The 1991 Healthcom Evaluation found that between the years 1987 to 1990 there had been a rise in the use of Oral Rehydration Solution from 58% to 75% in the villages.

Although there have been some improvements in health over the past years in the country, at present the situation is changing. There is a decline in the nutritional status of children, which is aggravated by

drought prevailing in the country, but mostly by poverty experienced by many people in the rural areas. The state of poverty is due to the fact that many males have been retrenched from the South African mining industry. Various recent studies have shown that real income is falling in Lesotho, a particularly important fact given that Lesotho is a highly monetised economy and does not solely rely on agriculture for the means to live (Click, 1998). It is therefore crucial for the Ministry of Health to find the necessary funds to improve the present situation of health in the country, and to maintain its commitment to health for all by the year 2 000.

3.5 THE DEVELOPMENT OF THE VILLAGE HEALTH WORKER PROGRAMME IN LESOTHO

In Lesotho the VHW Programme started in the early 1960s in the Roma Valley in the Maseru District. The Roma Valley is where the first Catholic Missionaries settled. However, it is not clear whether the Missionaries had some impact in this regard, but one would assume so, because they contributed much to the health care system in Lesotho. Because of the progress made in the Roma Valley, where many women started attending health clinics to have their children immunised, the Programme was extended to four other areas in 1975, namely Scott Hospital, also in the Maseru district, Tebellong in Qacha's-Neck, Tsakholo in Mafeteng, and Quthing districts. These areas in which the VHW Programme was implemented, are mainly in the rural areas and are therefore very remote from the health services offered by either the Government or the CHAL hospitals (Lephoto, 1997).

Although TBAs were already functioning within the villages in terms of delivery services, the MOH realised that there was a problem with

maternal and child care services. Hence there was a move by the MOH to encourage and educate mothers in the communities or villages about maternal health care services. During the same year that the VHW Programme was introduced, training started in the Scott, Tebellong and Quthing areas. In 1976 the results were amazing, with the percentage of women attending clinics rising from three to seven per cent (Lephoto, 1997). It was only after 1979 when Lesotho adopted the PHC structure proposed at the Alma-Ata Conference, that the VHW Programme was spread throughout the country.

In 1980 UNICEF became interested in the roles performed by VHWs in Lesotho. UNICEF then began organising funds for the training of VHWs throughout the country and ensured that their administration fell under a single body. In 1984 UNICEF conducted a situational analysis of women and children in Lesotho. From this analysis it was clear that the contribution of VHWs was indisputable. It was at this stage that the Lesotho Government also became involved in VHWs' activities under the MOH, by providing, for example, funds for the training of VHWs. Since the Government became involved, the first Programme was implemented from 1987 to 1991. The second was in the period 1992 to 1996, while the third started in 1997 and will continue to the year 2001 (Kalaka, 1997).

Sechaba Consultants (1993:74) explain that in Lesotho PHC has involved the participation of all tiers of health workers to devolve health initiatives into the community. The most basic level of PHC is at the village level and is through largely unpaid Village Health Workers. Ideally everyone in a village would consult first with the VHW, about 80% would then have to be referred to the clinic, 30% of those would be referred on to the hospital and 5% of them may need more specialised treatment at a referral hospital. VHWs spend most of their time motivating the

community to build latrines, improve the water supply by protecting their springs from diseases or persuade pregnant women to go to the clinic. They therefore have an important role to play in health education and motivation, but not much in health care provision. However, despite their relative importance, the VHWs are at the bottom of the hierarchical structure of health care. This aspect will be discussed later in the text.

3.5.1 The structure of the Village Health Worker Programme

Makhetha (1988:9-10) explains the structure of the Village Health Worker Programme in Lesotho in this way. The head of the PHC is the Director General of Health Services (DGHS) who reports directly to the Principle Secretary for Health. The DGHS is responsible for the national co-ordination of all district health services, including hospitals and health centre services. Reporting directly to the DGHS is the district Medical Officer, the District Health Inspector, and the District Public Health Nurse, the Hospital Administrator, and the Senior Pharmacist. All these people constitute the district health team. They are responsible for planning, co-ordinating, expediting and evaluating the overall health programmes throughout the district.

Within a district, each hospital has a defined service area to co-ordinate and support all health services (including health centres and other health-related activities). The Health Service Area medical director is professionally responsible to the District Medical Officer and oversees all PHC functions and staff (including the Health Centre supervisor). The nurse clinician is responsible for providing and co-ordinating preventive, promotive and curative services through the health centre. She also supervises the other members of the health centre team and the Village Health Workers and works closely with the Health Centre Advisory

Committee where they exit. The Village Health Worker is the key link between the health care system and the villages. It is planned that villages should have Village Health Committees, perhaps sub-committees of the Village Development Council, to help and guide the Village Health Workers activities. Appendix 12 delineates the structure of the Village Health Worker Programme in Lesotho.

The Queen Elizabeth II hospital situated in Maseru, the capital, and also the main referral hospital in the country, offers the highest level of health care. Both secondary and tertiary care are offered. Specialised care is supplemented through services of practitioners who visit periodically from neighbouring South Africa (Shale, 1996:10).

Although the roles performed by the chiefs/headmen in the health structure are not mentioned, one should never ignore nor undermine them. It is a well-known fact that in Lesotho the chiefs still play a very important role in the administration of village affairs and are highly influential and respected in their communities. Hence the task of establishing working relationships between modern health workers and the village authority cannot be delegated to the VHWs. That is, in order to establish formal ties, supervising health workers themselves have to contact the chiefs regularly, otherwise it will be impossible to implement any of the programmes in the villages.

A conducive political environment in the villages is also very important for programmes such as the VHW Programme to be effective. Sometimes the VHW faces great difficulties in implementing the Programme's policies in her own village, because the degree to which Primary Health Care is implemented in a village does not depend on the individual health worker, even if she has been elected by a village assembly, but on

whether the political situation of the village will allow a common decision to be reached and also followed up. Some villagers are so divided politically, that any joint action towards improvement of their health situation seems impossible for years (Kucholl, 1985:31). Today in countries where the VHWs have been given half a chance, they play an important role in the health care of rural and peri-urban communities. If given a proper chance, their impact could be far greater. However, to a large extent, politics still stand in the way. Thus the health of the people is influenced to a greater extent by politics and power groups, and by distribution of land and wealth, than it is by treatment or prevention of disease (Werner in Davey *et al,* 1995:286).

Apart from community involvement, the Primary Health Care Approach also requires political will on the part of the Government, and commitment from health and allied workers, health policy makers, health service managers and a broad range of health related sectors, such as education and others. The main reason is that the Government formulates national policies, strategies and plans of action to launch and sustain Primary Health Care as part of the comprehensive National Health System in co-ordination with other sectors (ANC, 1994:20-21). Thus it remains crucial that political support is maintained in order to achieve success in the promotion and implementation of good health (Setlogelo, 1998:07) (b).

3.5.2 Characteristics of the Village Health Workers

The Village Health Workers are at the bottom in the hierarchical health structure and the first people to be consulted by the villagers in PHC issues. The Ministry of Health and Social Welfare (1977:29) outlines the following as the essential characteristics of VHWs:

- The VHW must be acceptable both to the villagers themselves and to village leadership.

- The VHW should be a full-time village resident (not a "new" villager and not a person who is absent from the village for extended periods of time).

- There should be no specific age restrictions, but a "mature adult " is recommended.

- Marital status is not critical.

- People with full-time jobs are not acceptable as VHWs.

- The VHW must be prepared to render her services to every villager without exception.

3.5.2 Remuneration of the Village Health Workers

At present the VHWs in the country are not paid salaries, but are given incentives by their communities. However, the Ministry of Health is trying to organise some funds to improve the benefits of the VHWs to complement the remuneration package (Kalaka, 1997). Although the VHWs play an important role in health countrywide, many of them feel undervalued and hence become inactive. Various attempts have been made to increase the status of VHWs. In certain HSAs they have been provided with some commodities, such as free health services. Alternatively the VHWs may have been given specific tasks such as growth monitoring, or maintaining a village register or they may be equipped with particular skills, such as community based rehabilitation

of the disabled. These appear to be fairly successful in terms of raising Village Health Workers' status, but they often want remuneration for these tasks (Sechaba Consultants, 1993:74).

3.5.4 Functions of the Village Health Workers

The Village Health Workers function within a health care system and should be guided and supported by skilled supervisors. They should know when and where to seek guidance, and refer or seek help for patients who are seriously ill, or whose treatment is beyond their competence (Lephoto, 1997). The VHWs are the link between the village and the Health Centre on health-related issues. Since their training is primarily on environmental and preventive work, they are able to deal with some of the most common and minor diseases. In sudden illness or accident they are able to render first aid on very simple cases. VHWs are supplied with health kits and basic drugs to undertake their duties (Lekhotla & Liphafa, 1995:10).

The VHWs have two distinct overlapping functions, namely the provision of services and the promotion of health. Alternatively, the functions can be viewed as stretching along a continuum, with the provision of services at one end and the promotion of health at the other. Their curative activities represent the furthest outreach of conventional health services provision. Their promotive activities may range from advocating simple preventive measures, to fostering wider community development of direct relevance to health, such as literacy, housing, water supply and others. The VHW's position will vary according to the level of socio-economic development and the penetration of the health services. The curative role may be smaller where there is ready access to the formal health sector.

The promotive role applies at all levels of socio-economic development (Ministry of Health & Social Welfare, 1978:68).

In the case of Lesotho there are five basic functions of VHWs. Lephoto (1997) provides the following information: **Firstly,** there is health education to create awareness of the causes of illness, of certain symptoms, of prevention and promotion of good health. **Secondly,** VHWs encourage the use of facility-based services, such as family planning, especially to illiterate communities. **Thirdly,** they articulate service provision at primary level, for example, provision of first aid and diarrhoea management using the Oral Rehydration Solution (ORS). **Fourthly,** they undertake the responsibility of following up chronically ill patients, for example, those that are suffering from Tuberculosis and diabetes. Thus they motivate all persons needing medical care to go to the Health Centres and provide follow-up assistance needed by patients. **The last function** is concerned with taking care of pregnant women before and after delivery, for example, making sure that pregnant women attend nearby clinics or hospitals, as well as monitoring the growth rate of the child.

3.5.5 Training of the Village Health Workers

Training is a very important phase in the implementation of the VHW Programme. From the Primary Health Care perspective, the training of VHWs in Lesotho is viewed as the main strategy to build capacity within health workers to enhance their knowledge, skills and performance in health issues (Sagbohan, 1998:38). Through training VHWs are equipped intellectually and practically in the medical field, for example, the awareness of first aid and how to apply it. Kalaka (1997) says that in general the Basotho enjoy drama and music as part of their culture, and

these may be incorporated in training sessions to enhance both the VHWs' and the communities' attitude towards the programme. Mentz (1989:2) argues that when training the VHWs, those who are responsible are encouraged to use an appropriate adult educational approach. Moreover, the author emphasises that the trainees should also have experience in community work (the general principle of community development), PHC and adult education.

The Health Centre team organises and carries out the training of VHWs either at the Health Centre or in the village. There seems to be no specific period of training for the VHWs. Two weeks seem to be the usual period. The training is structured in such way, that the VHWs are taught to help the villagers to learn to solve their health problems. The training team uses the booklet "Health problems in the community" to stimulate the trainees to discuss the health problems in their communities. When the trainee VHWs have identified the serious health problems in their communities from the booklet, the trainers help them to learn more about the causes of these problems and how to manage them. The training puts emphasis on the practical aspects of problem identification and problem solving. The trainee VHWs are given plenty of opportunity to practise (UNICEF & PHAL 1983:3).

The VHWs' training is given close to their homes and involves to a minimum disruption of their lives. Some years back training programmes often removed the participants from the rural background where they functioned, to a sophisticated city. There they learned a different way of life and gathered many irrelevant experiences, which made the return to their previous life in the village difficult. The training programme is planned so that there is minimal disruption of farming or other activities and of her home life. In some areas the training is given on one day a

week, and in others during a season when little farming is done (Ministry of Health & Social Welfare, 1978:130).

3.5.6 Supervision of the Village Health Workers

Hanyane (1992:3) explains that VHWs are given supervision on the following: health education and problem-solving, weighing and registration of children, and filling in of monthly reports. The supervision of VHWs is carried out mostly by the clinic nurse, but other parties like the Primary Health Nurse (PHN) and PHC co-ordinators supervise the VHWs as well. Supervision of the VHWs by the PHN or Community Health Nurse (CHN) is very important, because it enhances the motivation of the parties concerned, thus both the trainers and the trainees. Through supervision many mistakes can be rectified and improved by either training or in-service courses.

The Community Health Nurse is responsible for the general supervision of the work of the VHW working in a specific health ward, during the refresher courses at the health centre. She has to prepare the local community before the VHW returns from training. The Community Health Nurse should introduce the VHW to the local headman, other members of the tribal authority, as well as to the community and explain the function and duties of the VHW to them and what they may expect of her. Each Community Health Nurse is issued with a duty sheet outlining her responsibilities in respect of the VHW. It is recommended that she should also spend at least a week full-time in the field with each VHW. In addition she has to visit the VHW's own household, ensuring this is setting a good example to the women in the community. An important aspect of the Community Health Nurse's responsibilities in respect of the

VHW, is to assist her in planning work on a weekly, monthly and annual basis (Mentz, 1989:2).

During supervision the following are undertaken (UNICEF & PHAL, 1983:3):

- Discussion about the community health problems with the VHWs and the health committee.
- In-service training needs.
- Health and record books.
- Digging pits and latrines.
- Checking conditions of toilets, springs, and tidiness in homes.
- Giving advice where needed to the VHWs.
- Visiting people in the village.
- Discussing the accomplishments of the VHWs and planning future activities.

3.6 THE CONTRIBUTION OF THE MINISTRY OF HEALTH, UNITED NATIONS CHILDREN'S FUND AND THE CHRISTIAN HEALTH ASSOCIATION OF LESOTHO IN THE VILLAGE HEALTH WORKER PROGRAMME

In Lesotho the VHW Programme depends to a greater extent on organisations, both within and outside the country, than on the Government. Therefore, it becomes clear that should these organisations decide to withdraw from the health sector, especially financially, many programmes will be seriously affected. Ever since the inception of the VHW Programme in Lesotho the contribution of the Government, particularly the MOH, UNICEF and CHAL has been very important. These role-players have played a very significant role in the awareness, training,

co-ordination and supervision of the VHW programme. The MOH, being responsible for health and social welfare of all the people within the country, tried to provide services for all, but could not manage, hence the intervention of UNICEF as a foreign body and CHAL as a Christian organisation.

UNICEF has been the backbone of the VHW Programme. The fact that it has been through its efforts that the VHW Programme was spread and integrated country-wide, shows beyond doubt that without its contribution this programme would not have been as successful as it is today. From 1992 to 1997, UNICEF contributed to the training of 11 362 VHWs on average of 2 072.4 per year, while other international organisations like United Nations Family Planning Agency (UNFPA) contributed to the training of 1 409 VHWs on average of 234 per year (Sagbohan, 1998:viii). Special credit must, however, be given to UNICEF who has been funding the VHW Programme until the present date, especially the 1997-2001 Health Development Plan.

CHAL has also played a very important role in the VHW Programme. Ever since the colonial era, the Christian community has always cared for the health of the Basotho. Several hospitals and clinics, especially in the rural areas of the country, were built by the missionaries, in particular the Roman Catholic Church. Although other denominations also provide health facilities within the country, when it comes to the VHW Programme, the Roman Catholic missions play an outstanding role (Click, 1998). So for instance, the Ethnomedical Evaluation in Lesotho, 1984-1985 was compiled by the Roman Catholic Paray hospital in Thaba-Tseka. Moreover, many VHW training sessions are held in the Catholic missions, because in almost all their missions in the country,

there are either hospitals or clinics, thus ensuring that PHC is practised in the communities.

Nearly all the Ministry of Health Programmes apply equally to CHAL hospitals and the relations between the implementors of programmes have generally been good. However, whilst CHAL would like to see an increase in the Government's subvention to cover the full cost of salaries and the retention allowance, the Ministry of Health is already operating under severe financial constraints (Sechaba Consultants, 1993:61).

3.7 THE RELATIONSHIP BETWEEN THE VILLAGE HEALTH WORKERS AND TRADITIONAL PRACTITIONERS IN THE VILLAGES

The VHWs play a mediating role between the community and the modern health sector, and could, if given a chance, also perform a similar function between modern and traditional health care practitioners. The reason is that the VHWs are in a better position to deal with what is happening in both modern medicine and traditional healing, because they understand the norms and values involved in each system. However, this does not mean that there are no conflicts between the VHWs and the traditional healers in the villages (Kalaka, 1997).

Since the VHWs emphasise aspects like hygiene, the traditional practitioners are sometimes offended by their ideas in promoting health and made to seem inferior. The VHWs maintain that using a razor blade in the healing process for more than one person is unhealthy, especially nowadays when Acquired Immune Deficiency Syndrome (AIDS) is a serious problem throughout the world. Moreover, the VHWs encourage pregnant women to attend the clinics or hospitals, rather than taking

some traditional herbs, which may sometimes be very dangerous. It is from instances such as these, that conflict ultimately emerges between the traditional doctors and the VHWs. Traditional healers and medicinemen may be antagonistic towards the VHWs, because they see them as a threat to their power and livelihood. Customs and taboos often militate against Primary Health Workers (Djukanovic & Mach, 1975:20).

It is a well-known fact that unresolved conflict has existed for decades between traditional and modern medicine, because both are not prepared to accept the norms and values involved in the other system. In the case of Lesotho several studies, such as the UNICEF and the WHO reports, reveal that in the rural areas of the country there have been constant contradiction and confrontations between the VHWs, who are considered to be modern doctors, and the traditional healers (Kalaka, 1997).

In this regard Maieane (1996:15) asserts that the idea of incorporating both biomedicine and traditional healing in PHC has stirred a controversial debate which has lasted for many years up to the present. However, some countries have tried to bring these two fields together, for example China, but the problem still remains unresolved to a large extent. The main reason is that biomedicine and traditional healing structures, politics, cultures and perceptions are very different, thus the former is urban-oriented and depends on high levels of technology, while the latter is rural-based and does not consider any form of technology as a prerogative at all. The main issue is that unlike modern medicine, traditional healing uses a holistic approach (refer chapter one).

Traditional medicine is the fundamental system of healing of the Basotho who live in the rural areas, and the modern medical system, including the roles performed by the VHWs, is an addition to it. Since many people

in the rural areas still believe in traditional healers, it is essential for the VHWs to co-operate with them. On the issue of whether traditional healers should become VHWs, it was argued that they are "people with full time jobs" who therefore do not qualify to be members in the VHW Programme (Ministry of Health and Social Welfare 1977:16).

The 1978 WHO Declaration implicitly acknowledged the important role that the traditional healers play in looking after the health of their communities. Although the process of amalgamation between traditional and modern medicines seems to be a complex problem, it is imperative that the two systems of medicine are brought together under one umbrella for the benefit of the people they are intended to serve, especially in countries which practise both systems like Lesotho (Jonothan, 1992:5).

The fact that there are some people in the country who consider the VHW Programme to be Eurocentric, while the main intention of the Programme is to provide health care services at the village level, so that each and every member of the concerned villages can participate at affordable cost, affects its implementation in the villages negatively (Molapo, 1998). Kucholl, (1985:16) explains that the WHO has argued that the VHWs could serve as mediators between the health centres and communities, hence the inclusion of services provided by the Traditional Birth Attendants in the VHW Programme. Although TBAs have been highly recommended in the VHW Programme, the situation in some villages in the country is difficult, because there are still some TBAs who prefer to use traditional medicine rather than the kits provided by the Health Centres. Moreover, when certain traditional rituals are performed, the things that the TBAs are encouraged to practise to maintain a healthy life simply do not feature.

3.8 CONCLUSION

The development of PHC and the VHW Programme in Lesotho have been influenced and promoted to a great extent by the Alma-Ata Declaration. Since the delivery of health care services is poor in the country, the VHW Programme was implemented to ease the burden of the Ministry of Health in the provision of health care services, especially in the rural areas. The fact that the VHW Programme makes use of the people in the villages in implementing health policies, makes the delivery of health services accessible to the people who need them most, in this case the rural dwellers. The next chapter relates to the Village Health Worker Programme in the Maseru Health Service Area.

CHAPTER FOUR

THE VILLAGE HEALTH WORKER PROGRAMME IN THE MASERU HEALTH SERVICE AREA

4.1 INTRODUCTION

In this chapter the VHW Programme in the Maseru Health Service Area will be discussed, based on the findings of this study. The following will be considered: The implementation of this Programme, the community perceptions of this Programme, the training of the Village Health Workers, the problems of the Programme, and suggestions for improving the VHW Programme. The VHW Programme in the Maseru HSA will also be compared with those in other developing countries in Southern Africa.

4.2 THE IMPLEMENTATION OF THE VILLAGE HEALTH WORKER PROGRAMME IN THE VILLAGES

The respondents in Ha Foso could not explain exactly when the VHW Programme was introduced to them. The only thing they remembered was that the Programme started some years back under the Basotho National Party (BNP), which ruled Lesotho from her independence in 1966 until 1986, whereas in Ha Thamae the respondents said they knew about the Programme as early as 1986. It is important to highlight that there were some villagers in Ha Thamae who did not know about the VHW Programme at all and were very surprised to find out that it existed in their village.

The respondents in both villages explained that when the VHW Programme was first introduced to them, their chiefs called a general gathering (*Pitso*), where nurses from Queen Elizabeth II Health Service

Area and their Health Centres were present. The nurses as representatives of the Ministry of Health from the Government of Lesotho told them about the aim of the Programme. They therefore encouraged the villagers to participate in the VHW Programme, for the benefit of improving the general health status in their villages. In that manner community participation was encouraged. Such participation has been called the key to PHC, because it is seen as a mechanism to ensure that health beneficiaries become involved in the decision-making process of setting health priorities and allocating resources. According to the WHO *et al,* (1995:01) one way of measuring achievements in PHC activities can be to assess community participation. It was in those *Pitsó*'s that the VHWs and the committees supporting the VHW Programme were elected in both villages. However, there were some respondents in Ha Foso who said they were only informed about the Programme during the VHWs' graduation ceremony at their chief's place.

4.3 COMMUNITY PERCEPTIONS ABOUT THE VILLAGE HEALTH WORKER PROGRAMME

The Maseru HSA is the main centre in the VHW Programme throughout the country. However, the researcher found that the experience of two villages under its management differ to quite an extent. In Ha Foso most of the villagers are aware of the VHW Programme and support it, while the opposite is true in respect of Ha Thamae. The VHWs in both villages appreciate and support the motive behind the VHW Programme, but are very unhappy about its implementation in their villages. The VHWs contend that the implementation of the VHW Programme is ineffective and inefficient and has caused many problems.

In Ha Thamae the negative attitude of the villagers is caused by the fact that the VHWs are not performing their duties as expected, while in Foso the villagers' perception is positive. This is corroborated by Sagbohan (1998:39), who explains that in some villages the use of trained VHWs do not correspond with the community's felt health needs and concerns. In Ha Thamae the villagers assert that the VHW Programme is useless, hence it is not well known in their village. On the other hand, in Ha Foso, the VHWs are considered useful in raising the awareness of the community regarding their normal health concerns and needs. In Ha Foso the VHWs mentioned several reasons for supporting the VHW Programme in their village. Firstly, they argue that **in case of accidents** the VHWs play a positive role by helping the victims with first aid treatment. One villager even gave an example of her child being burnt and the VHW neighbour offering help before they could go to the clinic. VHWs are trained to treat simple, easily recognisable conditions, and to refer the more complicated cases to the health centres (Fourie, 1988:26). The VHWs therefore help the villagers in case of **minor illnesses,** such as headaches and stomach-aches by prescribing appropriate pills and medicine.

Another significant role of the VHWs in Ha Foso is that they **take care of the children under six years of age** by monitoring their growth rate through home visits. **Breast-feeding** is another important aspect emphasised by the VHWs as far as proper nutrition is concerned. Women in Ha Foso are advised to bring their children to the VHWs before taking them to the clinics or hospitals. Lephoto (1997) argues that the VHWs are always available in their villages, unlike doctors or nurses in hospitals who are supposed to take care of many children within a short space of time. The VHWs are the first group to be consulted by the community regarding health matters. Most importantly is the fact that at

this level communication between the VHWs and the community is excellent, because they dwell in the same area. Thus they tend to have many things in common, be it politics, business, religion or anything which will facilitate a harmonious environment for both parties. This situation is unlike that in a clinic, where a nurse or a doctor may be a complete stranger who may not understand the client's background and could therefore be perceived as being somewhat insensitive.

The VHWs also teach and encourage the villagers in Ha Foso about **hygiene,** and inform them about **communicable diseases,** especially sexually transmitted diseases, as well as about the dangers of other diseases. Finally, the VHWs assist many women during their **pregnancy and in labour,** especially those that deliver at night. The villagers maintain that the VHWs have saved many lives in their village and without their contribution many things relating to health, especially at peripheral level, would have been impossible, hence they are important to the health status of the country.

4.4 THE VILLAGE HEALTH WORKER PROGRAMME TRAINING

Training of the VHWs in the Maseru HSA started in the early eighties. The training sessions are held at the Health Centres near the VHWs' villages and last for two weeks. The Ministry of Health and Social Welfare (1978:130) state that when training the VHWs, every effort is made to do this at the health centre or sub-centre in a rural setting identical to that in which they will practise. For example, the VHWs in Ha Foso are trained at the Khubetsoana Health Centre, while those in Ha Thamae are trained at Seabata Health Centre. Khubetsoana and Seabata Health Centres fall under the Maseru Health Service Area and administer the VHW Programme in the villages around them.

There are three types of training in the VHW Programme. The first one is **the initial training,** which normally takes two weeks. Here the trainees are taught basic skills in PHC at household level and first aid in case of accidents. They are also taught to monitor children's growth rate from infancy to the age of six, to help their communities in minor illnesses, such as taking Oral Rehydration Solution in case of gastro-enteritis and assisting pregnant women, especially those who may deliver at home, either accidentally or by choice.

Secondly, there is **a monthly session,** which is optional, and does not bind anyone who feels content in her job. In the monthly session there is nothing much to be done except to emphasise on what the VHWs were taught during their initial training. However, the VHWs are often advised to attend these monthly sessions. Finally, there is **a refresher-training course,** which is supposed to take place annually, but depends entirely on the availability of funds and is therefore not held every year. For the refresher course the trainees are given an opportunity to practise their job at the Health Centres for one day to enhance their understanding, as well as to motivate them. Thereafter, they are asked to show people in their villages what they have learned practically (UNICEF & PHAL 1983:3).

To qualify for training the VHWs are at minimum expected **to be able to read and write Sesotho, as well as to have a good health status.** Since VHWs often have to travel long distances on foot, it is essential that young and healthy people be selected as VHWs (Fourie, 1988:26). However, this is not the case in the villages under study where the VHWs seem to be old. This issue will be discussed later in the text. The VHWs should therefore be free from any illness or conditions, which would impede their work (Ministry of Health & Social Welfare 1977:29). The

trainees are not supposed to pay any fees, because both the Government of Lesotho and the United Nations Children's Fund provide funds for training in the VHW Programme. At the end of every training session the VHWs are usually awarded certificates.

All the VHWs in both villages seem to be very happy with the training sessions in the VHW Programme, because they become knowledgeable in matters relating to health, especially at household level.

It was also found that the trainers hold similar views concerning the trainees. They regard the VHW training programme as very crucial for various reasons. **Firstly,** they regard the training courses as benefiting the VHW herself, because some fundamental skills and experience in basic health care, which would have been somehow difficult to practice without her involvement in the programme, are gained. **Secondly,** the programme benefits the families of the VHWs, because medical service is offered to them free of charge at their respective Health Centres. This is not the case with the rest of the villagers, who are supposed to pay for the same service.

One of the crucial factors that must be noted is that in Lesotho the VHWs are not paid. Thus they render voluntary work, whereby the participants are offered only incentives such as free medical services. Sometimes they are paid in kind, depending on the attitude of the community they are serving. The issue of remuneration and incentives to the VHWs is currently under discussion, indeed, it appears that, together with free medical health services, free education for their children and free seeds and fertilisers could be added to a "package" of incentives which, without providing money directly, would have a positive impact (Sechaba Consultants, 1993:74).

Thirdly, the training programme benefits the villages the VHWs serve, because they teach their communities many things related to good health mainly at household level, as well as advising them on family planning methods, maintaining the slogan used by many health therapists that prevention is better than cure. For example, the VHWs in Ha Thamae are even given condoms and pills to supply the villagers to prevent communicable diseases and unnecessary pregnancies. Hence Chideme (1986:18) argues that the VHWs prevent diseases by using simple, but effective and appropriate technology. **Lastly,** the VHWs' training sessions help the Ministry of Health, because the VHWs bring the health reports from their villages to the Health Centres where they are checked to monitor the state of health in the villages. It is through these health reports that the Ministry of Health is enabled to identify where the problems in the villages are, especially those problems that inhibit the process of developing and extending Primary Health Care in the villages.

It is because of the above-mentioned reasons that the respondents, especially the trainers, feel that the VHW Programme has really improved the health status in many villages. They maintain that the Infant Mortality Rate has decreased in many villages according to the health reports of the VHWs and the Queen Elizabeth II, the main referral hospital in the country. According to Sechaba Consultants (1993:70) in 1993, the Infant Mortality Rate has been falling, and attributes this not only to immunisation, but also better ante-natal and post-natal care. 80% of mothers attend ante-natal care and the majority of them attend at least twice. 61% of all deliveries occur in a health facility and 39% at home. Of the 39%, 73.3% were delivered by a trained TBA/VHW, 22.5% by a relative or friend and 6.1% by a traditional midwife. However, the respondents do not rule out the fact there are still some people in the

villages who are either ignorant or without any interest in the VHW Programme and in a way contribute to its problems.

4.5 THE PROBLEMS OF THE VILLAGE HEALTH WORKER PROGRAMME

In Lesotho, as in other countries, there have been many debates about the capacity of Village Health Workers to assist in achieving health for all. Researchers have identified many weaknesses in community programmes, which have contributed to their failure. These include undemocratic selection procedures, and inadequate training, equipment and supervision. These researchers have also noted in particular the high turnover rate, particularly in volunteer programmes. The causes identified include inadequacies in training and community support, poor supervision and lack of support from the health care system. The unstable political and economic situation was also noted as a cause of weaknesses in programmes (Binidell & Miller, 1992:23). Illiteracy is another factor that must also be considered, because most people who participate and benefit from the community programmes are usually illiterate, as in the rural areas of Lesotho. Illiteracy is still a serious problem in the villages of the country and denies an individual the opportunity of self-actualisation, as well as that of participating fully in social, economic and political development. Such a person is liable to oppression and exploitation (Lesotho Distance Teaching Centre, 1997:2).

The following problems will be discussed in the next section: The poor incentives, structure, medical kits and supervision in the VHW Programme. The impact of politics and the role of chiefs in the VHW Programme will also require attention.

4.5.1 Poor incentives in the Village Health Worker Programme

According to the three categories of respondents in this study, the VHW Programme has many serious problems. The main problem in the VHW Programme revolves around **the financial aspect,** which results in poor incentives from the MOH to the VHWs. The concern of all the respondents is that there is **a lack of motivation** in the VHW Programme on the part of the VHWs, who are actually the backbone of the whole structure. It is true that the VHWs are elected by their communities on a voluntary basis, but other than being helped and encouraged by all the parties involved in the VHW Programme, they are discouraged because they also volunteered. They are therefore expected to work like "good Samaritans" as described by one of the respondents. The VHWs are very dissatisfied about the idea of **volunteerism.**

The VHWs complain that they are exploited and humiliated by both the Ministry of Health and their communities. They assert that in the villages people are not prepared to help them in any way, because they are volunteers. They give them mockery names such as "Jesus followers" who work for "Thy Name" instead of money and must therefore bear the consequences like their Master on the cross. They also say the trainers always remind them that they are not employed, but rather volunteers, which discourage them to continue in the Programme. They argue that from the community's point of view, they appear to be wasting their time, because anybody can actually do whatever they are performing in their, villages. To support this Binidell & Miller (1992:26) explain that the high turnover rate among volunteer workers is partially explained by the lack of motivation. One volunteer worker, speaking of the difficulty of working in a particular area, said that they are told that "After all, you are not

doing such a bad job but then, we do not even get pay. So we just give up, we do not go anymore".

In addition to the examples above, Lund (1993:64) gives a typical story from one VHW who relates how, in line with her duties, she took a person to a clinic with a letter of referral. The clinic sister, overworked, isolated, and with few resources, had run out of the required medication, and took her frustration out on the VHW in full view of everyone else in the clinic. This is abusive and undermining, rather than empowering. In this kind of situation, it was perhaps not surprising to observe a clinic sister scolding the VHW for not taking her notes fast enough, expressing irritation with her slowness in understanding a point, and finishing the session with an instruction to the VHW to go out and work with love. When she had left, the VHW said "She says we must love the community, but she has no love for us in her heart, and we are the community".

4.5.2 Poor policy structure of the Village Health Worker Programme

The VHWs complain that **the policy structure of the VHW Programme** is very poor and biased. They assert that one of the main issues discussed when they were elected, was that their families would benefit from the Programme by means of free medical services at the Health Centres, but unfortunately this was not the case. The main problem is that the majority of the VHWs are old people, on average over fifty years of age, who no longer live with their own children, but rather with grandchildren, who are excluded from the Programme. They say most of the VHWs lost interest in the Programme, because they did not need health care because of good health, but that their grandchildren needed it, but could not benefit from the Programme. Moreover, the villagers complain that the VHW Programme provides services that are not as

important to them, such as the provision of contraceptives, which are mainly used by the young generation who have no interest in the Programme.

4.5.3 Lack of government's support in the Village Health Worker Programme

The trainers state that the Lesotho Government through the Ministry of Health is not taking enough responsibility to make the VHW Programme efficient. The trainers maintain that the financial aspect is very crucial for the sustainability of the VHW Programme in many ways. They argue that sometimes the VHWs are not trained due to insufficient funds. The trainers also find it discouraging to keep on training new VHWs almost all the time, because they drop out of the Programme when better and paying job opportunities come their way. According to Djukanovic & Mach (1975:20) Primary Health Care Workers (also VHWs) in general may be willing to stay in the villages, but they become discouraged by the problems they face and prefer to move to the cities and better-paid jobs.

Moreover, because of limited time and insufficient funds the trainers say that they are not able to sustain continuity in monitoring and supervising the work of the VHWs. It is therefore very difficult for them to evaluate the performance of the VHWs. The trainers argue that there are some VHWs who continue to operate without attending several training courses and want to appear as professional nurses in their villages. This situation sometimes results in serious problems for people at grassroots level, especially the illiterate majority who consider the VHWs to be real doctors and trust them in everything in the medical field. A case in point was experienced in the Gazankulu VHW Programme, where during the interviews it was observed that some villagers (respondents) when using

the word "clinic" were actually referring in some cases to the houses of the VHWs (Mentz, 1989:7).

As it has been indicated earlier in the text, the majority of VHWs are unemployed and in a way depend on the benefits offered by the VHW Programme, which unfortunately are not delivered as promised. **The Village Health Workers** complain that they are expected to attend several training sessions in the VHW Programme, but are not given money for transport. They argue that the Health Centres are not close to their homes and they have to take taxis or alternatively walk very long distances to get there. The VHWs emphasise that it is unreasonable for the Government and especially those who are responsible for the VHW Programme in the Ministry of Health, to expect them to use their money as unemployed and poor to help the villagers who are almost in a similar position. Binidell & Miller (1992:27) point out that Community Health Workers like the communities they live in are impoverished. Requiring them to work without pay, and sometimes with their own resources, is exploitative. The VHWs say the officials promised to reimburse their transport costs for the past years, but this did not materialise. The VHWs maintain that their participation in the Programme costs them financially and emotionally where they are unable to help the people who are desperate for their services, and most importantly in terms of their time, which could be invested profitably somewhere else.

The villagers also regard the main problem in the VHW Programme to be with the Government, which seems to ignore the real facts in most villages throughout the country. They argue that most of the people who need the services provided by the VHWs are either young and unemployed, or old and poor. It is therefore unreasonable to expect these calibre of people to help in the VHW Programme, when the situation is

supposed to be vice versa. Also, some of the villagers maintain that they will never assist the VHWs financially, because they pay sales tax everywhere and it is the Government's responsibility to see to it that the VHWs are satisfied.

4.5.4 Inadequate medical kits and poor supervision in the Village Health Worker Programme

One of the serious problems in the VHW Programme is the poor restocking of **medical kits** used by the VHWs. All the VHWs argue that they are unable to help many people, because their medical kits are not replenished. The only equipment they have was given on their first training session ten years previously. The VHWs say the Ministry of Health promised to upgrade their medical kits, but unfortunately it did not. The VHWs assert that the poor medical kits have diminished their enthusiasm for the Programme. Mentz (1989:6) has argued that poor medical equipment used by the VHWs leads to the problem of loss of credibility. This was also experienced by the VHWs interviewed in this study. At present these VHWs are not able to supply anything more than advice to people who need help.

Similarly in Siavonga the VHWs' support is not good in terms of ensuring adequacy of supplies. Bicycles, which had been promised to ease the transport problems of VHWs, are not supplied. Drug kit supply is irregular and when it happens, it is not based on demand. Mission-supported VHWs are fortunate in having additional drugs supplied by the mission, but again without evidence of such supply based on need (WHO *et al*, 1995:65). The fourth and the sixth elements of the Primary Health care Declaration of Alma-Ata (see p.57) state that the health care sector is only one of the sectors that have to be involved in health planning.

But, as things are now in Lesotho, the various development programmes are not active at the same time in one specific village; so, more often than not, the Village Health Workers promote Primary Health Care alone and when it comes to curing people, they are the only ones who are present. However, since they have no medicines to cure the social and economic conditions of a patient, their help is limited. Strictly speaking, the Primary Health Care which the Village Health Workers provide at present, is only a fraction of the whole Primary Health Care strategy, which is a considerable disadvantage for everybody who is involved in it (Kucholl, 1985:28).

The VHWs also complain about **poor supervision** rendered by the Ministry of Health in the VHW Programme. In this regard Click (1998) states that the lack of supervision results from the nurses at the Health Centres not being trained in Primary Health Care, and so they do not know what and how to supervise the Village Health Workers. Also on this issue Sagbohan (1998:vii) says that the 1998 PHC Evaluation found that 60% of health personnel at Health Service Area and Health Centre levels conducting training are not PHC-orientated, and do not have the required profile, competence and capacities to do training. In both the villages that were studied, the VHWs could not remember when last the nurses from their Health Centres came to supervise their duties, isolating them from the rest of the Health Care team. Sechaba Consultants (1993:75) also regard the fact that the VHWs are not supervised properly, to be one of the major problems of the Programme. This raises particular concerns when it comes to the distribution of drugs. Most Health Centres find it impossible to supervise the VHWs on a regular basis. They have neither the staff nor the transport nor the inclination.

4.5.5 The impact of politics and the role of the chiefs in the Village Health Worker Programme

The unstable political situation in the country is also responsible for the state of the VHW Programme at present. The fact that people are often changed from one department to another in the Ministry of Health and certain health policies altered unnecessarily, but only to suit the interests of the people in power at that particular time, serve to hinder the progress of small programmes such as the VHW Programme. As mentioned earlier in the text, whether co-operation can be obtained and whether any action results, depend to a great extent on the political happenings in a village or the Ministry of Health Department and not on the personality of the Village Health Worker or Primary Health Care Nurse (Kucholl, 1985:48).

Moreover, the VHWs tend to compare the impact of the political parties which were in Government previously with the present situation, some saying that during the Basotho National Party rule, the situation of the VHW Programme was better than at present, while others would say exactly the opposite. People also seem to think that the VHWs should be of the ruling party, otherwise they are considered to be stupid to operate under a Government, which they do not support. Kucholl (1985:43) further asserts that in the villages, the restriction of power leads to the formation of groups who quarrel with each other for political supremacy. As long as these quarrels continue and as long the political leadership is not in favour of Primary Health Care, an easy and widespread implementation of PHC cannot be achieved.

The role of the chiefs in the villages is very important, because people still believe in their supremacy. Any programme that has to be implemented

in the village has to be approved by the respective chiefs, regardless of whether it is favoured by the Government or not. If the chiefs do not support a particular programme, the chances of its survival are very limited. In Ha Thamae, for example, both the VHWs and villagers complain that their chief is not co-operative in the VHW Programme. The VHWs explain that their chief is reluctant to call the village gatherings, which will enable them to improve the poor VHW Programme in their village.

4.6 SUGGESTIONS FOR IMPROVING THE VILLAGE HEALTH WORKER PROGRAMME

In planning programmes such as the VHW Programme, the above-mentioned problems and their effects must be considered. It is in the interest of the MOH and communities to ensure that VHWs do not find their work so difficult that they are forced to leave. The Village Health Worker Programme, which is concerned with the empowerment of these workers and their committees, should ensure that progressive health programme planners are more aware of their difficulties. It seems, from the experience in other countries, that even the basic human rights of the VHWs are ignored by the programmes' leaders (Binidell & Miller, 1992:27). The following suggestions have been put forward by the respondents of this study to improve the state of the VHW Programme in the villages: Improve the incentives and upgrade the services in the VHW Programme; address the political issues in the villages; maintain good relationships with the chiefs; and restructure the VHW Programme in the villages.

4.6.1 Improvement of incentives in the Village Health Worker Programme

The respondents suggest that since the VHWs are not paid, they should at least be given an opportunity to free medical service in all Government and CHAL clinics and hospitals country-wide, unlike at present where they are only served by their respective Health Centres. The VHWs assert that the services offered to them in the Health Centres must not be marginal, thus everything must be covered relating to their sickness, unlike at present where things like operations and serious illness are not covered. Moreover, the VHWs' benefits must not only cover their immediate family members, but other dependants who live with them, usually their grandchildren. As mentioned earlier, the main reason is that most of the VHWs are old and no longer stay with their own children and it is therefore unfair to exclude anybody staying with them and helping them, from their benefits. The VHWs maintain that even though they are not rewarded, if the VHW Programme policy would at least cover their dependants, they would be motivated. Most importantly, the Government must take the responsibility of providing some incentives to the VHWs who are mostly poor and unemployed. It is a fact that many people are willing and to a certain extent able to participate in the VHW Programme in the villages, but unfortunately are too poor to do anything for free. The trainers argue that the Government must increase its budget for the VHW Programme, to enable them to improve the training sessions as well as covering transport costs for the VHWs.

4.6.2 Upgrading the services in the Village Health Worker Programme

The credibility of the VHWs and the programme often depend heavily on the regular availability of essential supplies and equipment (Smith, 1992:120). The poor medical kits of the VHWs seem to inhibit their performance in the villages; hence **the nurses** argue that the Ministry of Health must find the means to regularly restock them. The main reason is that the VHWs are unable to help the villagers in most cases, especially when pills or medicine are to be given. Improving their medical kits will give the VHWs confidence in their work. Their communities will also hold them in higher esteem when they see them applying their training. However, the WHO *et al* (1995:72) are of the opinion that the delivery of drugs to the VHWs should be rationalised. Instead of providing standard drug kits, it would be better to supply drugs according to the needs of the population served. This requires better insight into the actual expenditure of drugs at each health post.

The villagers suggest that the nurses from the Health Centres must come to the villages frequently, to encourage the people to participate in the VHW Programme. More frequent supervision will boost the morale of the VHWs who are not trusted and supported by some people in the villages. **The VHWs** also argue that the visits by the nurses will also enable the villagers to ask the latter about other, complicated medical problems, such as symptoms of cancer or hypertension with which the former are not familiar. The VHWs feel that people with minor illness should not be allowed in clinics and hospitals, but be referred to them, in order that the nurses would only be involved in serious cases. The VHWs' main reason for this idea is that many people will then realise their role in the villages. It will therefore serve as an awareness strategy in the

VHW Programme. The VHWs explain that the whole process would help them to win and maintain the villagers' trust. In view of this Werner (in Davey *et al,* 1995:292) shows that the doctor or nurse as a specialist in advanced curative technology would be on call as needed for referrals and advice. The doctor or nurse would attend to those two to three per cent of illnesses, which lie beyond the VHW's capacity.

The VHWs also point out that the visit of the nurses in the villages will ease the problem of isolation they face in the communities, and probably strengthen their poor relationship with the Ministry of Health authorities responsible for the VHW Programme. Mentz (1989:9) argues that "...of all rural health workers, a lone village based worker is potentially the most geographically and socially and intellectually isolated". It has been shown that this isolation was often done deliberately by those responsible in the Department of Health, but something will have to be done to improve this state of affairs. Without sufficient support from the Community Health Nurse and other medical staff, it is difficult to see how the VHWs can deliver proper Primary Health Care service. The sense of isolation in which the VHW works should be addressed in some or other way, because this is a major contributing cause of frustration and generally leads to a lowering of the already poor standards of health care service she is supposed to give.

4.6.3 Address political problems and maintain good relationship with the chiefs in the villages

It is clear that political factors unquestionably comprise one of the major obstacles to community supportive programmes which favourably influence several factors in the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision-making

and self-reliance at the community level, and that build upon human dignity. This can be as true for village politics as for national politics. The political structure of the country must necessarily influence the extent to which its rural health programme is community supportive (Werner in Davey *et al,* 1995:288). Since politics are inevitable in the communities, it is important to orientate people in this regard. The idea being to show them the importance of working together for the benefit of their communities, regardless of their political differences.

The traditional role of the chiefs is still accorded a high premium in the local villages in Lesotho. If a chief is not positively involved in health planning, common decisions cannot be reached in his village. In order to bring health to the people, it is necessary to have the consent of the chief (Kucholl, 1985:68). For this reason many respondents strongly feel that the general gatherings which are only called with the permission of the chief, can be utilised to inform the people about the progress of the VHW Programme. These village gatherings could also be used to discuss the problems involved in the VHW Programme in the villages, as well as coming up with appropriate solutions when it is necessary. The respondents argue that it is the responsibility of all the people concerned in the VHW Programme to praise the VHWs where they deserve credit and vice versa. The VHWs maintain that this can only be done with the support of the chiefs in the general gatherings where the majority of the villagers will be present.

4.6.4 Restructuring the Village Health Worker Programme

The villagers in Ha Thamae suggest that the services offered by the VHW Programme in their village must be expanded to other health areas. They argue that this would also benefit them as older generation, because at

present the Programme addresses only the needs of the youth, for example by way of the provision of contraceptives. They emphasise that it is very difficult for them to support a programme that does not help them in any way and maintain that a good programme is one which is known, accepted, supported and offers services to everyone in the village in an equitable way. It is for the same reason that Sagbohan (1998:39) suggests that VHWs' training should be based on community needs assessment and address the community priorities and needs that are not directly related to health care delivery.

In order to make the VHW Programme sustainable in the villages, the respondents in Ha Thamae say that the VHWs must be given capital to start and manage the Programme on their own, while getting the same support from the Ministry of Health in training sessions and supervision in emergency cases. The respondents argue that this idea would benefit the villages in many ways. **Firstly,** the people would know for certain that there are people available in the villages at all times to attend to them, unlike going to the Health Centres or hospitals that may sometimes be distant. **Secondly,** the strategy would create employment for the VHWs who could at a small profit sell pills and other medicines, which are normally found in cafes in the villages. The respondents say that unlike in the shops where the people just buy medicine, in the proposed strategy the VHWs would prescribe the right medicine for the sickness as well as explaining the effects of overdose to illiterate villagers who are often in danger of abusing certain drugs. **Finally,** in Ha Foso the VHWs suggest that if the Ministry of Health would give them uniforms (overalls) it would save their clothes when working, especially in case of accidents and labour, and they would look like real professionals. Additionally, the VHWs maintain that they would be recognised as part of

the health structure by the rest of the people, some of whom still undermine their role in their village.

4.7 A COMPARISON BETWEEN THE VILLAGE HEALTH WORKER PROGRAMME IN MASERU HEALTH SERVICE AREA AND OTHER DEVELOPING COUNTRIES IN SOUTHERN AFRICA

The Village Health Worker Programme in the Maseru Health Service Area is similar in many respects to many developing countries in Southern Africa, but differs in the implementation of certain health policies influenced by circumstances prevailing in the country. In Lesotho there are important **internal cultural conditions, which are distinct and peculiar,** such as the role played by the chiefs in the villages, which actually helped shape a different situation in the VHW Programme. In South Africa for example, land is allocated by the Government under the Municipal Department, whereas in Lesotho it is the responsibility of chiefs, hence their influence in the villages.

Additionally, **administratively** in South Africa the VHW Programme is entirely controlled by the Department of Health in each province, but maintaining co-ordination at different levels, namely national and community levels. This situation is different in Lesotho where everything is administered nationally by the Ministry of Health. This shows that the way in which the villages are administered in various countries automatically influences a different scenario in the VHW Programme.

The most important factor is **the financial viability** within the Village Health Worker Programme at village level where it is mostly needed and effective. Given its relatively small size without any significant financial resources, the Maseru Health Service Area is financially too poor to develop a competitive Village Health Worker Programme typical of other

developing countries like Zimbabwe, where the Village Health Workers are even paid monthly salaries by the Government.

The structure of the Village Health Worker Programme in the Maseru Health Service Area is similar to other countries such as Zambia and Zimbabwe, where the Village Health Workers are functional at village level. However, in the Maseru Health Service Area, like in Zimbabwe, the Village Health Workers operate from their homes while in countries like Zambia they function from the Village Health Posts. There are also Village Health Committees, which are found in several countries, but function differently. In the Maseru HSA, for example, the VHCs only advise the VHWs when necessity arises, such as in conflict between the VHWs or in case of any other problems in the VHW Programme, whereas in other countries like Zambia, these committees are assigned specific duties that they have to perform on a daily or weekly basis. In the Siavonga case study, the WHO *et al* (1995:6), explain that the VHCs organise immunisation days, collect remuneration from the community members and monitor the performance of the VHWs.

Training, selection and supervision procedures are also undertaken in the VHW Programme in various countries. However, these are implemented differently depending on the availability of funds from the Government, and on community support. In the Maseru HSA, for example, the duration of training sessions is two weeks, while in Siavonga and Zimbabwe it is six weeks and two months respectively (WHO *et al,* 1995:5 & 11). In addition, in some countries the VHCs are trained. In Lesotho this does not happen. The selection process of the VHWs and VHCs is similar in many countries, where their respective communities elect them. The VHWs in the Maseru HSA are supervised by

the nurses from the Government and mission Health Centres like in Siavonga.

Religious institutions, such as the churches have an instrumental role in the VHW Programme. In the Maseru HSA various religious denominations participate in many ways to support the VHW Programme, for example the Roman Catholic Church trains some of the VHWs in the remote areas of the country. In Siavonga the missions also support the VHW Programme to a large extent, in the form of employing the VHWs in the local mission cooperatives. The VHWs therefore earn monthly stipends for their individual needs. This also helps the VHW Programme, since the VHWs are able to survive through employment organised by the local missions.

Poor medical kits used by the VHWs in the VHW Programme seem to be a common problem in various countries, leading to the VHWs being undermined and less supported by their respective communities. Although in some countries the VHWs are remunerated, **poor benefits** offered in the VHW Programme seem to be the main factor which contributes to the high rate of turnover of the VHWs in several countries, like in the Maseru HSA and Siavonga. The perception among VHWs seems to be that the Government is not doing enough to see to it that the VHW Programme is implemented properly and effectively in the villages.

4.8 CONCLUSION

The VHW Programme in the Maseru Health Service Area seems to have serious problems that need to be addressed by both the communities involved and the Ministry of Health. This will help the Programme fulfil what it has been implemented for, which is to facilitate the delivery of

health care services in the villages of the country. Moreover, if the people who are responsible for the implementation of the VHW Programme could focus on the problems prevailing, probably something may be done to improve the present situation.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter an evaluation of the Village Health Worker Programme in the Maseru Health Service Area will be discussed. The main motive is to find out whether the programme in the Maseru Health Service Area is sustainable or not, with special focus on the villages under study. Conclusion of the whole study will be drawn. Furthermore, recommendations will be given in the light of the results of the empirical phase of this study.

5.2 AN EVALUATION OF THE VILLAGE HEALTH WORKER PROGRAMME

The future of the VHW Programme in the Maseru Health Service Area is very unstable and unpredictable. At present, the VHW Programme faces many challenges, which appear almost insurmountable.

- In terms of the opinions of the VHWs and the nurses at the Queen Elizabeth II hospital, the Ministry of Health **is unable to facilitate appropriate services** required for the VHW Programme.

- Insufficient funds to run and support the VHW Programme **has contributed to the low morale among participants** from the Ministry of Health to the villages. As a result unnecessary problems that serve to seriously cripple the VHW Programme are currently being witnessed.

- The fact that the VHWs **are only women and of the same age group** is a serious problem. The reason would probably be that they constitute the majority of the population in the country, because many men have migrated to South Africa to work in the mines and industries. In most developing countries one usually finds more women than men in the rural areas, because large numbers of men are working in the cities as migrant labours (Boult *et al,* 1997:398). As a result, men and the younger female generation are not represented in the VHW Programme, hence their interests and needs in health care, especially at the village level are being marginalised. Moreover, it is the fact that people of the same age group tend to view things in the same way, hence the VHWs' perception is stereotypical and does not cover other people's interests sufficiently. For example, in Ha Thamae the villagers assert that the VHW Programme concentrates mainly on contraceptives, which are not necessary at their age. It is therefore very crucial that other groups should also participate in the VHW Programme so that their needs can be met as well as men, who are playing a minimal role in health at household level.

- Currently many men are retrenched from the South African mines and industries, and therefore **there is a need to seriously address their predicament within the health context** using programmes such as the VHW Programme. The majority of retrenched workers are rural dwellers and without any job their health status would automatically be negatively affected. The Ministry of Health Reproductive Health Programme has already recognised this and is incorporating male issues in its programme (Click, 1998). Therefore, if all the people can be involved in the VHW Programme, the chances of co-operation amongst villagers are likely to be higher.

- One of the crucial factors to be considered is that **in the urban areas of the country the VHW Programme is not taken seriously,** because of accessible health care facilities. However, the Ministry of Health should not ignore the situation, because it is responsible for the welfare of all the people regardless of whether they are rural or urban dwellers. Sechaba Consultants (1993:74-75) point out that if the prime role of the Government at present is in health education, then the VHW Programme is as necessary in the urban areas as in the rural. Most towns have limited health care facilities and community outreach programmes. In reality, it is very difficult for Community Health Workers to operate in the loose social structures of the towns, but this is not to say they are not needed.

- The Government has to work out the financial source and structure, especially in the Ministry of Health because, if the organisations involved in the VHW Programme at the moment **decide to withdraw, especially UNICEF, which is providing half of the financial resources,** it would probably be the end of the Programme.

- Taking into consideration the fact that **most of the people in the villages are poor,** it is unacceptable to expect them to work for absolutely nothing, be it in terms of benefits or payment. It is true that the VHWs are elected on a voluntary basis, but were promised some benefits from the Ministry of Health which are not delivered, and that played a crucial role in discouraging them in the VHW Programme.

- It is also quite clear that the VHWs are unable to perform their duties as expected, because of **the poor medical kits** and the nurses are discouraged to train the VHWs who always **opt for better job**

opportunities. The villagers also argue that as long as the situation of the VHW Programme is the same in the villages, **there is no one who can volunteer** to undertake the work performed by the VHWs, especially the younger generation.

Although the VHW Programme has many problems, there are still some positive aspects related to its implementation in the villages. Where the VHWs are functional, the villagers are attended to in case of accidents and minor illness as mentioned earlier. Moreover, the VHWs have been responsible for an awareness of communicable diseases and hygiene in the villages. However, the respondents maintain that unless something drastic is done to improve the present situation in the VHW Programme, there is simply no future for it in the country.

5.3 CONCLUSION

The VHW Programme and its implementation in the Maseru HSA has been received with different attitudes. Some failures or achievements of the programme are therefore attributable to such perceptions. In the villages where the VHWs are accepted and supported, for example in Ha Foso, the VHW Programme has managed to improve the health status of the villagers, especially at household level, for example the VHWs monitor the children's growth rate from infancy to the age of five years. However, it is exactly the opposite in the villages where the Programme has been implemented poorly and hence unacceptable, like in Ha Thamae where most of the villagers are simply not interested in the VHW Programme. Their reason is that the VHWs are not performing their duties as expected in the village.

It is very important to note that the VHW Programme has good intentions that would definitely benefit most of the people who are in need of Primary Health Care services, but it has many serious shortcomings. Lack of funds to run the VHW Programme and poor benefits for the VHWs have discouraged the latter as well as the trainers from the Health Centres. Moreover, the VHWs are unable to do their job properly, because of poor medical kits. It is because of the existing problems that the VHW Programme has partially failed to deliver its services in some villages. The VHW Programme in Siavonga in Zambia was mainly used in this study for comparison purposes, especially in the Southern African countries. It was found that the programme in Siavonga was firmly established and the VHWs are even paid monthly salaries, while the situation is quite the opposite in the Maseru Health Service Area. The main concern of the participants is that the Government is not taking enough responsibility to support the VHW Programme, like increasing its budget to improve the current situation, although assisted to a great extent by other organisations, especially UNICEF.

5.4 RECOMMENDATIONS

It can therefore be recommended that it is crucial that the attitudes and perceptions of the people should be oriented towards developmental programmes. The VHW Programme is an example of programmes that develop and improve the lives of the people in the villages. Hence, it is crucial to call the people's attention to the fact that political bickering does not help, especially when all the people are expected to work together for the benefit of their communities. This is an area where the chiefs are expected to play a role as leaders, mainly to bring the people together and encourage co-operation in order to develop their communities.

It is also important for the Government to increase its budget to improve the services offered in the VHW Programme. This would probably help in the poor benefits offered to the VHWs. Training sessions are too short to cover the syllabus and must be extended to one month instead of two weeks. The policy of the VHW Programme regarding the VHWs should be changed. The VHWs must not only be married people, younger persons such as teenagers must be included. In this way it will be easy to mobilise the younger generation and increase their interest in the VHW Programme. This would also help in the sustainability of the programme in the villages, where the respondents of this study clearly pointed out that the VHWs functioning at present are the last group and no one would undertake their roles in the future. Hence one may assert that, unless the health care structure is reviewed and structured differently from what it is at present, especially at peripheral level, programmes such as the VHW Programme have no future for Basotho. The Alma-Ata Primary Health Care Conference in 1978 proposed that there should be proper and appropriate health care facilities for everyone globally by the year 2000, regardless of the country's level of economy. It is merely a dream to consider that Lesotho would be able to achieve the said proposal given the prevailing health care situation.

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APPENDIX 1

LETTER TO THE CHIEF OF HA FOSO

MINISTRY OF JUSTICE & HUMAN RIGHTS
P.O. BOX 402
MASERU 100
TEL: (09266) 322683

DATE: 19/01/1998

THE CHIEF OF HA-FOSO

RE: PERMISSION TO CONDUCT EDUCATIONAL RESEARCH

Dear Chief,

On behalf of my sister, Malika Maieane, currently studying in South Africa, I hereby request you to allow her to conduct an educational research on the topic "Village Health Care" in your jurisdiction on the 26/01/1998. Would you kindly invite five women from your village who are involved in community health care to please participate in the research.

I will appreciate all the necessary support and assistance that the Chief can provide for the succession of this important project.

Yours faithfully,

CHARLES MANTSOE (MR)

MINISTRY OF JUSTICE & HUMAN RIGHTS
P.O. BOX 402
MASERU 100
TEL: (09266) 322683

DATE: 19/01/1998

MORENA OA HA FOSO

RE: KOPO EA TUMELLO PATLISISONG EA THUTO

Morena ea Khabane,

Lebitsong la Khaitseli ea ka e sekolong Afrika Boroa, 'Malika Maieane, ke etsa kopo ka hlompho hore ka letsatsi la la 26/01/1998, u mpe u molumelle ho tla etsa lipatlisiso tsa thuto ea "Bophelo bo Botle Metseng, Motseng oa Hao". Ke tsoela pele hore ke tla kopa Morena hore a mofumanele Bo 'me' ba bahlano hona motseng moo ba ikarabellang ho tsa maphelo a nepahetseng hona motseng moo.

Ke tla thabela tsebelisano e mofuthu eo Morena a tla mpha eona mosebetsing oona o khahlehang.

Oa hao

CHARLES MANTSOE

APPENDIX 2

LETTER TO THE CHIEF OF HA THAMAE

MINISTRY OF JUSTICE AND HUMAN RIGHTS
P.O. BOX 402
MASERU. 100
(09266 - 322683)

Date: 27/04/1998

CHIEF MALEKARE
UPPER THAMAE VILLAGE

Dear Ward Chief,

On behalf of my sister, "Malika Maieane, currently studying in the Republic of South Africa, may you (on my behalf) assist her in any way you can to conduct educational interviews in your area.

Your cooperation in this regard will be highly appreciated.

Yours Faithfully,

Charles .M. Mantsoe

MINISTRY OF JUSTICE AND HUMAN RIGHTS
P.O. BOX 402
MASERU. 100
(09266 - 322683)

Date: 27/04/1998

MORENA MALEKARE
UPPER THAMAE VILLAGE

Morena ea Hlomphehang,

Lebitsong la motsoalle oa ka, "Malika Maieane, ea ntseng a le sekolong Republic of South Africa, ke kopa hore o mo lumelle ho ts'oara lipatlisiso motseng oa hao.

Thuso ea hao ntlheng ena e tla thabeloa haholo.

Lebitsong la Mokopi,

CHARLES MANTSOE

APPENDIX 3

FOCUS GROUP DISCUSSION –GROUPA

(The Village Health Workers)

FOCUS GROUP DISCUSSION GROUP A

THE VILAGE HEALTH WORKERS (VHWs)

1) When did you come to know about the VHW Programme?

2) Where did you receive the information?

3) What are your feelings about the VHW Programme?

4) Have you attended formal training in the VHW Programme?

5) How do you feel about the VHW training?

6) Did you experience any problems in the VHW Programme?

7) What can you suggest to minimise these problems?

8) How do view the future of the VHW Programme in Lesotho?

THANK YOU FOR YOUR CO-OPERATION

APPENDIX 4

FOCUS GROUP DISCUSSION –GROUP B

(The trainers)

Focus Group Discussion Group B

The Trainers

1) When did you start training in the VHW Programme?

2) Where do you train the VHWs?

3) How often do you conduct the training sessions?

4) What level of qualification do you require for VHWs trainees?

5) Are VHWs supposed to pay for training?

6) How do you feel about these training sessions?

7) Do you award certificates at the end of training?

8) Do you think the implementation of the VHW Programme has improved the general health status of the people in the villages? (explain)

9) What kind of problems do you encounter in the VHW Programme?

10) What can you suggest to minimise these problems?

11) What can you say about the future of the VHW Programme?

THANK YOU FOR YOUR CO-ORPORATION

APPENDIX 5

FOCUS GROUP DISCUSSION –GROUP C

(The villagers)

Focus Group Discussion Group C

The Villagers

1) When did you come to know about the VHW Programme?

2) Where did you receive the information about VHWs?

3) Are you satisfied with the services provided by the VHWs?

4) What kind of problems do you see in the VHW Programme?

5) What can be the solution to these problems?

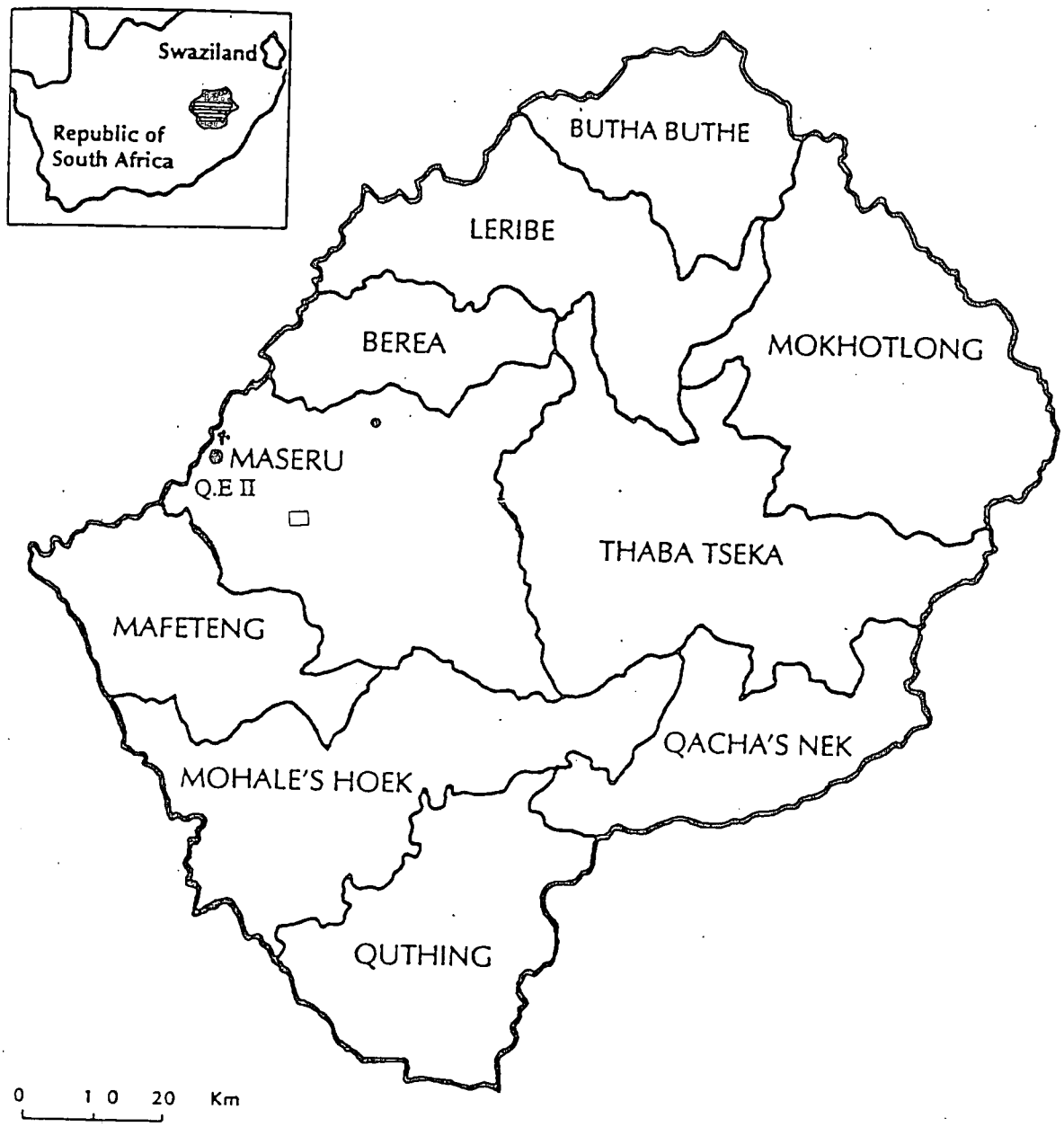
6) How do you see the future of the VHW Programme?

THANK FOR YOUR CO-OPERATION

APPENDIX 6

THE MAP OF LESOTHO

Lesotho Districts - 1986

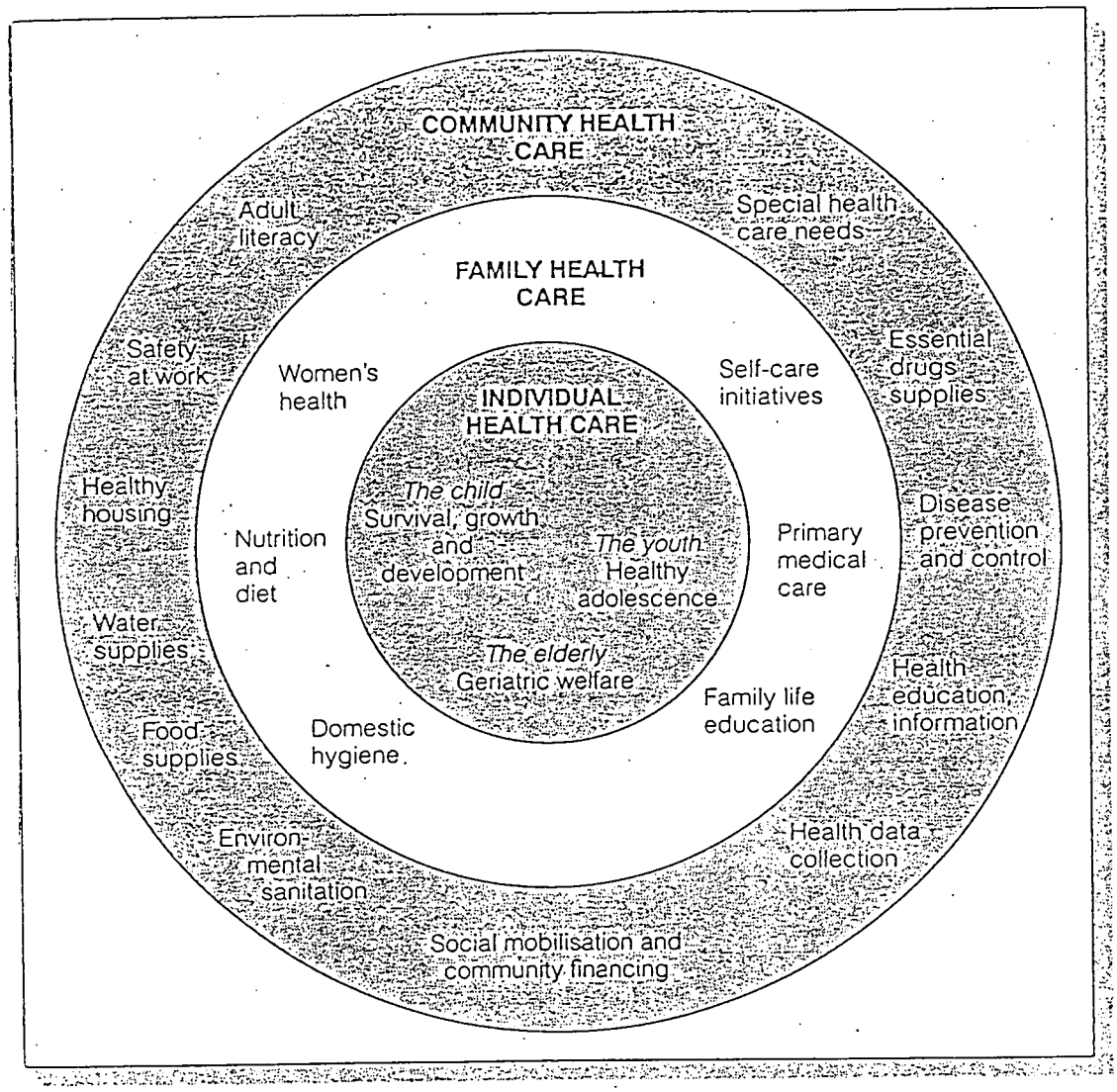


□..... Ha Foso
⚬..... Ha Thamae

APPENDIX 7

PRIMARY HEALTH CARE LEVELS

PRIMARY HEALTH CARE LEVELS

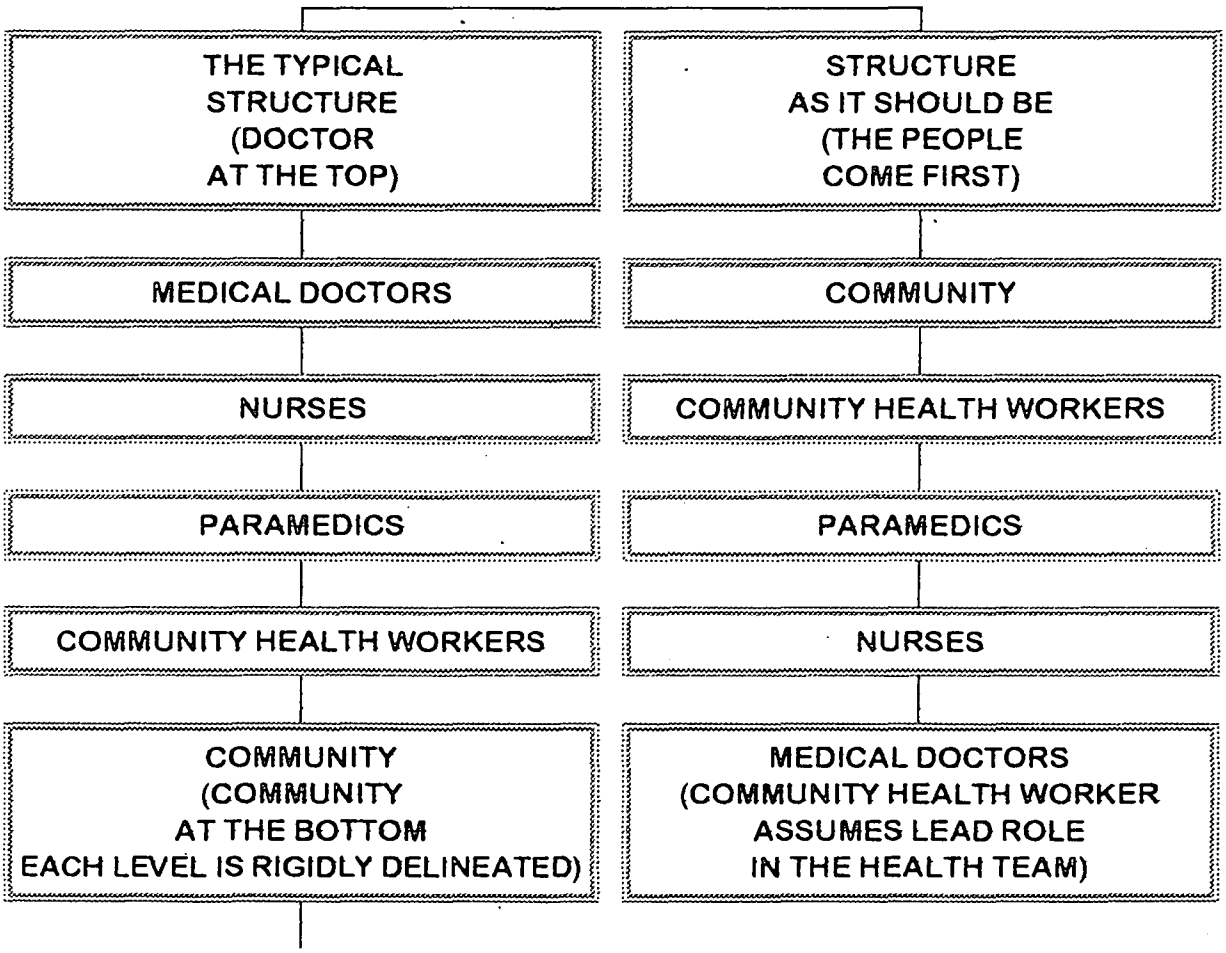


Source: Adopted from Monekosso in Dennill *et al*, 1995:81

APPENDIX 8

THE VILLAGE HEALTH WORKER PROGRAMME STRUCTURE

THE VILLAGE HEALTH WORKER PROGRAMME STRUCTURE

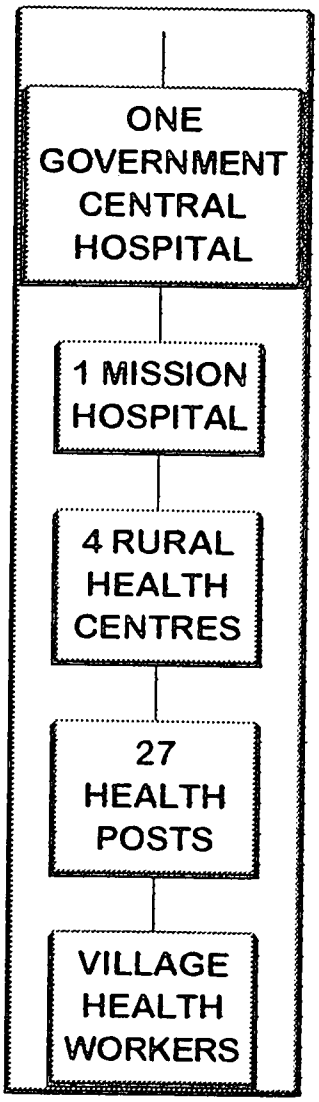


Source: Adapted from Werner in Davey et al, 1995:291

APPENDIX 9

FRAMEWORK FOR THE VILLAGE HEALTH WORKER PROGRAMME IN SIAVONGA

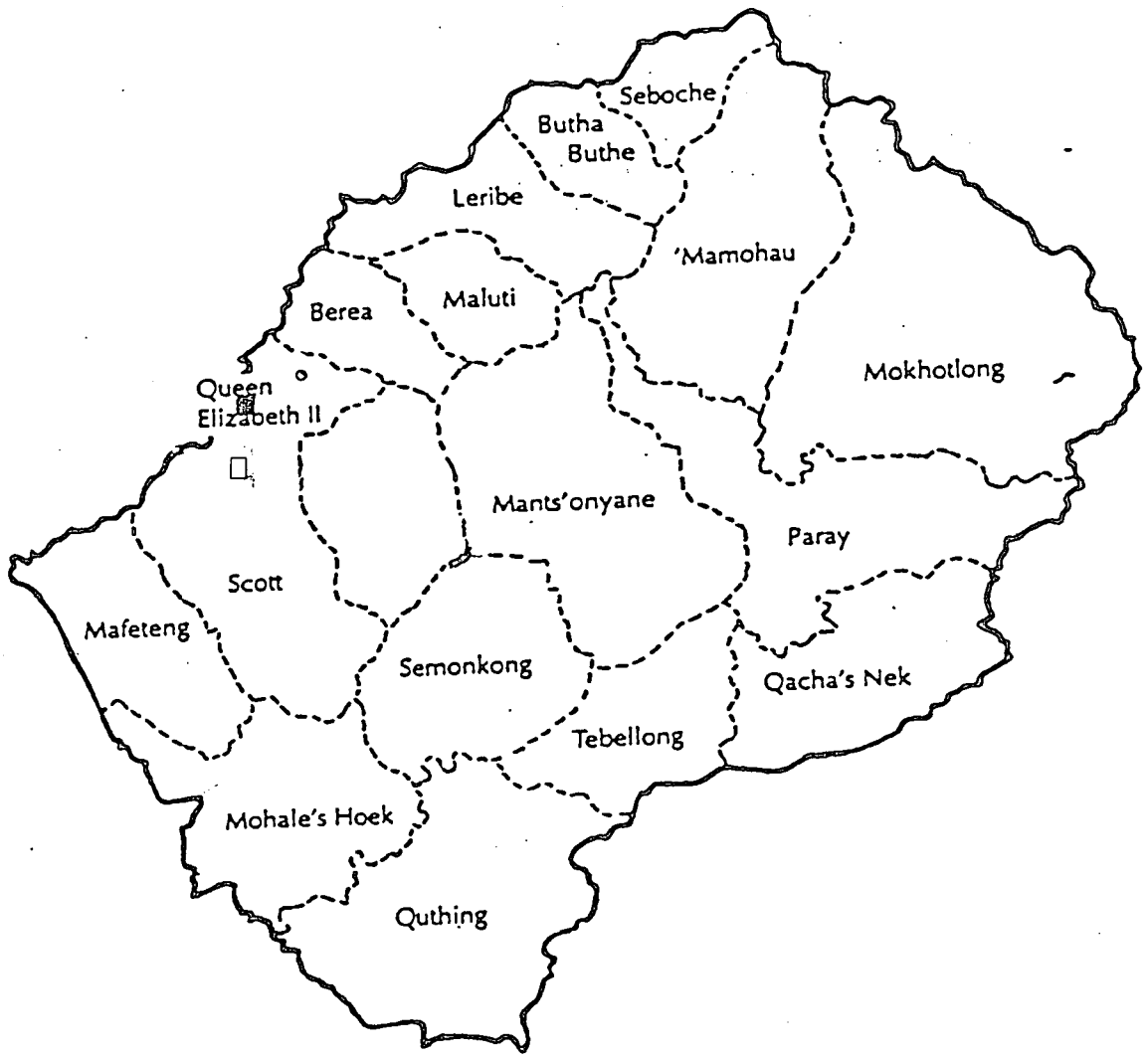
FRAMEWORK FOR THE VILLAGE HEALTH WORKER PROGRAMME IN SIAVONGA



APPENDIX 10

THE HEALTH SERVICE AREA MAP

Lesotho Health Servivce Areas

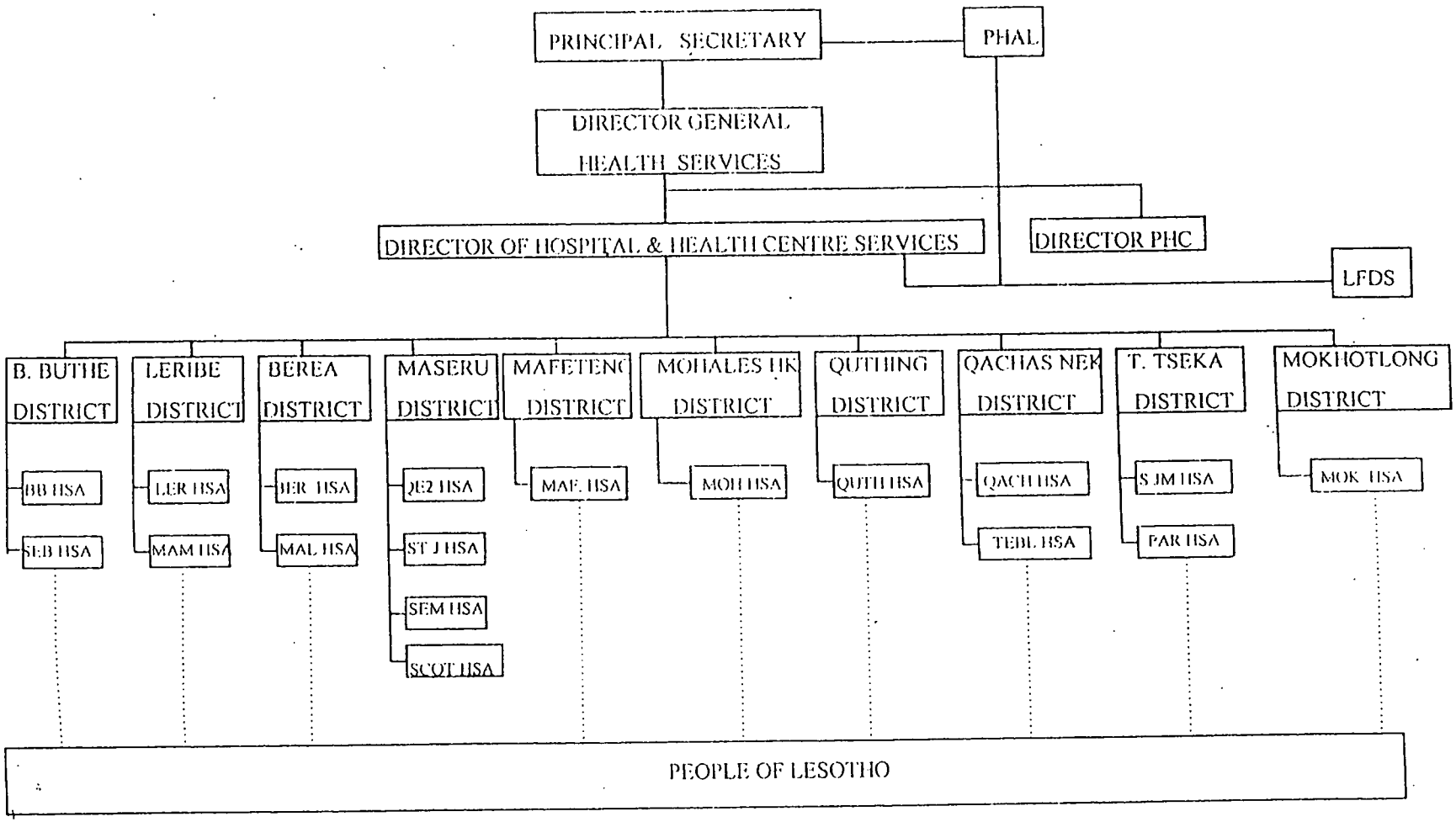


□..... Ha Foso
•..... Ha Thamae

APPENDIX 11

THE PRIMARY HEATH CARE STRUCTURE IN LESOTHO

PHC ORGANISATION STRUCTURE - KINGDOM OF LESOTHO

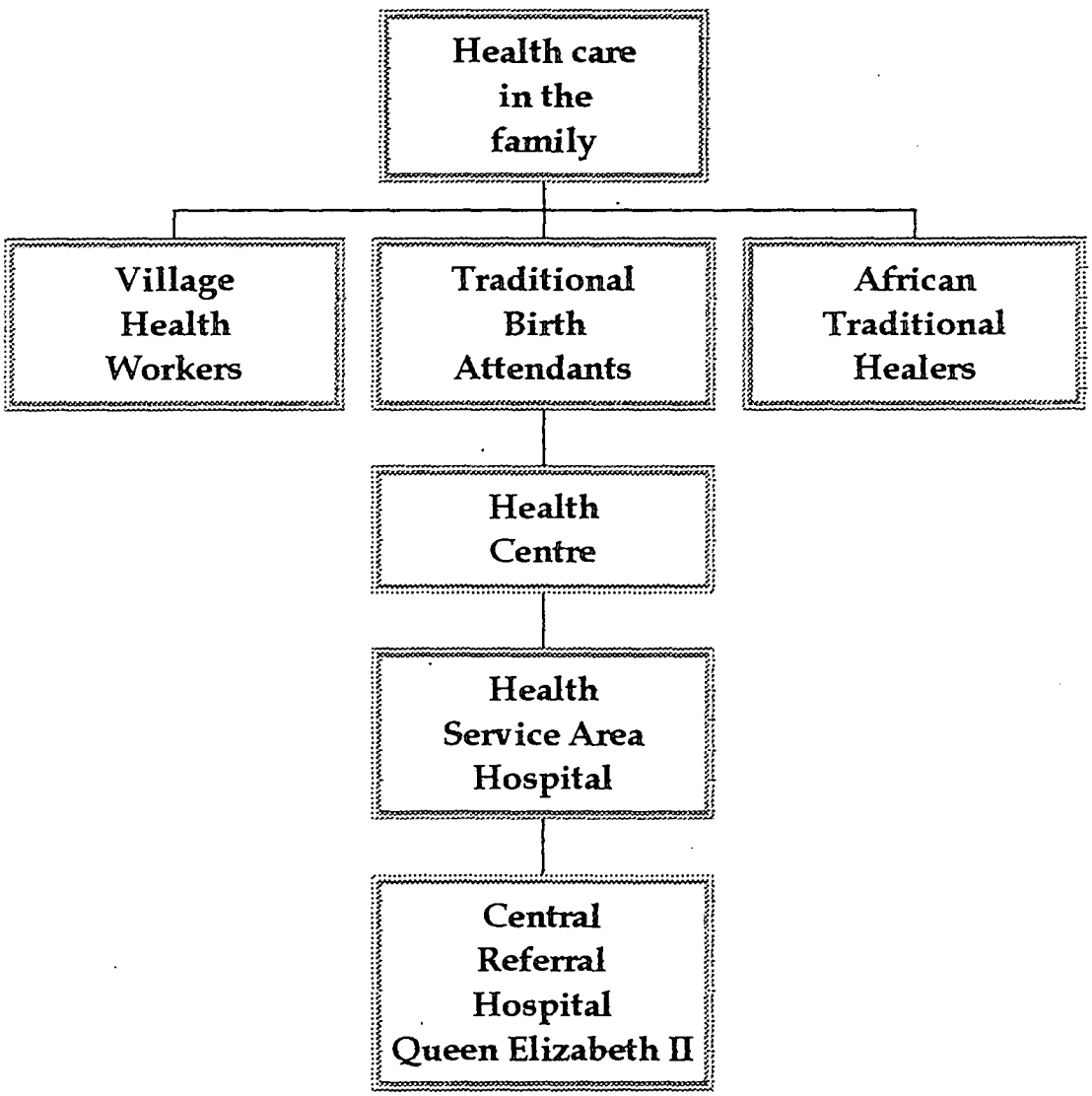


Source: Lekhotla & Liphafa (1995).

APPENDIX 12

THE STRUCTURE OF THE VILLAGE HEALTH WORKER PROGRAMME IN LESOTHO

THE STRUCTURE OF THE VILLAGE HEALTH WORKER PROGRAMME IN LESOTHO



ABSTRACT

Health in Lesotho is similar to many developing countries, where health care facilities are poor. The delivery of health care services is especially poor in the rural villages. The aim of this study was to find out whether the implementation of the Village Health Worker Programme has improved the provision of health care services and the health status in the Maseru Health Service Area. The Village Health Workers' support in the villages and the problems, which may have resulted in poor delivery of services, were also investigated.

In the empirical phase a qualitative survey was undertaken using Focus Group Discussions for three categories of respondents, namely the trainers, Village Health Workers (VHWs) and villagers. The interviews in the villages were arranged with the consent of the chiefs in Ha Foso and Ha Thamae. The interviews with the respondents were conducted in English and Sesotho. The reason was that the respondents in the villages could only communicate in Sesotho, while the VHW staff was proficient in English.

The following factors can be highlighted regarding the Village Health Worker Programme in the Maseru Health Service Area:

- **Firstly,** the greater percentage of Lesotho's population resides in the rural villages. The findings of this study reveal that many people in these villages are old, poor and unemployed. This situation results in poor health status in the villages.

- **Secondly,** the delivery of health care services in the villages is poor. The researcher found that where the Programme was implemented properly, it was accepted and supported by the communities involved

for example Ha Foso. Here the Programme also managed to improve the delivery of health care services, which resulted in a good health status within the community. On the other hand, the opposite was found in the villages that did not support the Programme, for example in Ha Thamae.

- **Thirdly,** the problems in the VHW Programme have affected its implementation in the villages. The respondents asserted that if the aim of the Government is to improve health in the villages, incentives to the VHWs must be a priority.

In the light of the data obtained from the literature study and from the respondents, one may conclude that unless the structure and policies of the VHW Programme are changed to suit the interests of all the people involved, it has no future in the Maseru HSA.

OPSOMMING

Gesondheid in Lesotho is in ooreenstemming met dié van talle ander ontwikkelende lande met swak gesondheidsdienste. Gesondheidsdienslewering is by uitstek swak in die landelike gebiede. Die doel van hierdie studie was om vas te stel of die implementering van die *Village Health Worker*-Program die voorsiening van gesondheidsdienste en die gesondheidstatus in die Maseru Gesondheidsdiensarea verbeter het. Ondersoek is ook ingestel na die ondersteuning van die *VHWs* en die probleme wat tot swak gesondheidsdienslewering aanleiding kon gee.

In die empiriese fase van die studie is 'n kwalitatiewe ondersoek uitgevoer met behulp van fokusgroepbesprekings met drie kategorieë van

respondente, naamlik die opleidingsbeamptes, die *Village Health Workers (VHWs)* en die inwoners van die dorpies. Dié onderhoude is gereël met die toestemming van die stamhoofde in Ha Foso en Ha Thamae. Die onderhoude met die respondente is in beide Engels en Sesotho gevoer, omdat die respondente in die dorpies slegs in Sesotho kon kommunikeer, terwyl die *VHW*-personeel net Engels magtig is.

Die volgende faktore rakende die *Village Health Worker*-Program in die Maseru Gesondheidsdiensarea kan uitgelig word:

- **Eerstens,** die grootste persentasie van Lesotho se bevolking woon in die landelike dorpies. Die bevindinge van dié studie toon dat talle inwoners van die dorpies oud, arm en werkloos is. Hierdie situasie gee aanleiding tot swak gesondheidstatus in die dorpies.

- **Tweedens,** die gesondheidsorgdienslewering in die dorpies is swak. Die navorser het bevind dat waar die Program behoorlik geïmplementeer is, dit deur die betrokke gemeenskappe aanvaar en ondersteun is. Dit was die geval in Ha Foso. Hier het die Program daarin geslaag om die lewering van gesondheidsorgdienste te verbeter, wat ook 'n positiewe invloed op die gesondheidstatus in die gemeenskap gehad het. Hierteenoor is die teenoorgestelde bevind in die dorpies wat die Program nie ondersteun het nie, byvoorbeeld in Ha Thamae.

- **Derdens,** die probleme in die *VHW*-Program het die implementering daarvan in die dorpies belemmer. Die respondente het aangevoer dat indien dit 'n doelstelling van die Regering is om gesondheid in die dorpies te verbeter, moet die voordele van die *VHWs* prioriteit geniet.

In die lig van die data bekom uit die literatuur en van die respondente, kom die navorser tot die gevolgtrekking dat die struktuur en beleid van die *VHW*-Program gewysig moet word om die belange van al die betrokkenes te dien, anders het dit geen toekoms in die Maseru Gesondheidsdiensarea nie.