AN APPRAISAL OF THE COMMUNITY-BASED VOLUNTEER HEALTH WORKERS' PROGRAMME IN LAGELU LOCAL GOVERNMENT AREA, OYO STATE - NIGERIA

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A Dissertation in the Department of Health Promotion and Education, submitted to the Faculty of Public Health, College of Medicine, in Partial Fulfillment of the Requirements for the Award of the Degree of Master of Public Health (Health Education) University of Ibadan.

2005

CERTIFICATION

I certify that this work was carried out by the Very Rev Olusoji Olukunle Mewoyeka in the Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan, Ibadan, Nigeria under my supervision

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DEDICATION

This work is dedicated to the glory of God and to the village yearning for promoting its community health through direct participation.

ACKNOWLEDGEMENT

I acknowledge the grace God gave me to undergo this course, unto Him be the glory, honour, power, majesty, and dominion forever and ever

My profound gratitude goes to my able, untiring, hardworking, understanding and patient supervisor, Professor Joshua D Adeniyi for his great encouragement and advice which were instrumental to the completion of this work

I am indeed very grateful to all members of staff of the department of Health Promotion and Education Prof O Oladepo, Dr I O Olaseha, Dr Ajuwon, Dr Osiname, Dr Fawole and Dr Mrs Adekunle of the Department of Epidemiology, Statistics and Environmental Health I received a lot of encouragement from Prof Mrs Oyemade and Dr Mrs Onadeko I thank Prof R A Elegbe and Prof D D O Oyebola of the Dept of Physiology who several years ago gave me the courage to go for academics

I thank my friends Dr A R A Alada, Dr Y Raji, Dr S B Olaleye, Dr G Ademowo and Dr M O Bolaji

I appreciate in no small measure the supportive role of my wife Mrs Grace Tolulope Mewoyeka, my children Tosin, Yammie and Ebun

I thank the Ven G B Daramola and his family for their support

I also wish to thank all the members of staff of Lagelu Local Government especially, Mrs S D Bello, the Supervisor for VHW and Co-ordinator Maternal and Child Health/ Family Planning, Mrs Oladimeji, the Community Health Extension Worker (CHEW) and co-supervisor for VHW, Mr I O Shittu, the Records and

Biostatistics Officer, Mrs B O Lawal, Head, Monitoring and Evaluation Unit (M&E) and Mr I A Oyelere, the Chief Pharmacy Technician and Assistant Primary Health Care (PHC) Co-ordinator on Essential Drugs

I am quite grateful to Mrs Temitope Malik and Mrs Comfort O Olorode (of the Pathology Dept , UCH) for typing and arranging the manuscript

The study was carried out with funds provided by Dr Olu Agunloye Mr Arowo Ajaja and Engr Fade Iwun

GLOSSARY OF ACRONYMS IN THE TEXT

VHW -	Volunteer Health Worker or Village Health Worker
PHC -	Primary Health Care
PHC -	Primary Health Centre (a place of health facilities where both Health Care and Maternity exist jointly
FMOH -	Federal Ministry of Health
CHEW -	Community Health Extension Worker
WHO -	World Health Organization
LGA -	Local Government Area/Authority
PHW -	Primary Health Worker
BI -	Bamako Initiative
DRF -	Drug Revolving Fund
MCH -	Maternal and Child Health
UNICEF	-United Nations (International Children's) Emergency Fund
SAP -	Structural Adjustment Program
EIPOL -	Environmental Input, Process Outcome, Long range and Product
CIPP -	Context, Input, Process and Product
PTA -	Parent Teachers Association
WATSAN -	Water and Sanitation
ME -	Monitoring and Evaluation
NGO -	Non-governmental Organization
GOBIFF -	Growth Monitoring, Oral Rehydration, Breast Feeding, Immunization, Food Supplement and Family Planning
TDR -	Tropical Disease Research
TBA -	Traditional Birth Attendant
SSS -	Salt, Sugar, Solution
ORT -	Oral Rehyration Therapy
ATO -	Antecedents, Transaction and Outcomes
MCH -	Maternal and Child Health
CBD -	Community – Based Distributors

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ABSTRACT

The Volunteer Health Workers' (VHWs) Programme emanated from the World Health Organization (WHO) Alma-Ata Declaration (1978) Article Six that recognized the people's right and duty to participate individually and collectively in the planning and implementation of their health care. Nigeria embraced this Declaration through its National Health Policy in 1988. The Programme was launched in Lagelu Local Government Area (LGA) of Oyo State, Nigeria in 1992 but has so far not been appraised. The objective of the study is to appraise the implementation of the programme in Lagelu LGA.

The study is descriptive in design and was carried out in Lagelu LGA with approximate population of 88,894. The respondents were all the 60 trained VHWs who had initially volunteered to distribute ivermectin under the Onchocerciasis Control Programme. 5 staff members of the Health Department involved in VHW programme and also two members of the Village Health Committee. Information was obtained through review of records at the LGA Health Department using the Federal Ministry of Health (FMOH) Checklist for Village Health Services, interview of the respondents, observation and review of minutes at the VHWs' Association's Monthly Meetings.

Of the 60 VHWs, 12(20%) were males, while 48(80%) were females. Mean age was 48 years (SD±12). All the females were traders while 10(83%) of the males were farmers. None of the females had secondary education. Also, only 5(42%) of the males went beyond primary education. The 5 LGA staff consisted of a trained Nurse, a Community Health Extension Worker (CHEW), the LGA Statistician, the Pharmacy

Technician, and a Clerical Officer. The 2 Village Health Committee members were the Traditional Ruler and a Chief of Oyedeji Village. The study revealed that the National Health Guidelines of the FMOH were not fully complied with by the VHWs. Hence, there were no records on activities relating to Water, Sanitation and Food Demonstration. The VHWs were observed to be overworked as one VHW served 1,500 people instead of 500 recommended by the Guidelines. None of the VHWs participated in community mobilization for routine or mass immunization activities, as they were not trained for the activities. All the VHWs were asking for remuneration for their services although they came in as Volunteers. Observation at the VHWs Meetings showed that the Drug Revolving Fund Scheme was in place and members restocked drugs from the LGA Pharmacy Store, which had in stock all the drugs in the List of Nigerian Essential Drugs for VHWs. However the VHWs were unable to restock their drug kits during the LGA Workers' Strikes, as a result they were rendered inactive during this period. The Nurse and the CHEW regularly carried out monitoring and supervision fortnightly. One VHW was found to be using his position to legitimize an illegal clinic set up by him. Two of the VHWs reported that two of the VHW's were selling their allocated drugs to peddlers or patent medicine stores. It was also observed that the Village Health Committee was inactive in their scheduled activities such as keeping a drugs account as specified by the Guidelines.

The Appraisal revealed that more VHWs needed to be trained so as to meet recommended ratio of 1:500. Materials for record keeping should be provided and VHWs trained to use them. Monitoring should be intensified to prevent pilfering of

drugs and abuse of privilege to participate in health work by the VHW. Also, the Village Health Committee should be revitalized in their activities.

KEY WORDS: Appraisal, Community, Volunteer Health Worker, Drug Revolving Scheme, and Training.

CHAPTER ONE

INTRODUCTION

Background to the Study

The Volunteer Health Workers' (VHWs') System emanated from Article Six of the WHO Alma-Ata Declaration (1978) which recognized that the people have the right to participate individually and collectively in the planning and implementation of their own health care. The people will appreciate the value of such programme, their ego evoked and they will see the project as theirs, thereby make effective use of it, maintain and sustain the health project or service maximally. In pursuance of this, Nigeria released a document in 1988 tagged, "National Health Policy and Strategy to Achieve Health for All Nigerians". The document has since been revised FMOH (2004)

The Volunteer Health Workers' (VHWs) System was created at the Village level and it involves at least two components – a Local Committee of mainly community – based members and a Volunteer Health Worker. The Committee accepts some responsibility for health matters while the VHWs who are fully community based, are selected from the community on health matters after some few days or a few weeks of training in the fundamentals of treating and preventing disease, thereafter functioning as first level health providers.

The prevalence of disease in a population is greatly influenced by custom, behaviour and mode of living and the permanent reduction of disease will be possible only if changes in the patterns of community behaviour can be achieved. Davey and Wilson (1971). Professed belief is frequently at variance with behaviour, and therefore

enquiries must include observations on what people do in certain circumstances The active co-operation of the people will be forthcoming if the health worker can start by dealing with some subject, which they themselves regard as important, rather than relying on his own list of priorities Sharma (1998)

While launching Guidelines for the Development of Primary Health Care System in Nigeria, the Federal Ministry of Health FMOH (1990) acknowledged that in the Alma Ata Declaration of 1978, Primary Health Care was defined as "Essential Health Care, made universally accessible to individuals and Communities---" It has therefore become necessary to make essential health care (maternal and child health including family planning, immunization, health education, treatment of common ailments, nutrition, etc.) accessible to everyone at a cost that the community and country can afford in the present economic circumstance In most developing countries where health manpower, health facilities and other resources are major constraints, one popular strategy that has been adopted is the training and use of corps of volunteer workers to provide Primary Health Care Services Brieger (1987) The volunteer workers are variously regarded as extenders of health services and agents for educational and developmental change Walt (1990) This strategy is being used in Zimbabwe, Benin Republic, Sierra Leone, Thailand, Cameroun, South America, Asia and Indonesia to mention just a few countries (Frankel 1992) Egypt used it to tackle polio (Esmat Monsour 1995) Burkino Faso used VHW System in its Hygiene Promotion Programme (Valerie and Bernadette 1998) Its use was reported by Van

Balen (1994) in the Kasongo project Lesotho also practiced the VHW System Andriessen et al (1990)

The term "community health worker" only came into use in the 1980s, and in many parts of the world they are still known by other names, such as "Family Welfare Educators," "Health Promoters", "Health Volunteers", "Community Health Aides" or "Village Health Workers" (VHWs) Frankel S (1992)

The Federal Ministry of Health in Nigeria adopted "Volunteer Health Worker" FMOH, Nigeria (1990) The term "Volunteer Health Worker, (VHW)" was used in this project The definition of community health workers (CHW)/ (VHW), adopted by the 1986 Yaounde' Conference was that they should be "members of the communities where they work, should be selected by the communities, should be answerable to the community for their activities, should be supported by the health system but not necessarily a part of its organization, and have a shorter training than professional workers" WHO (1987) VHW provides an ideal bridge between the community and the health sector (Torrance et al 1999)

In the current National Primary Health Care Programme in Nigeria, it was planned that each village and neighbourhood with an urban centre will nominate and have a trained and volunteer health worker (VHW) for approximate 500 people FMOH, Nigeria (1990) The VHWs will work only part – time within the geographical area of that comm unity and may function either from their home or a health post provided by the community The volunteer health worker will know his or her community thoroughly, the number of people, the rough age groupings, health status at any given

point, the number of pregnant women, the number of births and deaths in a given period and other such information that will be vital in facilitating health workers

Also, she/he would attend to those health problems for which she/he had been trained such as mobilization for health actions, treatment of minor ailments, supply of essential drugs and refer cases for which she/he has not been trained, those at risk, and those she/he was in doubt to the first referred health facility The VHWs would function under the supervision of the Village/Neighbourhood Development Community and Community Health Extension Workers (CHEWs)

Problem statement

Volunteer Health Workers' (VHWs) system has achieved much in many countries at different times, but the frequent disappointment with the outcome of the system is often attributed to inadequacies in the VHW concept, or even laid at the door of the VHWs themselves Frankel S (1992) The widespread difficulty in achieving the undoubted potential of this category of worker stem not from medical or other technical problems, but from organization and management issues Frankel S (1992) When success in Primary Health Care is expressed in terms of the numbers of VHWs trained, rather than in the quality of their performance, then 'health for all' becomes 'VHWs for all' and the Primary Health Care strategy using the VHWs is robbed of its spirit and power Matomora (1989, Mburu and Boerma (1989) A report from WHO Study Group (1989) identifies eight areas of weakness, the over whelming majority of which stem from the social, cultural, and management issues that are the necessary and inevitable consequence of VHWs' structural position at the interface between the

health sector and local population Failure to acknowledge these issues fully can only result in an ineffective programme and wasted resources An appraisal of the various aspects of the VHWs system is therefore imperative

Justification for the Study:

Nigeria introduced the VHWs system in 1990 through its Federal Ministry of Health This was 14years ago Between then and now, many things have changed There had been changes in government from the Military at the time the System was introduced to the present Civilian government, with various economic reforms and recessions, new trends in disease patterns, changes in the social lives of the people All these have a direct effect on the health status of the community members especially at grass root level It is therefore necessary to appraise the System in order to reflect the new realities and trends in the national health policy as it affects the grass root particularly within the primary health care delivery services at community level and participation The Local Government Area was the choice of the study area because of the grass root involvement in the VHWs' System

Research Questions

Questions the study intended to answer

- How was the VHW selected and trained?
- How were the activities of the VHW monitored and evaluated and by whom?
- What management support did the VHW receive?
- Was Bamako Initiative on Drug Revolving Scheme practiced?

Any Continuing Education workshop/seminar since training?

Objectives of the study

Broad objectives

To appraise the extent to which the objectives set for VHWs system in Nigeria National Health Policy in 1988 as revised in 2004 had been met and how far the Federal Ministry of Health (FMOH) Checklist for village Heath Services had been implemented

The Evaluation Model of Stufflebeam et al (1971) was used in this evaluation work because it provides four levels at which evaluation of social action could be undertaken namely Context-to inform planning decisions, Input-to serve structuring decisions Process-to guide implementation and Product-to serve recycling decisions

Research Objectives

- The selection and training of the VHW were defective
- The Village Development Committee was moribund in its activities
- There was no adequate Management Support
- Community members did not patronize the VHW adequately
- There was no Refresher Course for the VHW since after training
- VHW rejected financial remuneration despite being volunteer

Limitations of the Study.

Data The study was limited by the non-availability of base-line data Secondary data was used for the study These were the Minutes of the VHWs Association Monthly Meeting and documentaty search The researcher examined all available files and extracted relevant data there from

Map of the LGA The map of the area of study was inadequate Therefore the LGA Demographer was engaged to produce an authentic and acceptable one for the study Area The study had to provide a neat and readable one (Appendix I)

Financial constraints Finance was a major constraint in the study Hence, the scope was limited to the study area The scope may not therefore adequately represent the entire state.

VHWs' population The 60 trained VHWs ,although regarded as small for the study were still used as respondent because they served as 100% of the entire population of VHWS in Lagelu Local Government Area which is the study area (Appendix II)

Definition of terms

(1) The FMOH Health Sector Reform Program 2004 – 2007 indicated that

(i) Consumers' health knowledge and awareness of their rights to the quality care are low.

(ii) The health management information system is weak and it has not been able to provide adequate evidence for policy programme development and implementation

(2) There are no available data to show that this type of evaluation has been done before

CHAPTER TWO

A REVIEW OF LITERATURE

Village Health Worker and Volunteerism

Village Health Workers (VHWs) system is primary health care participation at community or village level. Health is defined as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity WHO (1948) It is the quality, resulting from the total functioning of the individual that empowers him to achieve a personally satisfying and socially useful life. It is a condition under which the individual is able to mobilize all his resources- intellectual, emotional and physical, for optimum living. Article IV of the Alma-Ata Declaration (1978) emphasizes the importance of full participation by the respective communities in order that Primary Health Care could achieve its set objective successfully WHO (1978a) The realization in the past is that communities have been left out in decision-making and actions that have direct bearings on their own health. Through participation, it is thought that the communities can make contributions to improve the quality of decision-making in health actions and also be partners in monitoring and evaluating of these decisions and actions Shaffer (1999), Nickson P (1991). In order to effect this, a bottom up concept of planning from the village to the Federal levels was applied. The Volunteer Health Worker (VHW) is the focus at Village level (Appendix III)

In spite of the failure of most large, centrally controlled programmes to achieve effective community participation in many countries, there are outstanding examples of

enthusiastic community involvement in heahh This is especially true in a "people-centered" or "community-strengthening" approach to health care The powerless are helped to gain strength through a greater understanding of the factors that shape their health and lives Werner and Bower. (1988)

Volunteerism may be taken to mean participation in a project by an individual. group, or community. But there is more to volunteerism than just participating according to WHO (1980). it connotes involvement Therefore community involvement is simply a process to enable people to become responsibility for some decisions and activities in their environment

Volunteering emanated from the idea of strengthening of development process need to attain good life for themselves and communities and communities To achieve this there must be community participation and involvement This is desirable for social. economic and technical achievement WHO (1979) This volunteerism is now seen as a radical means of health improvements for the majority of the world's people Ritkin (1986) This volunteerism in health grows from a tradition that defines heahlr in the context of promoting better living conditions, including improved housing, agriculhure, education, and employment opportunities It also relies on a decision – making process that focuses on community wants rather than a "top-down" process Rifkin(1986) Volunteerism views health as a human condition, and health improvement as a response to any educational process by which community members begin to take control and responsibility for their own health care It expects community participation to be the result of lay peoples' involvement in health care Volunteering,

according to Baldock (1974) is concerned with social life outside two great sets of institution in government and industry. This is what they want and what they would do to achieve it on their own.

The participation of communities in health care partnership means different things to different people. Nantulya (1998) defined it as the process of involving communities in setting their priorities, and planning, implementing and evaluating activities relating to improvements in their own health status. The process entails a truly democratic dialogue with communities, not only is community involvement a democratic right, but also, it should be seen as part of broader social development and utilization of human potential Mills and Kila (1989). The process is empowering, and builds skills and confidence in the people involved. It is also a mechanism of mobilizing human and material resources at local level for health and development efforts. Annet and Nickson (1991).

Community participating is not sporadic and superficial consultation with not-so-representative community forums or with a few top-down appointees from the community. Rampresad (1988). Moreover, it does not imply abdication by government of its responsibilities in providing health services. Community development often starts with people who are concerned about their community, and therefore must be encouraged to participate in the community based health project, for them to appreciate the value of such project. If they were not involved in the planning of such project, the people's ego would not be evoked and therefore would not see the project as theirs, hence they were not likely to use, maintain and sustain the health project or service

maximally Participation is an educational approach. which builds up the confidence and self-reliance of the people However, if the communities who are the users of the health project services are involved in the planning and decisions over the kind of services, the services will probably be more appropriate and more relevant, and therefore may likely be used by the people Rampresad (1988)

Before we can work with the community people effectively, we should try to know the community in terms of its physical environment and the special features that may affect the success of community participation programmes Also, understanding the power structure of a community is an important step in organizing for development

In the traditional health care delivery system, the emphasis was on the development of local health centers and hospitals, which had little or no drugs and personnel The approach was replaced by the concept of "Primary Health Care" at the WHO Conference at Alma-Ata in 1978 which regarded 'Primary Health Care' as 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 in their development in the spirit of self-reliance and determination

The WHO Alma Ata Conference in 1978 extended the notion of appropriate health care beyond that of simply providing decentralized services. It also considers the need to tackle economic and social causes of ill health In a review of the experiences of primary health care initiatives during his period as Director WHO, Mahler indicated

that health education and community participation were essential (and often missing) ingredients of primary health care

Primary health care starts with people and their health problems and since they have a major role to play in solving these problems, they have to be actively involved in doing just that rather than being passive recipients of care from above It is active involvement that most distinguishes primary health care from the kind of basic health services that were so much looked forward to in the past and that subsequently were so disappointing in practice However for people to be intelligently involved in caring for their own health they have to understand what leads to health and what endanger it...the very first element of primary health care is people and communities on health matters

Concept of Volunteer Health Workers' (VHWs) System

The concept of Community Health Workers (CHW), also known as Village Health Workers (VHW), or Primary Health Workers (PHW), derived from the 1978 Alma Ata declaration which stated inter-alia "The people have the right and duty to participate individually, and collectively in the planning and implementation of their health care" WHO (1978a) The people who are concerned about their community are encouraged to participate in the community based health project, for them to appreciate the value of such project This will evoke their ego, make them see the project as theirs, make of them use, maintain and sustain the health project to service maximally The community health workers, being an integral part of the community, fulfill the role of "natural helpers" in this concept Communities in this part of the world live in

Africa) have their indigenous healthcare systems, including self-care, that have long (even before the colonial era) preceded the introduction of allopathic medicine and continue to co-exist with Western models of health service. The notion of involving local volunteers in health care appeals to the health workers who are over-stretched in their duties and lacking in basic resources to conduct needed outreach – especially at the village and sub-urban levels. Inya Krugma-Randolf (1991).

As interpreted by most African Countries accepting the Alma-Ata Declaration (1978), primary health care refers to a voluntary health service created at the village level. This normally involves at least two components – a local Health Committee and a Volunteer Health Worker. The committee accepts some responsibility for village matters and development. Baer and Yoder (1988). These include:

- Choosing candidates to be trained as Voluntary Health Worker (VHW)
- Supervising their activities, and
- Providing material or in-kind assistance to the Voluntary Health Worker (VHW).

The members of the Village Health Committee play a critical role in health education, environmental sanitation, agriculture and infrastructure building. Baer and Yoder (1988) chose the term "development committee" rather than "health committee" to emphasize this interdisciplinary responsibility. Emphasis is placed on the responsibility of the villages in influencing their health. Motivations that appear to work best are those, which raise the social status of the members of the committee.

In general, the Village Health Workers are trained to accomplish four main tasks Baer and Yoder (1988)

Conduct under-five clinics

- Diagnose and treat simple disorders
- Instruct villagers in disease prevention and good nutrition
- Promote community action for environmental sanitation

In Nigeria, the Revised National Health Policy released by the Federal Ministry of Health FMOH (2004) had recommended the establishment of a 'Village Health Committee' (VHC) by the Local Government Authority in every Village where there is no Primary Health Care Centre. The VHC was to mobilize the community for health action, be resourceful for health development, planning for community health and welfare while forwarding such plans to the health facility level. Other duties of Health Village Committee were supervisory role on the implementation of approved health plans, establishment of a village health post, monitoring and evaluation of the impact of the services on the health of the community and the activities of the VHWs. The VHW is the vital link in providing healthcare services to remote areas where access is difficult and where cultural and other reservations to perceived changes in health intervention could be overcome Ransome-Kuti et al (1991)

The Committee would select the Volunteer Health Worker from the village community and to service the village on health matters. These volunteer health workers were given a few weeks of training in the fundamentals of treating and preventing disease, and offer their community one to two hours of health service each

day. They may or may not be compensated by the community but are administratively responsible to them through the committee. They are volunteers Carlaw (1988). These community workers would function as first level health providers in their neighbourhood and refer more complicated cases to the PHC Clinics, most of which do not run a shift duty roster WHO (1991).

This agreed with Schaefer and Reynolds (1989) who noted that these "community health workers, in contrast to specialist in various disease and disciplines, can facilitate provision of integrated health care, can link preventive and curative services, and can collaborate with agents and activities of the sectors." Even though the use of community health workers is central to the PHC strategies of many developing countries, Schaefer and Reynolds (1989) opined that "a number of issues related to the design of effective community health work programmes remain unsolved." Erik Blass (1999) agreed with this opinion.

Constraints to VHW's System

The services that are rendered by the VHW in the community are constrained by their levels of knowledge and skills. Other problems could be attributed to their beliefs that they need to be remunerated and so would not work to their maximum best within the community they live in. Also that VHW's job would hinder/disturb personal occupation and source of income. Some other problems do confront them. These are financial incapability to buy adequate quantity of drug and for transportation during follow-up, partisan politics among members, problems posed by vocal

members, time factor and lack of proper understanding of the role of VHW in the community.

Failure of many national regional community health programmes is not surprising because most are carried out in quite the opposite way. Although their top planners speak proudly of decision making by the community, seldom do the people have much say about what their health workers are taught to do (Werner and Bower 1988). 'Community participation' too often has come to mean 'getting people do what we decide'. Rather than helping the poor become more self-reliant, many national health development programmes end up increasing poor people's dependence on outside services, aid and authority. One of the biggest obstacles to "health by the people" has been the unwillingness of experts, professionals, and health authorities to let go of their control. Werner and Bower (1988) 'As a result, supervisors of VHWs', the Community Health Extension Workers (CHEWs), are made to feel that their first duty is to the health system rather than to the poor. Usually they are taught only a very limited range of skills. The CHEWs become the servants or "auxiliaries" to visiting doctors and nurses, rather than leader for change. Werner and Bower (1988) observed that such health workers learn to follow orders and fill out forms, instead of to take initiative or to help people solve their problems on their terms. Such health workers win little respect and have almost no influence on overall community health. Results have been so disappointing that some experts, even within WHO, have began to feel that the goal of 'health for all through community involvement' is like the pot of gold

at the end of the rainbow – a dream that has been tried, but failed Paul Ostrogen (1995)

The prevalence of disease in a population is greatly influenced by custom, behaviour and made of living, and the permanent reduction of disease will be possible only if changes in the pattern of behaviour can be achieved Community involvement in health prevention is essentially concerned with getting individuals and families to participate in health related activities The promotion of healthier life-style in rural communities is an essential component of health development activities in Nigeria

Role of VHWs

Knowles J. [1995] observed in his study that the community members treatment by VHWs per annum was approximately equal to the treatment given by the hospital out-patients department, so, greatly reducing the hospital's work load and greatly increasing cost efficiency. In a similar way, if VHWs are properly selected according to the rule, adequately trained, supervised, monitored and given all the necessary tools and material to work with, the efficiency of Roll Back malaria, campaign to eradicate AIDS and community health care programme will be greatly increased Appropriate training and utilization have a vital role in the effective performance and utilization of VHWs.

Community Participation

The outcome of maximizing community participation in health work is a function of the extent to which the management of primary health care resources were used and operated by members of community Stephens et al (1990), (when and

Uphoff (1980). From this perspective, operating and being in control of health programmes may serve as an incentive for community members. This position can be used to support the feasibility of providing incentives to enhance participation. In addition to being in control of health programmes as incentive, providing incentives in the form of money and other novel necessities may stimulate participation. As a result, longevity of the community health programme will depend on a combination of factors, mainly community control and ownership, government participation and financial incentive. The use of incentives to increase participation has been recommended by Richards et *al* (1996).

Recruitment of VHWs

It is not uncommon for community-based participation in health promotion projects to be direct consequences of recruitment efforts. A review of the practice of recruitment with respect to public health activities has been considered to be a function of community participation. It is more specifically a function of community contribution, community organization and community empowerment (Doguet A. McVicvar (1990).

The recruitment process may be affected by political, economic, and social factors revealed at the community level. The World Health Organization acknowledged that such determination include, but are not limited to, cultural practices, cognitive responses to changes and other factors that reduce open participation WHO (1991).

Primitive people differ widely in their social, cultural and educational, attainments so that techniques on achieving changes in the pattern of behaviour must

also vary and be adopted to suit the mentality of the particular community Krishna-B Ghimire (1991)

Community ailments (whether endemic or epidemic) cut across religions, ethnic and political barriers Therefore any health programme should be devoid of religions, ethnic and political settings Dhillon (1989) The VHWs system is ideal in such a situation The system as is being practiced in Lagelu Local Government should be encouraged and empowered financially

Enhancing the performance of VHWs through Health Education

Umeh (2000) had recommended the use of VHWs as personnel to monitor the achievement of improvement in home management of malaria With proper selection, appropriate training and retraining, provision of adequate but proper health-material to work with, regular supervision by well-trained personnel, effective monitoring and evaluation Capps and Crane (1989) coupled with respect for the VHWs by doctors and nurses, the VHWs System can be advanced to reduce endemic diseases and prevent "community invasion" by epidemic disease The system should be well utilized in the Malaria/HIV/AIDS Control Campaign Programme It can also function effectively in drug abuse eradication program and some other social vices that have direct effect on the health of the community at large

VHW is a living example of how to demystify medical science The fact that a layperson from the community can treat ailments and give guidance in health-matters helps demystify medicine Secondly VHW's many times use more appropriate words, phrases etc to explain medical points Thus also helps to demystify medicine

All suggestions presented within the context of this appraisal focussed on ways to increase and / or stimulate participation by community members on matters affecting their health through Health Promotion and Education Programmes

Health Education training therefore becomes relevant as a very crucial component of medical-services

Health education by VHW involves propagation of specific, predetermined messages and is intellectually not a very demanding task like diagnosis and management of a whole variety of ailments. Hence this task can be easily carried out by a layperson after a short course for training. However, this is not to suggest that health-education is "easy" or is devoid of theoretical basis. It only means that a short course of training is sufficient to teach the basics of health-education to VHWs

Limited training means cheaper human power. This is a distinct advantage in a poor country. (VHW's honorarium should not, however, be paltry as it is today)

The additional, specific advantage of health-education done through the VHW is that VHW can present the health-messages in a language and in the cultural context which people can understand. S/He can modify the message in a better way than an 'educated' outsider can do

In short, VHWs are in a better position to elicit people's cooperation for community action on health-issues. Such subtle methods may improve the overall implementation as well as enhance the ability to reach stated programme objectives by the VHW system. By extending VHWs' participation in health matters beyond just the diagnosis and treatment of certain ailments in this system, individuals may be more

likely to participate in other health promotion activities – Water and Sanitation (WATSAN), Mobilisation for Mass Immunisation, Food Demonstration, Family Planning Programme, Nutrition, Home Management of Malaria and HIV/AIDS Eradication programme, all of which may use the VHW system to achieve their goal

VHWs as Mobilisers in other Sectors of Community life

At grass-root level, there are some areas where no clear divisions can be seen between health-related and non-health related activities. All programmes can use the VHWs System to enhance participations in community activity that have aftermath effect on health – e g community mobilisation for Agriculture, resolving conflict in the community and any community effort aimed at eradicating social vices among the Youths. If there were a social revolution, VHW would remain relevant for many years even after such social revolution. This is simply because VHWs can be community-organizers, as has been seen in many health-projects

Many VHWs have leadership qualities, which take them far beyond health-work alone. But this role of community leader or community-organizer is not an essential part of the role of VHW. If a VHW can play this role, it is to be considered as bonus

Acceptability of VHWs

The role and scope of VHW in different areas may differ. In areas where modern medical care is not only unavailable, but is also inaccessible due to difficult terrain and lack of proper roads and other facilities, VHWs are more accepted by the

people and would have larger therapeutic responsibilities to share. Secondly, although any VHW has to be part of a health-team in remote areas, VHW's link with the team should be rather loose. In such areas, VHWs have to carry out tasks without direct help from the health-team. According to Adeniyi, J.D. (1988), the selection, training, and recruitment of villagers as primary health care workers are justified as effective means of providing health care to the neglected rural and hard-to-reach urban communities, in which resides about 75% of the African population Adeniyi, J.D. (1988).

On the contrary, in areas where medical services are easily accessible, (peri-urban areas, and developed rural areas) the VHWs are less accepted by the people.

People prefer to go even to quacks for injections rather than take rational advice and treatment from a VHW. In such areas VHW will have to be given other tasks not usually carried by the established medical services. For example, early detection of various disabilities in the community, health education about these disabilities, counseling, etc. This is in addition to the usual training of the VHW. Moreover, in these areas, if VHW's training is upgraded, people will accept their services. Philosophically speaking, VHWs should be useful in all areas, even in urban and well-to-do areas. VHW System should not be considered as a cheap populist measure to create a semblance of health-care for rural areas.

Volunteering work in some parts of Africa.

Fauna (1995) carried out a survey of volunteering work in some parts of Africa and came out with the following list of the activities of 'Volunteers in Work in Africa'

Benin

Environment Volunteers are teaching villagers new tree-growing techniques to produce needed lumber and income, and to fight soil erosion. Volunteers help communities establish tree nurseries to meet their needs rather than cutting down increasingly scarce forests, and are training villagers to build fuel-efficient cooking stoves to decrease the amount of firewood used.

One Rural Community Development volunteer created a women's theater group in her town which presents highly popular shows including health oriented topics, at the same time generating earnings for the women through entrance fees. Another volunteer helped her health center organize and receive funding to train 30 villagers to teach health and nutrition topics to members of their own communities.

Cameroon

Agriculture Volunteers train farmers in new agro-forestry practices that prevent erosion and improve soil fertility, identifying tree species and cultural techniques that work best under local conditions. In 1993, Volunteers trained over 150 women and over 60 men farmers in erosion prevention and soil fertility improvement techniques. Over 70 tree nurseries were established, and Volunteers collaborated with staff from the International Institute of Tropical Agriculture to produce flyers targeted at local farmers on new agro forestry techniques. The health Volunteers conduct training workshops for health workers and community members, and have opened 11

community co-managed pharmacies. One volunteer's team worked with three pharmacies that have excelled and become the pilot facility for their province.

Comoros

Volunteers on the island of Mochli are assisting the National Comorian Environmental Agency in the creation and organization of the country's first marine park. Part of this project includes protecting, tagging, and measuring giant sea turtles.

Cote d'Ivoire

One volunteer living in the Ivorian town of Soubre developed a low-cost medical incinerator, after observing the routine disposal of used syringes, needles and bandages, which was endangering public health. The Volunteer then launched a public education campaign about the importance of proper medical waste disposal. As a direct result, the Ivorian Ministry of Health now requires all new public hospitals and clinics to construct incinerators.

Gabon

Volunteers are working as math and science teachers in rural secondary schools using traditional teaching methods, library development, math clubs, and science experiments to develop problem solving and critical thinking skills. Volunteers are also teaching construction skills as they help students and community citizens build schools, housing for teachers, and classroom furniture.

Ghana

Volunteers in northern Ghana have developed community tree nurseries which produce over one million seedlings a year. Volunteers also direct the growing and out planting of the seedlings in an effort to slow environmental degradation in the arid Sahelian zone. They train local villagers in tree nursery management and out planting techniques with the goal of making village nurseries financially self-sustaining. Two Volunteers founded a women's center which operates a cooperative credit union business classes and a vocational training center for young unemployed girls

Guinea

One Volunteer taught women in eight villages to make and use mud stoves to increase cooking efficiency and reduce consumption of precious wood

Guinea Bissau

Volunteers are working with women farmers on a rice project to improve their yields. Together, the Volunteers and women experimented with different methods to evaluate what works and what doesn't in that area. Based on the findings of their own experiments, the women farmers are now using better seed varieties, they changed planting methods to improve weed control and constructed earthen dikes to better manage their water.

Kenya

Volunteers are working to reduce the incidence of waterborne diseases by improving access to potable water. Through construction of water and sanitation facilities such as water tanks. Volunteers are also training Kenyans in the operation and maintenance of

these facilities, and helping them to adopt improved sanitary and environmental practices. Volunteers built 88 facilities while assisting in many ways, and trained 93 artisans and 176 community members in water tank construction.

Lesotho

Volunteers in Lesotho work on a home gardens project which trains village garden leaders--almost all of whom are women--who then serve as unpaid extension agents in their local communities. In the short life of this project, some 90 women leaders have been trained. Volunteers have also established gardens at 16 schools. They are teaching children irrigation techniques and how to raise poultry and livestock. The children also learn the importance of safe drinking water and the value of a balanced diet. And the gardens supply the students with a nourishing meal every school day.

Environment. Volunteers are working with the Ministries of Agriculture and Environment and directly with dozens of communities on land management, reforestation, soil erosion control, rationalized livestock grazing, and water system development. 77 rainwater catchment systems have been established this year, in addition to numerous dams and boreholes.

Malawi

Volunteers work in urban development projects in four of Malawi's largest cities. In Lilongwe, a Volunteer designs low-cost traditional housing for families who previously would not have qualified for home ownership. He has been asked to replicate his work in a second city. In Blantyre, a Volunteer working as a sanitation engineer and his

Malawian counterpart developed a new design in latrine technology and were invited to present their design at an International Water Sanitation Conference in Ghana

An Environment Volunteer posted along Lake Malawi at Cape Clear is utilizing his talent as a guitarist and travels to villages with his "six-string outreach" program. He educates school groups and communities by singing about environmental issues such "kukukolokoka"(erosion) and "mitengo ili mbwenzi"(the trees are friends of mine). He composed three songs in Chichewa about conservation and the environment

Mali

Volunteers work to improve the health of children by helping rural mid-wives and first-aid workers address maternal and child health problems. In the first two years of the project, Volunteers carried out a survey that identified the local health problems in 35 villages. Survey results will be used by successive Volunteers to develop activities to solve these problems.

Mauritania

Volunteers are developing potable water sources and sanitation facilities, increasing community health awareness about disease transmission by water, and improving methods of treating water. Volunteers have also become participants in the government of Mauritania's efforts to eradicate Guinea Worm by the end of 1995. One Volunteer couple worked with villagers from Tequebeza to construct the village's first well, and then the Volunteers identified funding sources for the second well in the

village. Now there is enough clean water for the needs of the village and the risk of infection from Guinea Worm has been significantly decreased.

One Volunteer introduced the idea of producing and selling fencing made from locally available materials to the Women's Cooperative of Boulematar. This project was an immediate success and the women have since organized classes so that they may be able to better manage their earnings from the project.

Namibia:

In Sangwali in the Caprivi Region, a Volunteer obtained funding for tape measures, scales, vision charts, and auditory testing equipment so that his life science students can have a hands-on approach to clinical health practices, in addition to their studies in nutrition and health education. In the village of Aus in the south, an education Volunteer introduced solar ovens which save scarce cooking fuel and help reduce deforestation. The ovens have created an income-generation project, as local tradesmen are now producing them for sale within the community.

Niger

Volunteers help local communities achieve food and natural resource self sufficiency by improving the management of their land, and find ways to combine environmental conservation and rural development. One Volunteer has become an expert on tube well technology. Tube wells are made of PVC pipe and are the most economical type of well at shallow depths, costing as little as 20% of the price of a cement-lined well. Over the past two years the Volunteer has improved digging tool design, streamlined

installation methods, and conducted several training sessions for Volunteers and their Nigerian counterparts. In 1993, he installed over 40 wells, many with manually operated water- lifting devices. More than 40 Nigerians cultivating dry- season vegetable gardens and fruit orchards have been able to increase their production, and as a result, their income.

Seychelles

A natural forest that once covered over 90% of the Seychelles Islands is being converted to exotic plantations consisting of palm and cinnamon trees planted by commercial interests. To halt the decline, the Forestry Volunteer began a program of seed collection and reforestation with indigenous species in order to maintain the genetic resources of the original natural forest.

Swaziland

Volunteers work with the Ministry of Housing and Urban Development providing on-the-job training to Swazi counterparts. One Volunteer completed a commercial and residential subdivision design for two secondary cities, and updated the development codes for the capital city of Mbabane. Volunteers also provide hands-on training to nearly 100 students each year in needed trade skills such as plumbing, construction, auto mechanics and metal working.

Senegal

Volunteers have helped three villages begin raising Guinea fowl to help increase the

amount of protein in the villagers' diet, and to produce eggs to sell to supplement their income.

Tanzania

Environmental Volunteers are involved in a variety of projects to preserve the world's largest wildlife refuge. In Dar es Salaam, two Volunteers are codifying Tanzanian Environmental Law and have insured the protection of birds being exported by developing quota, handling, and endangered species protection guidelines for government of Tanzania. Two Volunteers have prepared a management plan for Ifeje Forestry Reserve. In addition, a Volunteer assigned to Ngorongoro Crater organized and trained mechanics and initiated the purchase of a community bus for people who would otherwise have to walk great distances to work in the Crater. In Arusha, Volunteers are undertaking secondary projects with their schools and communities in the areas of income generation, environmental and conservation projects, and school improvement projects. Another Volunteer acquired a $100,000 grant for the Malihai Clubs of Tanzania (environmental clubs for schools) to implement wetlands education in the schools.

Volunteers work with village communities to improve school sanitation by building latrines at their schools. Two Volunteers are introducing sex education in the classroom as an initiative to create honest dialogue about growing global problems of teenage pregnancy and AIDS. Two Volunteers have helped their school new forms in building a chicken coop and maize mill which will provide income for the school to purchase

needed supplies. On Zanzibar, Volunteers have begun an evening school teaching English to adults.

Togo

Guinea worm is one of the most debilitating water-borne diseases afflicting a number of African countries. In 1993, Volunteers in Togo trained some 6-10 village-based health workers in guinea worm eradication and other endemic health problems. Volunteers have also developed a village-bases survey which monitors the number of active guinea worm cases throughout the country and provides this important health data to the Ministry of Health.

Another Volunteer in Togo helped a local farming cooperative raise chickens for meat and egg production and use the generated revenues to expand activities into vegetable raising. Volunteers also provide businesses with individualized consulting services on problems such as market identification, product pricing, cost control, quality control, and new business start-up.

VHW programme in some parts of south- west geographical zone of Nigeria

The promotion of healthier life-styles in rural communities is an essential component of health development activities in Nigeria. As a result, it is not uncommon for community-based participation in health promotion projects to be a direct consequence of recruitment efforts. A review of the practice of recruitment with respect to public health activities has been considered to be a function of community participation. It is more specifically a function of community contribution, community organization, and

community empowerment. The interest in guineaworm control for example was mobilized into participation in a pilot project comprising ten farm hamlets. Effort by trained volunteer primary health worker (PHWs/VHWs) resulted in pond water being filtered, wells being dug and disease prevalence dropping to ten percent or less (Akpovi et al, 1981).

Also in Idere, Ibarapa District of Oyo State, organizers of the Control of Onchocerciasis Programme created an environment where the citizens of each social unit took responsibility for selecting their own candidate(s) for VHW training. Local residents were able to provide encouragement and support to enable the VHW to attend training. (Brieger et al 1988). After training, the VHW, along with hamlet or compound leaders was supposed to assume the organizing role and to mobilize community resources to meet needs like well construction, Village sanitation and maintenance of a supply of basic medicines. Their training was based entirely on health education principles (Brieger and Akpovi, 1982/83). Content was derived from real and perceived community needs.

Cultural relevant teaching methods were employed, among others. Training experiences focused on real life problems to enhance role development. This framework of Health Education Interventions to control onchocerciasis itself could be adapted for use on controlling other diseases like malaria especially the "Roll-back malaria" programme. (TDR News no 11 Feb 2001).

In the home management of malaria, VHW was the preferred trained personnel to operationalize the strategy (Uzoeh 2000).

The Primary Health Care Department of the Federal Ministry of Health (1990) released guidelines for the development of Primary Health Care System in Nigeria stating;

(i) the Criteria for selection of VHWs and THAs,

(ii) Job Description;

(iii) Functions of the Village Health Worker.

(iv) Training and equipping them

Criteria for selection of VHWs and THAs.

For LGAs. which have to train Community Based Health Workers, the criteria for selecting such health workers should include the following

- Must reside permanently in the community.
- Must be willing to serve the community at all times;
- Must understand and speak the local language;
- Must be knowledgeable about and share the community's culture, attitudes and beliefs.
- Must command the respect of the community and be accessible to the people.
- Must be preferably married with children;
- Must have other means of livelihood within the community.
- May be literate, preferably, or illiterate.
- Must be as the case with THAs, already practicing and well known.
- Must be matured, age 30 years and above, and

- Where two volunteers come from one village/neighbourhood, one must be a woman

Job Description

- Job Title — Volunteer health worker/Traditional birth attendant
- Location of Job — Sponsoring village or/neighbourhood (name ...
- Duration of Job — Indefinitely – as long as performance is satisfactory and willing to serve
- Remuneration — As agreed upon with the Village Health Committee
- Summary of Function — Promote and maintain personal and community health (VHW) in addition to above ensure good antenatal, delivery post-natal services (TBA)

Functions of the Volunteer Health Worker.

- Mobilize the community to improve health generally.
- Improve personal health, food hygiene and environmental sanitation.
- provide basic preventive and curative care, following Standing Orders.
- keep records of work;
- keep all drugs and supplies securely.
- account for all monies collected from sales of drugs;
- hand all monies collected to the committee's treasurer or supervisor at intervals prescribed by the committee.

- on days of supervision by CHEW, mobilize all children and pregnant women due for immunization,
- mobilize those due for growth monitoring, referral and other services, and
- refer emergency and complicated cases to the supervising Health Facility.
- provide Family Planning Services

Training and Equipping VHWs

- Assigning a supervisor to a group of VHWs;
- Deciding how often VHWs will be supervised;
- Identifying means of transportation for VHW supervisors;
- Making appropriate financial allocations for support and supervision system.
- Obtaining and distributing supervision checklist;
- Obtaining and distributing monitoring and evaluation forms, and
- Making appropriate arrangements for monitoring and evaluation returns

Composition of Village Health Committee: according to the Guidelines was as follows,

- Village head or other respectable person appointed by committee members (as Chairman)
- Primary school headmaster
- Representatives of religious groups
- Representatives of women's groups/associations
- Representatives of occupational/professional groups
- Representatives of NGO's

This membership has since been modified by the Revised National Health Policy (2004) to consist of five members appointed by the Local Government

The Terms of Reference of the Village Health Committee are as follows:

The Committee shall

- Plan for the health and welfare of the community.
- Set achievement local health targets.
- Identify available resources (human and material) within the community and allocate as appropriate.
- Supervise the implementation of developed health plans.
- Monitor and evaluate the impacts of the services on the health status of the community.
- Select appropriate persons----- within the community for training as Volunteer Health Workers (VHWs).
- Select appropriate Traditional Birth Attendants for training.
- Supervise the activities of the Volunteer Health Workers and Traditional Birth Attendants.
- Remunerate in cash or kind, the Volunteer Health Worker for his work in the community.
- Agree with the Volunteer Health Worker the number of hours he shall work per day.
- Establish a village health post.

- Liaise with other officials living in the village to provide health care and other development activities
- Provide necessary support to VHW for the provision of health care services

Village Health Committee Operational Guidelines.

In following, the above terms of reference the committee shall:

- Meet at least once every month.
- Record minutes of meeting;
- Minutes of meetings shall be signed by the Chairman and Secretary after adoption at the next meeting;
- Maintain a quorum for starting meetings.
- The treasurer should record and keep all monies;
- The treasurer should spend money only after approval by committee;
- The treasurer should record all expenditure
- Where there is a Bank Account signatories will be committee chairman, treasurer, and secretary

The Primary Health Care Department of the Federal Ministry of Health (1990) released guidelines for the development of Primary Health Care System in Nigeria. The Guidelines allow VHWs and TBAs to purchase and dispense certain categories of Essential drugs, (APPENDIX IV). VHW collects and pays directly to the Facility that

supervises it on cash and carry basis or submits money collected from drug sales to the Treasurer of the Village Health Committee

Steps for setting up Monitoring and Evaluation (M&E) System at Village level

In order to set Monitoring and Evaluation in the Village, the District Supervisor must do the following

- Mobilize VHW/TBA/Village Development Committee on the importance of M & E Records
- Place home-based records in the homes
- Complete Clinic Master Cards
- Upgrade the knowledge of VHW/TBA on Monitoring and Evaluation
- Supply the TBA/VHW with records of work i e Tally Sheet, Wall Chart, such as Family Planning Profile, Demographic Profile and Maternity Profile

Continuing Education for VHWs/TBAs

The Facility level staff, during supervisory visits to the village health level will identify training needs to the VHW/TBA through the following

- "Observe at work,"
- Work out-put,
- Interview with Village Development Committee,
- Community and Village Head,
- Records of work,

- Information collected from the community, and
- Discuss findings on training needs with the District supervisor
- Plan continuing education programme with the district level staff,
- Conduct training with the district level staff,
- Participate in the evaluation of the training programmes with the district level staff.

Factors that affect a successful implementation of the VHWs programme are the attitude of the VHWs themselves, the Drug Revolving Scheme of the Bamako Initiative, Supervision and Drug Placement/Drug Management skill (storage, pricing and payment), and community mobilization for positive health change in behaviour

Drug Revolving System of Bamako Initiative

Many countries regard health as a basic need and would normally not charge users for health facilities. In recent years however, many developing countries have found it necessary to attempt to recover costs of healthcare, especially for consumables like drugs that are essential for preventive and therapeutic health services (Akademka 1992).

Hull (1986) observed that significant demands, limited funds and high prices combined to frequent shortages of drugs in many public health programmes. Also, Vogel (1989) attributed shortages to the fact that public sector always operate under myriad of constraints and inherent bureaucracy, while religious and other private health facilities have the advantages of better management and access to logistic support

Drug sale strategy in which consumer contributions cover the costs of drugs procure is frequently conceptualized as Drug Revolving Funds (DRF). This strategy allows seed money to be provided to purchase an initial supply of drugs, which are then sold. The proceeds from the sale are used to purchase replacement stocks that are in turn sold. The cycle can be repeated indefinitely without further government allocation as long as the funds recovered from sales are sufficient to purchase replacement stock. Revolving funds are theoretically self-financing, once start up funds has been provided.

To ensure availability of drugs at all levels of health care, DRF emphasizes the need for the people to pay for their drugs in order to sustain the system and ensure self-sufficiency. All too often however, the funds actually recovered are insufficient to replenish supplies and the funds are soon depleted and consequently lead to out-of-stock syndrome.

The drug cost recovery scheme is a commercial scheme with a difference. As a publicly sponsored programme, it is service-motivated, not profit-motivated. Akalemika (1991) noted in support of this idea that it should not have as its objective the recovery of all costs and expenses plus some profit, as in a private commercial pharmacy.

An innovative scheme to solve the drug supply, Maternal and Child Health (MCH) problems of Sub-Saharan Africa through the funding and management of Essential Drugs at community level was introduced was introduced in September 1987 at the thirty-seventh session of the Regional Committee for Africa in Bamako, Mali

African Health Ministers attended the meeting Kanji (1989) According to Kanji (1989) the basic proposal known as Bamako Initiative is that UNICEF, working with WHO, the World Bank and the African Development Bank as well as other bilateral agencies, will provide and use 180 million dollars for the period 1989-1991 to less developed countries in Sub-Saharan Africa for initial launching of development costs for basic equipment required at Primary level health services and a limited number of basic drugs and support costs (supervision, training and social mobilization) during the programme period.

The initiative was based on two small pilot projects, one in the Republic of Benin with 12,000 people and the other in Ghana with 30,000 people Garner (1989) In essence, the initiative aims to improve financing and implementation of PHC through the MCH services in poorly served rural areas by supplying them with essential drugs which would be sold there at two or three times the cost price or amounts sufficient to cover operational costs, including salaries and the replenishment of drugs and supplies. Kanji 1989). The proceeds would be used to establish a revolving fund for drugs and to provide an income for the local community to maintain and develop local primary care including MCH activities.

"The goal of the Bamako Initiative is universal accessibility to PHC. The attainment of this goal would be enhanced through a substantial decentralization of health decision making to the district level, community level management of PHC, user financing under community control and a realistic national drug policy and provision

of basic essential drugs. leading to a self-sustaining PHC with emphasis on promoting the health of women and children". WHO (1988)

According to Hardon (1990) the three main components of the initiative to revitalize PHC in Africa by encouraging three aspects of PHC – community participation, community financing and use of essential drugs are strengthening community capacity; strengthening the essential drug supply system and ensuring the financing of recurrent cost

Establishment of Bamako Initiative in Nigeria

Nigeria is one of the countries adversely affected by the economic restructuring following the crisis caused by the fall in oil prices in the 1980s This led to the adoption of Structural Adjustment Programme (SAP), which began in 1986, and resulted in reduced resources for the public sector. The insufficient funds for supplies, maintenance, logistic supervision and most importantly drugs and vaccines led to a search for alternative ways of financing the health sector. Thus, cost sharing and cost recovery was the guiding principle.

BI strategy which was to strengthen PHC was introduced in 1989 but implementation started in Nigeria in March 1990. FMOH (1991) Most of the infrastructure for the successful implementation such as cost recovery through Drug Revolving Fund System (DRF) and development of managerial capacity though establishment of committees for community mobilization and participation had already been set up. BI does not represent a new development in Nigeria, but it reinforces activities, which were being implemented.

In Nigeria, according to Adeniyi et al (1994) and Mc Parke and Hinson, (1993), drug price-setting mechanism differs from LGA to LGA and from district to district because, the various development committees have been charged to do pricing according to what obtains at their various localities, in commercial pharmacies, in secondary care and in public facilities before finally determining drug prices.

Although, drugs are not only important element in health care they make the health services credible because they cure diseases and alleviate symptoms

Therefore, it is necessary to manage drugs efficiently to ensure constant availability of essential drugs at all levels of the health care delivery system through proper selection, procurement, distribution and use. Drug management is one of the functions that most health workers need to perform. It is easiest to see the process of supply of drugs as a logistic cycle called the Drug Revolving Fund Scheme (DRFS), which is divided into components of drug selection, procurement, storage, distribution and utilization, Aladenika (1991)

Similarly, with the WATER and SANITATION Programme of the VHW system, mosquitoes and enteric fever could be reduced in the community. The System was also of tremendous use in Mass Immunisation Campaign Programme in creating awareness and detecting defaulters among community members. Also the System had been found helpful in Birth Control and Child spacing programme

Since operators of the system were community based and were volunteers, the system could be enhanced to assist in the Government bid to eradicate HIV/AIDS and

in Kicking out Polio. The System should be sustained. It is democracy in health care delivery and participation.

Evaluation of VHW's System.

Evaluation has been defined as a systematic way of learning from experience and using the lessons learned to improve current activities and promote better planning by careful selection of alternatives for future action WHO (1981). It is a fundamental activity aimed at ensuring the satisfactory performance of the health delivery system (FMOH 2004).

According to Bajah, (1978), evaluation generally can be applied in two broad dimensions. An evaluation can be carried out on an entire programme and in parts of a programme.

In recent years, one of the purposes of evaluation is to improve health programmes and the health infrastructure for delivering them and to guide the allocation of resources in current and future programmes. Health programme evaluation which is part of a broader managerial process for national health development, should thus be a continuing process aimed at rendering health activities more relevant, efficient and more effective.

Model of Evaluation

For the purpose of this study, the evaluation framework by Stufflebeam was adopted.

The model provides for four levels at which evaluation of social action programmes may be undertaken. These four levels are: Context, Input, Process and Product.

(a) Context Evaluation, Stufflebeam et al 1971)

Context evaluation is the most basic type. Its purpose is to provide a rationale for determination of operational objectives. Specifically, it defines the relevant environment, describes the desired and actual conditions pertaining to the environment, identifies unmet needs and unused opportunities and diagnoses the problems that prevent needs from being met and opportunities from being used.

Context evaluation has many distinguishing characteristics. It indicates the boundaries of the system to be evaluated and then describes and analysis it. It describes the values and goals of the system by continuous monitoring of the system and a basis for change within the designated environment by identifying unmet needs and unused opportunities. It also looks for a new emerging value orientation outside the system to change the value of orientation within the system.

Context evaluation provides a basis for stating change objectives through diagnosing and ranking problems in meeting needs or using opportunities and it analyses change objectives to determine the amount of change to be affected and the amount of information grasp available for support. Thereby, it provides an initial basis for defining objectives operationally.

(b) Input Evaluation Stufflebeam et al 1971)

Input evaluation is to provide information for determining how to utilize resources to meet programme goals. This is accomplished by identifying and assessing relevant capabilities of the responsible agency, strategies for achieving programme goals and design for implementing a selected strategy.

This information is essential for structuring specific designs to accomplish programme objectives. The end product of input evaluation is an analysis of one or more procedural designs in terms of potential costs and benefits. Specifically, alternative designs are assessed concerning staffing time and budget requirements, potential procedural barriers, the consequences of not overcoming them, relevance of the designs to programme objectives and overall potential of the design to meet the objectives.

Essentially, input evaluation provides information to decide if outside assistance is required to meet objectives, how the objectives should be stated operationally and what general strategy should be employed to implement the selected strategy. Input evaluation is essentially adhoc and micro analytic. Its input in the objective for change established due to needs, opportunities and problems in the context. Its function is to determine how best to meet newly stated objectives. Evaluation asks such questions as: — Are the given objectives stated operationally? And are their accomplishments feasible? What strategies already exist with potential relevance for meeting the established objectives? How can alternative strategies be generated? What are the potential costs and benefits of each several competing strategies etc? These and similar questions indicate the importance of input evaluation data.

Decisions based upon input evaluation usually result in the specification of procedures, materials, facilities, equipment schedules, organizational schemes, staff requirements, materials and budget in proposals to funding agencies. Once a proposal

is funded, input evaluation is performed specifically to aid in programming the activities and events to be employed.

(c) Process Evaluation Stufflebeam et al (1971)

Process evaluation assesses the extent to which procedures are implemented as planned, that is, once a designed course of action has been approved and implementation has begun, process evaluation is necessary to provide feedback to persons responsible for implementing plans and procedures. Process evaluation has three main objectives. The first is to detect or predict defects in the procedural design or its implementation during the implementation stages, the second is to provide information for programme decisions and the third is to maintain a record of the procedure as it occurs.

There are three strategies to be followed in processing process evaluation. The first is to identify and monitor continuously the potential sources of failure in a project. These include but not limited to interpersonal relationships among health staff and consumers communication channels, logistics, understanding of and agreements with the intent of the programme by persons involved in and affected by it and adequacy of the resources, physical facilities, staff and time schedule.

The second strategy involves projecting and servicing pre-programmed decision to be made by project managers during the implementation of a project. The third strategy is to note the main features or the project design, such as concepts to be taught and the amount of discussions to take place and in these terms, to describe what

actually takes place. This information will be useful later in determining why objectives were or were not achieved.

In collecting information, the process evaluator must rely on both formal and informal procedures- intervention analysis, openend, end-of-the day reaction sheets, interviews, rating scales, diaries kept by project personnel, records of staff meetings and suggestion boxes. While the process evaluator should focus on theoretically important variables and use systematic approaches to monitor them, he should also look for any unanticipated but significant events. Then he should use whatever means available to investigate the identified problems.

Process evaluation is a function of the extent to which context and input evaluation have been performed adequately. The more adequate the context and input evaluation, the more certain the project director can be of how well his design will operate and the less critical is the need for process evaluation. When the rationale for the given objectives and design is vague, the project probably is headed for trouble and perhaps failure.

There is interdependency between process and product evaluation. Process evaluation is needed to aid in interpreting outcomes. Conversely, the need for changes in the present process cannot be properly determined without knowledge of what effects it is producing. The decisions for restructuring designs or procedures in process that are based upon process evaluation should be supported by product evaluation information. In summary, under process evaluation, information is delineated, obtained and reported as often as project personnel require such information. This provides

decision makers not only with information needed for anticipating and overcoming procedural difficulties but also with a record of process information for interpreting project attainments

(d) Product Evaluation Stufflebeam et al (1971)

Product evaluation explores the extent to which objectives have been achieved. Its purpose is to measure and interpret attainments not only at the end of a project cycle, but as often as necessary during the project term.

The general method of product evaluation includes devising operational definitions of objectives, measuring criteria associated with the objectives of the activity, comparing these measurements with predetermined absolute or relative standards and making rational interpretation of the outcomes using the recorded content, input and process information.

In summary, Stufflebeam et al (1971) view evaluation as "the process of delineating, obtaining, and providing useful information for judging decision alternates" In essence; Context evaluation is to inform planning decisions while Input evaluation is to serve structuring decisions. Also, Process evaluation guides implementation, and Product evaluation serves recycling decisions.

The most important purpose of evaluation, therefore, is not to prove but to improve.

Product level

- Extent to which National Health Guidelines of FMOH on VHWs are complied with
- Availability of the number of VHWs each to serve required number of community members
- Adequacy of Resources.
- Extent to which Management support is provided
- Utilization of VHW services by community members
- Extent to which VHWs are involved in mobilization for Mass Immunisation programme
- Extent to which Water and Sanitation activities are carried out:
- Extent to which guidelines for selecting VHWs are complied with
- Access to essential Drugs.
- Frequency of Continuing Education programme
- Effectiveness of Bamako Initiative of Drug Revolving Scheme (DRS)
- Extent to which other health related duties are carried out

Context level

- Partial compliance with FMOH Guidelines for VHWs
- Improper constitution of Development Committee in villages
- Inactive Development Committee in Village
- Non-practice of Bamako initiative of DRS
- Non-recognition of VHWs by community members
- Non consultation of VHWs by community members
- No interaction of VHWS
- …nmil members
- …ical members
- …itically-minded members
- …ndrance /Disturbance in personal occupation and source of income
- Inadequate training of VHS.
- Financial constraint in purchasing drugs
- Uneven distribution of facilities
- Lack of transportation e.g. bicycles
- Irregular access to essential drug by trade union workers' strike
- Lack of remuneration
- No promotion of Community action for Environmental Sanitation
- No provision for Growth Monitoring, Referral and other service.
- Non- participation in community mobilization for Mass Immunisation Programme

Process level

- Set up Development Committee in villages
- Select candidate from community members to be trained as VHWs
- Provide materials for record keeping
- Provide equipment for transportation
- Provide suitable container for drug storage by VHWs
- Remunerate VHW in cash and/or in kind
- Drug selection following recognised pattern
- Trained pharmacy Technician to [illegible] the state
- Continuous Education
- Adequate drug storage and set up a drug revolving fund system with separate bank account
- Mobilize community members by VHWs for mass Immunization Campaign
- Establish Monthly Meeting for VHWs
- Environmental sanitation
- Growth monitoring activity
- Water and Food sanitation campaign
- Supervision by CHEW

Input level

- Provision of initial grant to establish Drug Revolving Scheme
- Training of Volunteer Health Worker (VHW)
- Logistic support
- Provision of equipment and supplies
- Organizing the trained VHWs into an Association
- Regular continuing education

Theoretical and Conceptual Framework

The theoretical and conceptual model, which is adapted from Stufflebeam et al (1971), (Appendix V), provides for evaluation at four levels-Context, Input, Process and Products levels – which as described above have been adjusted for application in this appraisal. The context forms the basis for the definition of programme objectives to inform planning decisions, Input-to serve structuring decisions, Process-to guide implementation and Product-to serve recycling decisions.

These were modified for the appraisal of the Volunteer Health Worker's System in Lagelu Local Government Area (LGA) of Oyo State.

CHAPTER THREE

METHODOLOGY

Study Design

This study appraised the performance of Community-based Volunteer Health Workers Programme in Lagelu Local Government Area of Oyo State. Therefore it is a form of Evaluative Study.

In practical terms, the work appraised the following programme elements with selected indicators;

Elements	Indicators
• VHW Establishment	Existence of Village Development Committee
• Quality of Training	Inclusion of Primary Health Care Service, GOBBIF, WATSAN and Health Education in the training curriculum
• Management and organization	Availability and provision of Personnel, Resources, Management Support, Village Health Worker Facilities, Volunteer Health Worker performance, Immunizations, Water and Sanitation services
• Community patronage	Level of consultation by community members
• External Support	NGO (Non-Governmental Organisation) collaboration
• Continuing Education	Refresher courses
• The VHW's Attitude	- Active participation in VHWs' Association -Perceived benefits\constraints of voluntary work

Description of the Study Area.

Lagelu Local Government Area was the study area It had a projected approximate population of 88,894 from the 1991 Census as base Three were 80 public primary Schools (with a population of about 30,000), and 42 secondary Schools (both private and public), with a population of about 10,000. It is bounded in the North and East by Osun State, in the West by Akinyele Local Government, in the South West by Ibadan north local Government and in the South by Egbeda Local Government There are social interactions and belongingness regardless of religious difference among the communities in LGA. It shows that despite the differing system of beliefs (Christianity, Islam and African traditional religion), the extended family system is still maintained and there is still a certain obligation to one's relatives and fellow villages that has not been lost despite the gradual westernization of the people The youth of all ages do interact with one another, house-to-house, compound-to-compound and village-to-village (especially during festivals and other occasions like naming, burial and house warming)

People share materials including food and clothing during festivals when they eat, dance and sleep together in large numbers

The climate is characterized by high humidity and substantial rainfall Lagelu L.G.A is very rich in human and natural resources It is blessed with tracts of land suitable for cash crops such as cocoa, kolanuts and palm products Majority of the inhabitants are farmers who earn their living from cocoa, plantain, cassava, and palm products. Major occupations apart from farming are, trading (marketing) and artisan

jobs like sewing, carpentry, blacksmithing and brick layering. All the functional capacity and activities of the L.G.A. are geared towards maintaining peace and order for the good health and welfare of its citizenry.

The L.G.A. is sub-urban with over 42 villages and hamlets. Some of the notable towns include Lalupon, Ejioku, Iyana Ore, Iyana Church, Ohorunda, Oyedeji, Olla Igbo, Elegbaadan, Alegongo-notable in the sense that they all Primary Health Centres (PHC's). In addition to the 9 PHCs above, there were 12 Health Clinics at Orita-Dagbolu, Sagbe, Abuduro, Apateere, Akitiko, Olowade, IdiAgba, Jagun, Oteda, Oghuro, Iyana Offa, and Idi Ogun. (See Map of the LGA, Appendix I). The LGA was divided into 7 Health Districts for the purpose of distribution of PTA Drugs. The Health Department had five units, which were Maternal and Child health, immunization services, essential drugs, health education\Water and Sanitation (WATSAN), and Monitoring and Evaluation (M&E). It was headed by the most Senior Health staff (a Nurse at Matron level) designated PHC Co-ordinator who had an assistant to oversee the activities of the VHWs. The Chief Pharmacy Technician is the Assistant PHC Co-ordinator who kept the custody of the PTF Essential Drugs until they were purchased on the principle and practice of the Bamako Initiative as co-ordinated by the Nursing Matron with the Executive members of the VHWS' Association in attendance. The next level of operation at the L.G.A. level is the Districts with the most senior member of the Districts health team as Supervisor-otherwise called "Super-" in the Lagelu L.G.A. The VHWs\TBA function at the lowest level of operation in the Village/Community. (Appendix III shows the ORGANOGRAM)

Sampling

The 60 trained VHWs who had initially volunteered to distribute ivermectin under the Onchocerciasis Control Programme in their respective communities (see Appendix X), 5 staff members of the LGA Health Department involved in VHWs programme, two members of the Village Health Committee and twenty -two village heads were interviewed.

In view of the existing structure at the L.G.A., four categories of respondents were targeted in this study.

They were:

(i) Village Health Committee. This is the body set up to oversee the VHWs in order to progressively improve the effectiveness and efficiency of the System. It was therefore included so that its activities could be appraised.

(ii) L.G.A. Health Department workers in charge of monitoring of VHWs. This Department serves as the Local Government Primary Health Authority to support and ensure that every Local Government is involved in the development and provision of health services in the community through advocacy and continuing education programme for health workers (FMOH 2004). -Its role in community health care provision was therefore appraised in this work.

(iii) The Volunteer Health Workers. The volunteer workers were variously regarded as extenders of health services and agents for educational and developmental change (Walt 1990), focusing at village level. They were for this reason included in the study.

(iv) Village Heads were included because of their influence on the people, together with the cultural values and religious belief of the people especially on causes of disease and health matters.

Village Health Committee

As specified by the FMOH Guidelines in the VHWs System, the Village Health Committee was to comprise of village head or other respectable person appointed by Committee members as chairman, primary school head teacher, representative of religious groups, representative of women's groups\associations, representatives of occupational/professional groups and representatives of Non-Government Organisations (NGOs). The Executive members of the VHWs Association were requested for a visit to the Village Head who was the Chairman of the Village Health Committee (VHC). Four other members of VHC, who were called upon when going, accompanied the visit. It was on a market day.

LGA Health Department Workers.

The sample included the PHC Co-ordinator who was a trained Nurse and the assistant who was a CHEW, the Supervisor, the Chief Pharmacy Technician, the LGA Statistician, the LGA Community Health Officer (CHO), a Clerical Officer and the Local Inspection Education (LIE) Office

The Volunteer Health Workers (VHWs)

All the 60 trained VHWs were recruited as respondents in this study because of the fact that there number was already far below expected, relative to the population of the community (APPENDIX II)

Community Members opinion. This was done by paying a visit each to twenty-two (22) village heads to assess any knowledge of the existence of the VHWs within their respective village communities. Health care services are expected to be provided for different categories of members of the communities. Opinions of health care seekers are highly essential to be able to improve performance. The major objective of the VHW's System is to bring health care facilities to the grassroots, making it participatory by the user themselves in order to reduce maternal and infant mortality rates. Thus, the study considered community members to find out if they were aware of the existence of the VHWs' System and whether or not they were utilizing health facilities as provided by the system. This was done through visits to twenty – two village

Instrument Design

(a) The following instruments were used for data collection

(i) Demographic Data: All the trained 60 VHWs were respondents. Of the 60 VHWs, 12[20%] were males, while 48[80%] were females. All the female were traders while 10[83%] of the males were farmers. None of the females had secondary education, while 5[42%] of the males went beyond primary education. Mean age was 48years (SD±12)

(ii) Observation during Monthly meetings of the VIIW's was corroborated through Home visits to some VIIWs to see how they were being patronised for health purposes and how the patronage is carried out. This was to validate the information given at the monthly meeting of the VIIW Association.

(iii) The Checklist of the Federal Ministry of Health Guidelines for village Health Services (Appendix VI) was used for the record review, as the checklist was considered adequate, standard, intensive and extensive in design.

(iv) A Questionnaire (Appendix VII) designed to obtain information on

- The factors which encouraged VIIW's involvement in the system
- The VIIW's knowledge of the objective of the system
- The extent to which the VIIW had participated in the system
- The community involvement in the System
- The role of LGA staff members in the implementation of the programme with particular reference the Continuing Education
- How the LGA staff had been keeping record of events as it affected the VIIWs activities in the LGA

(v) An observation check-list to assess the performance of VIIWs on,

- System of drug procurement (the Bamako Initiative);
- Relationships among members,

- Storage of drugs;
- Management of the Drug Revolving Fund.
- How conflicts were managed and resolved among members

Observation. The VHWs had constituted themselves into an Association that met once a month (at every first Monday of the month) The Investigator attended seven meetings

A number of steps or procedure was adopted to enhance the sensitivity of the instruments for data collection. These are means of ensuring that the instruments of data collection are sensitive enough to collect accurate information from respondents. They were mainly Validity and Reliability.

Validity:

This the ability of a test or study to measure what the Investigator will like to measure. This was done by pre-testing the Questionnaire in a different study population which has been known to have a long time practice of the VHWs System regarded as the "gold standard". This is with a view to dispelling doubts about the capacity of the measure to yield reasonable and full responses

Reliability:

This, also termed reproducibility or repeatability is the stability or the consistency of information, i.e. the extent to which similar information is supplied or obtained when a measurement is performed more than once (test-retest).

(b) Data Collection. The following methods were used for data collection

(i) Review of Records

The Records were

- The minutes of the Monthly Meeting of the VHWs
- Records at the LGA statistics division
- Records at the Local Inspectorate of Education
- Review of Treatment Record Cards of the VHW
- Records of Training and continue Education programme
- The NGOS intervention

Pre-Testing

To ensure Validity of the instruments used in this study, the questionnaires/checklist was pretested at Ouireke Headquarters of Ibadan North-East LGA while the observation check-list for the VHWs meetings were pre-tested in Ibarapa LGA because of its long – standing experience in the running of VHWs' programme.

As for ensuring the Reliability of the instrument used, the test-retest method was performed twice on the LGA Staff involved in PHC with regards to VHWs System as respondents.

As for the Check-list, (see Appendix VI) the standard UNICEF checklist was administered unabridged to the trained, educated and literate respondents (CHEW, Nurse/Matron and LGA statistician). Other questions were (conducted in Yoruba) in an open-ended fashion to facilitate respondents' freedom and independence in expressing themselves. The questions were framed in such a way to eliminate any ambiguity in

their meaning. Questions that appeared sensitive were asked in such a way as not to connote any political, sectional, religious or social undertone. Efforts were also made to control inter-observer bias by verifying instruments for congruency between questions and elicited responses.

Permission was solicited and consent given by respondents for tape recording during the interview and home visit. This enabled the investigator to validate the information given by the respondents at previous meeting as regards patronage-indicator of community recognition and acceptance of the system. This was at the evening time when the investigator used to stay overnigh within the community.

Administration of the Instrument

The investigator administered the entire instrument for the study for six weeks on Fridays and Saturdays of each week. The respondents VHWs were visited, some at home and others in their shops where they traded their commodities. The questionnaire was explained to each one of them and the investigator recorded the responses of those of them who could not do so in writing.

The respondent LGA Staff were however interviewed in their offices where they themselves filled the questionnaire unaided. No questionnaire was however left overnight with any respondent.

Data Analysis

The data were sorted out manually.

The questionnaire and the answer supplied were treated as a raw data and analysed statistically in percentiles of frequency and converted into frequency tables.

Ethical Consideration

At the commencement of the study, a "Letter of Introduction and Appeal for Assistance" was obtained from the Ag. Head, Sub-Department of Health promotion and Education (APPENDIX VIII)

The letter was presented to the Chairman of the Local Government, who approved the Study in his domain and informed all others concerned through the Secretary

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CHAPTER FOUR

FINDINGS

The findings of this appraisal are presented in two sections. Firstly, as Tables of Findings from the administration of Questionnaire and Secondly as some other incidental findings.

Table 1: Profile of the VHWs (Occupation, Educational Level and Age)

N=60 RESPONDENTS

	Male		Female	
	No	(%)	No	(%)
Gender	12	20%	48	80%
Occupation a. Trading	-		48	100%
b. Farming	10	83%	-	
c. Others	2	17%	-	
Education (a) Primary	7	58%	48	100%
(b) Secondary	5	42%	-	
AGE	33-56years		32-62years	
Average Age	49 (SD±14)		47 (SD±15)	
Means Age	48 (SD ±12)			

All the trained 60 VHWs were respondents. Of the 60 VHWs. 12[20%] were males, while 48[80%] were females]. All the female were traders while 10[83%] of the

males were farmers. None of the females had secondary education, while 5[42%] of the males went beyond primary education. Mean age was 48years [SD±12]

Table 2: Knowledge of Bamako Initiative and how drug purchases was financed

N=60 RESPONDENTS

Response	VHW		
	Yes	No	No response
	No (%)	No (%)	No %
Knowledge of BI	-	60 (100%)	
Knowledge of Drug Revolving Fund Scheme	60 (100%)	-	-
Drug purchase by			
(a) Pay-and-buy at the spot i.e. (cash down)	60 (100%)	-	-
(b) Credit from the LGA	-	60 (100%)	-

All the VHWs knew and participated in the Drug Revolving Fund Scheme but they were all ignorant of 'Bamako Initiative'.

Table 3: How drugs were procured by the VHWs

N=60 RESPONDENTS

Response	Yes		No		No response	
	No	(%)	No	(%)	No	(%)
Traveled to Ibadan	-		60	(100%)	-	
From patent medicine seller's shop	-		60	(100%)	-	
From Drug peddlers	-		60	(100%)	-	
From LGA Pharmacy Store through the Association	60	(100%)	-		-	
Brought to my doorstep	-		60	(100%)	-	

All the VHWs purchased drug in bulk from the LGA Pharmacy Store through their Association. And sold them to members during the Association meetings in accordance with the BI except during the L.G.A Workers' strikes when it was observed that their drug store could not be replenished.

Table 4 Problems encountered by the VHWs N=60 RESPONDENTS

Response	VHWs					
	Yes		No		No response	
	No	(%)	No	%	No	%
Financed / money	60	100%	-		-	
Transportation	60	100%	-		-	
Domineering members at meetings	5	8%	-		-	
Recovery of money from debtors	45	75%	-		-	
Strikes by LGA staff	60	100%	-		-	

Problems encountered by the VHWs were finance, transportation, and strikes by the LGA Staff. 5(8%) complained about the domineering attitude of the vocal members while 45(75%) had problem in recovering money from community members that bought drugs on credit. Five members (three males and two females) in particular were observed to be in the habit of exhibiting a domineering attitude during meetings

Table 5: VHWs opinion on how to enhance of VHW activity within the community

(N=60) RESPONDENTS

Response	VHWs					
	Yes		No		No response	
	No	(%)	No	%	No	%
Financial remuneration	60	100%	-		-	
Provision of transportation	60	100%	-		-	
Reduction of cost of drugs	8	13%	5	8%	47	79%

All the VHWs in Lagelu Local Government were however asking for financial remuneration for their health work even though they were volunteers. They all wanted provision of Transportation while 8(13%) wanted reduction in the cost of drugs purchased.

Table 6: The training given to the VHWs N=60 RESPONDENTS

Response	Yes		No		No response	
	No	(%)	No	%	No	%
WATSAN	-		60	100%	-	
Mobilising for EPI	-		60	100%	-	
Treatment of common ailment	60	100%	-		-	
Food Demonstration	-		60	100%	-	
Family planning	-		60	100%	-	
ORT	60	100%	-		-	

The National Health Guidelines of the Federal Ministry of Health [FMOH] as regards the work and activities of the VHWs were not fully complied with. Although the Drug Revolving Fund Scheme of Bamako Initiative was fully complied with, but there were no Water Sanitation and Food Demonstration activities, neither did the VHWs mobilise the community for Expanded Programme for Mass Immunization, nor did they detect defaulters for immunization purpose. However, the VHWs had been trained to prepare salt and sugar solution (SSS) for Oral Rehydration Therapy (ORT) programme.

Table 7: Record of work ever handled or seen by VHW N=60 RESPONDENTS

Respondent	VHWs					
Response	Yes		No		No response	
	No	(%)	No	%	No	%
Record of work for VHWs & TBAs	-		60	100%	-	
Materials for Health Report	-		60	100%	-	
CBD monthly Tally sheet	-		60	100%	-	
All of the above	-		60	100%	-	
None of the above	60	100%	-		-	

There were no Daily Record of Work (Appendix IX), no Maternal Health Report (Appendix X) no CBD Monthly Tally Sheet (Appendix XI)

Table 8: Visitation and Frequency by LGA staff N=60 RESPONDENTS

	Response	VHWs					
		Yes		No		No response	
		No	(%)	No	%	No	%
Staff visiting:	Nurse	60	100%	-		-	
	CHEW	60	100%	-		-	
Frequency:	Weekly	-		60	100%	-	
	Fornightly	60	100%	-		-	
	Monthly	-		60	100%	-	
	No visit at all	-		60	100%	-	

The Nurse and the CHEW regularly carried out monitoring and supervision fortnightly.

Table 9: Types of Training Received by the VHWs

Response	N=60 RESPONDENTS					
	Yes		NO		No Response	
	No	(%)	No	%	No	(%)
Treatment of ailments	60	100%	-		-	
After the Onchocerca Eradication Programme	60	100%	-		-	
Mobilisation for EPI	-		-		60	100%
WATSAN Activities	-		-		60	100%
Food Demonstration	-		-		60	100%
Family Planning Activities	-		-		60	100%

Although VHWs were trained to conduct under-five clinics, diagnose and treat simple disorders, instruct villagers in disease prevention and food nutrition, promote community action for environmental sanitation, they concentrated on only the treatment of common ailments which was the only training given to them. Only the BI was fully practiced

There were no Health Promotion or Health Education activities, even though the VHWs were of the opinion that the programme was set to provide drugs for the community, to make the community healthy and to eradicate diseases in the community

Table 10: Knowledge of the objectives of the Programme

N=60 RESPONDENTS

Response	Yes		No		No response	
	No	(%)	No	%	No	%
To sell drug	60	100%	-		-	
To make money	-		60	100%	-	
To form a political party	-		60	100%	-	
To make the community healthy	60	100%	-		-	
To eradicate disease in the community	60	100%	-		-	

All the VHWs regarded the System as health related and a way of making money for themselves.

Table 11: Factors that encourage the VHWs' Association members

N=60 RESPONDENTS

Response	Yes		No		No response	
	No	(%)	No	%	No	%
Financial help	60	100%	-		-	
Participation at social functions	60	100%	-		-	
Good for forming political party	-		-		60	100%
Advice on business and family life	13	21%	-		47	79%
Settle quarrels among members	-		-		60	1000%

All the VHWs Association members were encouraged by financial help from members and participation at social functions while 13(21%) enjoyed the advice received on business and family life.

Table 12: How VHWs were recognized by Community members

N=60 RESPONDENTS

Response	Yes		No		No response	
	No	(%)	No	%	No	%
Respect from community members	60	100%	-		-	
Use of VHWs services by community members	60	100%	-		-	
More friends within the community	-		-		60	100%
Realization to be a "small doctor"	3	5% (all males)	-		-	
Joy of being consulted	60	100%	-		-	

They also all felt recognized as VHWs by the respect they got from community members, the use of their (VHWs) services and the joy of being consulted 3(5%) all, males) were proud to be regarded as a "small doctor" by community members

Other findings

From Records, only 5 of them [about 8%] were provided with kits. Records showed that one VIIW served 1,500 community members instead of 500 recommended by the FMOH Guidelines (1991) on the programme. All the VIIWs in Lagelu Local Government were however asking for financial remuneration for their health work even though they were volunteers.

During monitoring and supervision one VIIW was found using his position to legitimise an illegal clinic set up by him. He was reportedly caught administering injection and having some antibiotics for sale, whereas these activities were beyond the scope of their training and duty. One community member was found selling the Bamako-Initiative drug, which he procured through a member who over-stocked during the VIIWs meeting, even though the community member was not trained as a VIIW. The four Health Posts visited were kept clean with "VIIW" poster displaced at the doorstep. It was found that the VIIWs had formed a kind of group called Volunteer Health Workers' Association that met every first Monday of each month where members purchased drugs under the Drug Revolving System of Bamako Initiative.

Five members (three males and two females) in particular were observed to be in the habit of exhibiting a domineering attitude during meetings as they used to 'lord' their opinions successfully on the Asscination except when such opinions were at variance with the directives from the State Ministry of Health. At such occasion the meetings were unduly prolonged due to what was observed to be an inadequate communication skill by the Supervisor and the Assistant- (the Nurse and the CHEW)

further observation showed that these domineering members had a greater financial empowerment above all others in the Association. At a particular meeting, members proposed and were insisting that the provision of snacks during meetings be converted to cash but the Supervisor refused to accede to the request, claiming that it would amount to misappropriation of public fund because the fund for snacks at the meetings was provided by the State Ministry of Health, and the Supervisor was accountable for its spending, as audited account of the fund would be sent back to the Ministry.

All the VHWs were, however observed to be happily involved in this aspect of primary Health care delivery service.

Other matters usually discussed at the meetings were contribution for social function such as witnessed during the naming ceremony of a member's newborn baby or grand-baby. This social obligation was freely and cheerfully done by the VHWs. At the VHWs' Association monthly meetings and during sessions, there was obvious evidence of dominating attitude of some members, rivalry amongst villagers, members seeking benefits (in kind or in cash), and conflicts between the Association and the Monitoring Team (the Nurse and the CHEW) especially on purchase of snacks. The VHWs wanted the snacks in cash while the monitoring team felt that it would amount to mis-appropriation of public fund since the money was given through the state Ministry of Health. However, there was no evidence of discouragement in the VHWS system because meetings were attended regularly and punctually except during any early morning downpour of rain. During some sessions at their monthly meetings, all the VHWs were of the opinion that the commonest ailments within the community

were malaria and diarrhoea, although some added rheumatism and back pains as also affecting some community members.

Three male members also complained that there was injustice and partiality in the way and manner bicycles meant for the VHWS were distributed.

The Village Health Committee.

The Committee had been appointed some time ago but no record could be found as to the selection of its members or the time that it was first established. neither was any record found of its activities (if any) in the past. Three members of the Committee identified by the Executive members of the VHWs were however called upon for a visit to the Chairman of the Committee. The Chairman himself could not give any information with regards to the life of the Committee. So the Committee was inactive in its scheduled activities such as keeping a Drugs Account as specified by the Guidelines. There was therefore nobody seen receiving feedback on Monitoring and Evaluation since there was no meeting of the Village Health Committee.

The Monthly Meeting of the VHWs' Association was observed to meet regularly except during a heavy downpour of rain and during strikes by the Local Government staff when drug kits could not be replenished.

Community Utilization of VHW Services.

At all the ten (10) impromptu visits made to the 6 VHWs (all women) seen at the market on market days, it was observed that an average of five clients did patronize each VHWs on market days apart from week days. However, no adequate record was kept by the VHW to facilitate statistical analysis.

Visits also made to heads of some towns and villages which were fairly motorable also showed that the VHWs (where they existed) were recognized and their services utilized because the village heads visited acknowledged the usefulness of the VHWs to their respective villages, sharing some interesting story with the investigator who went in the company of two of his friends as observers and repertoires.

Women and the children were the most users. Few men, especially farmers and blacksmiths also utilized the health care facility. One male VHW narrated how he was wakened up late evening one day when a child having diarrhea and vomiting was brought to him. He said that the child took about five bottles of salt and sugar solution (SSS) for Oral Rehydration Therapy (ORT) and was taken to the nearby Health Centre on his own bicycle to see the Nurse. The child, he said, was now well. He narrated the story while he was making case for the provision of bicycles for VHWs when an unscheduled visit was paid to him in his house at ABOKE Village.

In this appraisal, it was observed that the VHWs were well trained at their level in the areas of diagnosis and treatment of some specified ailments, they were also properly supervised by the Public Health Nurse and the CHEW.

There used to be too much argument at meetings especially when Supervisors were passing instruction that was supposed to be mere information to the VHWs. At times, the Nurse and the CHEW often expressed sharp differences in opinion on community health matters even in the presence of the VHWs. It was observed that they both lack adequate communication skill for the programme of monitoring, evaluation and supervision.

The VHWs. in Lagelu Local Government were observed to be keenly enthusiastic about their community health work of diagnosis and treatment of common ailments only. This could be due to the financial gain they realized from the sales of drug through the Drug Revolving Scheme of Bamako Initiatives.

The Drug Revolving System

The practice of Bamako Initiative on Drug Revolving System was commendable except that there was no Bank Account for that purpose, although there was no allegation of any financial impropriety against anyone at the time of the Appraisal. This perhaps was as a result of this small number of the entire VHWs in he LGA which enabled every one to have access to how the finances were operated

Record Keeping

Materials for record keeping needed to be provided. When some of the materials were obtained from Oyo State Ministry of Health Daily Record (Appendix V), Maternal Health Report (Appendix VI), CBD Monthly Tally Sheet (Appendix VII), which were all for Field work Reports of TBAs & VHWs), and shown to them, all the VHWs admitted that they had not seen such documents before. The VHWs had complained that the commonest disease in their various villages were fever and diarrhoea. This was likely to be the result of lack of Hand Demonstration, Water and Environmental Sanitation activities. It was therefore necessary to organize the train-the-trainers workshops on these activities.

CHAPTER FIVE

DISCUSSION

The FMOH Health Sector Reform Program Strategic Thrusts, Key Performance Objectives and Plan of Action 2004 – 2007 showed that there is a current situation of limited consumer and community involved in health In the study area, only the Drug Revolving Scheme of Bamako Initiative was in practice This has resulted in low levels of community involvement in health care matters and missed opportunity to use traditional communication systems to elicit community and personnel empowerment by the public health system.

It was noted in the Reform that effective health mass mobilization has not been achieved to the level necessary to generate desired health behaviour change at both individual and community levels This was the situation in the study area whereby the VHWs were not involved in Expanded Program on Immunisation by mobilizing community members for the exercise as expected of them. The Reform indicated what the results could be if community and personal involvement were effective in community health matters These include the fact that the communities must be seen participating in the design, implementation, monitoring and evaluation of health care delivery as it affects them Also communities must become co-owner and co-finances of health care delivery. These activities were defective in the study area

Similarly health consumer protection groups should be formed and seen actively engaging with health issues. In addition consumer and communities must have imbibed practical actions that support health life styles. The VHWs had formest an

Association that met every first Monday of the month. This Association was the health consumer protection group as observed by their activities of monitoring one another in the purchase and sales of drugs

VHWs system is democracy in heath care delivery and participating at the village community level. The system was established in 1988 in Lagelu Local Government however, during the military Rule in Nigeria when they people were made to do what the government had dictated rather than the people achieving a say in the planning and implementation of matters affecting their health within the community However, the recent return to democratic and open government and the growing public demand for better health care has opened up new opportunity to reverse these declines

The underlying assumption and cross-cutting principles for the Health Sector Reform Program reflects the belief of the FMOH, among other things, that the people. particularly the poor should be closely involved at the community level, in the design and implementation the of the interventions the Reform was to effect. This is the level at which the VHWs are involved

The FMOH stated further that assessing the health needs of the poor cannot be over – emphasized since the people themselves will have an important role to play in the implementation of the intervention for desired results and outcomes to be realized. The VHWs were not carrying out any Food Demonstration and WATSAN activities, the importance of which cannot be over-emphasied. World Bank (2000, 2001) has recognized that the environment in which people live from the household to the community and to the global level significantly affects their health. Every year in

developing countries an estimated 3 million people die prematurely from water-related diseases and 2 million people die from exposure to stove smoke inside their homes. The largest proportion of these deaths is among infants and young children, followed by women from poor rural families who lack access to safe water, sanitation and modern household fuels. Akinyele (2005). Another million people die from air pollution in the urban environment, and there is a reason to believe that here too the poor suffer most.

Traditional environmental hazard affect the poor mostly in Nigeria as elsewhere. Water-borne diseases, caused by inadequate water supply and sanitation impose an especially large health burden on the Nigerian. Vector-borne diseases are affected by a range of environmental conditions and factors, including polluted and standing water, open sewers and certain types of sanitation; clogged storm drains, and floods. In Africa alone, malaria is responsible for about 800,000 deaths annually. Environmental health outcomes show significant variations that cannot be simply explained by a household's economic status, and hence reflect indicators of human development other than income measure alone. Poor people typically face greater environmental health risks in their surroundings because they live in unhealthy location, such as low-lying and marginal lands and lack basic infrastructure services, like clean water and sanitation. A holistic approach is particularly important for improving the health of the poor, who are most vulnerable both to the main environmental hazards and to deficiencies in health service delivery. Akinyele (2005)

If this category of health workers at grassroots did not have knowledge of the Materials for record keeping nor possess them, adequate data might not be available for health statistics of the community. Professor A B O O. Oyediran had observed that the reality on ground belies the statistics given by Akinyele (2005) at the 25th Interdisciplinary Research Discourse that some 63% of the inhabitants had adequate sanitation, and 57% water. Prof. Oyediran noted that in several communities, faeces are disposed in the bush, on account of lack of toilets while about 50% of schools in southwestern Nigeria lack toilets. Professor Akinyele replied that the data was from the United Nations Development Programme UNDP Human Development Report for Nigeria. He however, stated that this underscores the need for standardized data based which will involve the collection of data on a continuous basis, so that we can have accurate and reliable data. The VHWs where they operate should therefore be provided with materials for record keeping and trained to use them.

According to the Health Sector Reform 2004-2007 of the Federal Ministry of Health, routine immunization coverage rate of over 80% in early 1990s dropped to less than 25% and is now beginning to show marginal improvements which could be better still if VHWs were to mobilize the community for the immunization program. There was therefore the need to involve the VHWs in mobilizing community members during the Mass Immunisation Campaign Programme. It would therefore be easier to recruit appropriate children for the immunization, follow up at the next phase and determine defaulters and level of attritions.

CONCLUSION

Appropriate training and utilization have a vital role in the effective performance and utilization of VHWs. They should however, be well educated right from the selection process on the true nature of the programme so that the kind of VHW attrition observer by Ewoigbokhan and Brieger (1994) in Ile-Ife area of Nigeria would not occur. This should include letting them know their responsibilities and limitations in the discharge of their duties as community-based Volunteer Health Workers. Since one VHW was serving 500 community members, there was therefore the need to increase the number of the VHWs to get close to the recommended one VHW serving 500 community members. However, this should not be done in a way to create an impression of "VHW for All", rather than "Health for All". Materials for record keeping should be provided and VHWs trained to use them. Monitoring should be intensified to prevent pilfering of drugs and abuse of privilege to participate in health work by the VHW. Also, the Village Health Committee should be revitalized in their activities.

The trainees had thought that the work would grant them enough for daily living but were disappointed that this was not so. Some of them absconded while others took up paid jobs elsewhere. The use of incentives to increase participation has been recommended by Richards F. J. et al (1996). The VHWs in Lagelu LGA should be given financial remuneration despite been volunteers. This would be more encouraging to them.

Although, there were no records of the way and manner the VHWs were selected, all efforts should still be made to select and recruit only individuals with genuine interest and motivation. The same should also be applied to membership of Village Health Committee after due consideration of the FMOH Guidelines for their selection and the composition to be in accordance with the Revised National Health Policy, FMOH (2004). The A Appraisalrevealed that more VHWs needed to be trained so as to meet recommended ratio of 1:500. Materials for record keeping should be provided and VHWs trained to use them. Monitoring should be intensified to prevent pilfering of drugs and abuse of privilege to participate in health work by the VHW. Also, the Village Health Committee should be revitalized in their activities.

If health care providers still want the VHWs system to be effective in implementating health care delivery services and participation by the community at the community level, then the VHWs' system has to be reviewed. It is either that the system is cancelled entirely and the status quo before its introduction maintained or the system be completely overhauled to be in conformity with the implementation of the newly introduced National Health Policy (2004) and the Health Sector Reform Program Strategic Thrusts, Key Performance Objectives and Plan of Action (2004 – 2007) both of the Federal Ministry of Health.

It is when this is done, that the desired results and outcomes of community health care participation at village level will be realised.

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APPENDIX I

LAGELU LOCAL GOVT. OYO STATE.

MAP SHEWING

HEALTH FACILITIES

SCALE:- 1:75,000

REFERENCE

1 TOWN / VILLAGE	•
2 MAIN ROADS	▬▬
3 OTHER ROADS	▬▬
4 RAIN PISTES	------
5 BOUNDARIES: STATE	———
6 BOUNDARIES: LOCAL GOVT	———
7 RIVERS & STREAMS	~~~
8 DISPENSARY	+ Disp
9 PRIMARY HEALTH CENTRES	+ PHC
10 MATERNITY CENTRES	+ M

APPENDIX II

Geographical Spread of the VHW's within the LGA

Ile Igbon	1
Arikuyeri	1
Offatedo	2
Oladejo	1
Lagun	2
Ogidi-olu	1
Oluwole	1
Akinsawe	1
Elesu	2
Elewi Odo	1
Sukuru	1
Eiioku	1
Akamo	1
Lapata	1
Iabaro	1
Awonde	2
Ogunjana	1
Oyedeji	5
Elesu	4
Olode	6
Apatcere	4
Aboke	2
Afape	2
Abule Osun	2
Bamgbola	1
Fadina	1
Lafupon	2

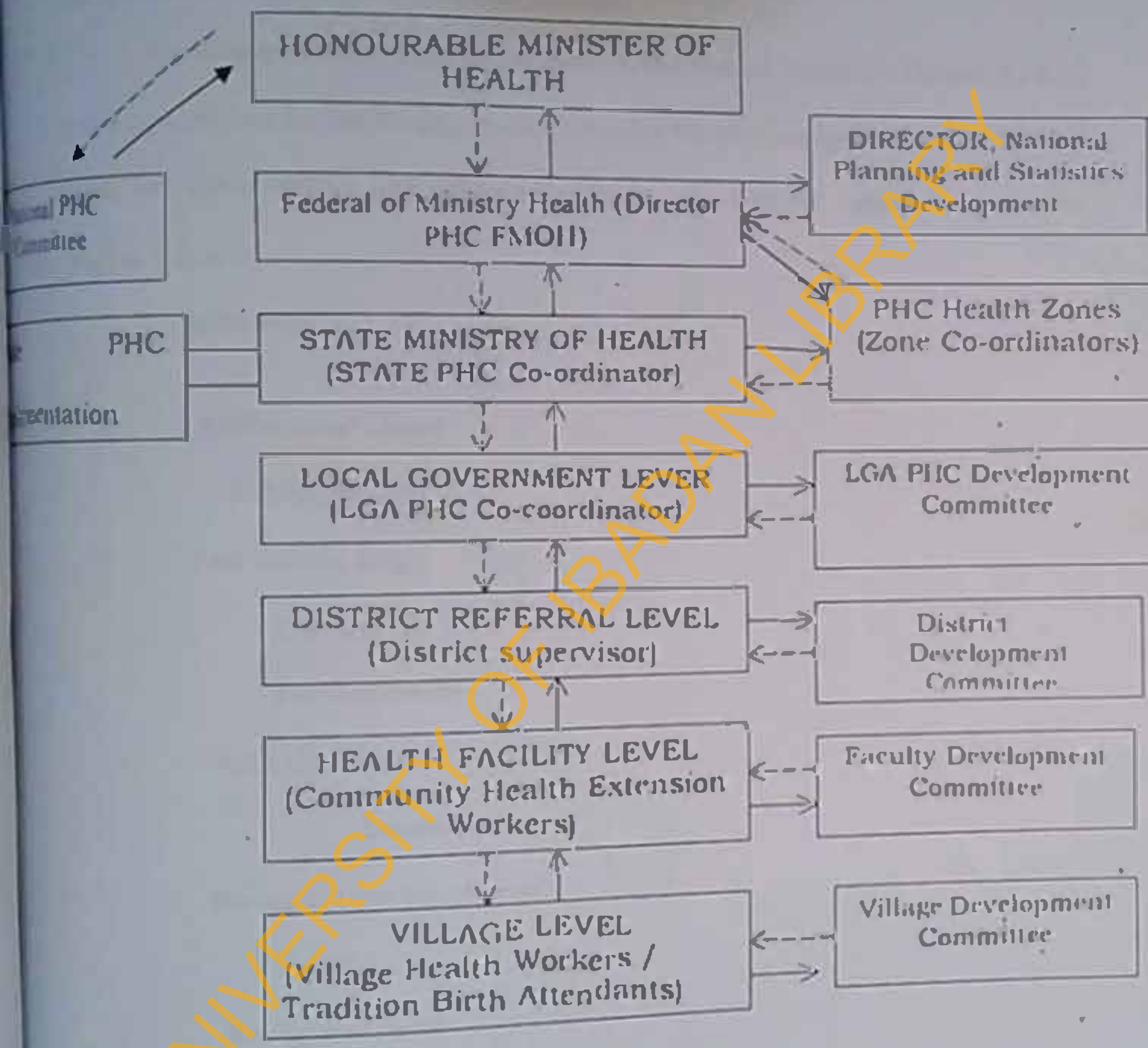
APPENDIX II

Geographical Spread of the VHWs within the LGA

Ile Igbon	1
Arikuyeri	1
Offatedo	2
Oladejo	1
Lagun	3
Ogidi-oba	1
Olowole	1
Akinmawe	1
[illegible]	2
[illegible] Odo	1
Sokuru	1
Erinlu	1
Akanbi	1
Lapata	1
Igbaro	1
Awosule	2
Ogunyemi	1
[illegible]	5
[illegible]	4
Oode	6
[illegible]	4
[illegible]	2
Agbo	2
[illegible]	3
Songbede	1
[illegible]	1
[illegible]	2

APPENDIX III

A BOTTOM – UP ORGANOGRAM SHOWING THE POSITION



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APPENDIX IV

Nigerian Essential Drugs List For Community Health Extension Workers (CHEWs) & Volunteer Village Health Workers (VHWs)

The Primary Health Care Department of the Federal Ministry of Health (1990) released guidelines for the development of Primary Health Care System in Nigeria. The Guidelines allow VHWs and TBAs to purchase and dispense certain categories of drugs as follows:

1 Infections

a Antibacterial Drugs

Sulphadimidine

b Anti malaria drugs

Chloroquine

Pyrimethamine

c Antihelminthics

Levamisole

2 Antiseptics and disinfectants

Iodine

Diethylated spirit

Saponated cresol

Sodium hypochlorite

2 Nervous System and Analgesics

Analgesics and Antipyretics

Acetyl-salicylic acid

Paracetamol

3 Gastro Intestinal System.

a Antacid

Aluminium hydroxide + magnesium trisilicate

Magnesium trisilicate

b Laxatives

4 Blood Disorders And Nutritional

a Anemia

Ferrous salts

Folic acid

b Vitamins and Minerals

Multivitamins

5 Skin Disease

a Anti-infective drugs

Benzoin Compound tincture

Chloroxylenol

Gentian violet

b Anti-fungal drug

Benzoic acid/Boclosamide + salicylic acid

c Anti-inflammatory and anti-pruritic agents

Calamine lotion

Zinc oxide

d Scabies and other parasitic disease

Benzyl benzoate

Monosulfiram

6 Obstetrics And Gynaecology

Barrier contraceptives

Condoms

APPENDIX V

Stufflebeam *et al* (1971)

Context Objectives Context evaluation is the most basic type. It is to inform planning decisions. Its purpose is to provide a rationale for determination of educational objectives. It specifically defines the relevant environment, describes the desired and actual conditions pertaining to the environment, identifies unmet needs and unused opportunities and diagnoses the problems that prevent needs from being met and opportunities from being used.

Input Objectives

Input evaluation is essentially adhoc and micro analytic. The information obtained is essential for structuring specific designs to accomplish programme objectives, the end product of which is an analysis of one or more procedural designs in terms of potential costs and benefits. Specifically, alternative designs are assessed concerning staffing, time and budget requirements, potential procedural barriers, the consequences of not overcoming them, relevance of the designs to programme objectives and overall potential of the design to meet the objectives.

Essentially, the information from input evaluation is used to decide if outside assistance is required to meet objectives, how the objectives should be stated operationally in accordance to the National Health Policy (2001) and what general strategy should be employed to implement the selected strategy. It involves indicators like funding, Logistic Support (Transportation), Equipment and Supplies (Drugs).

Process Objectives

As important as input is in programming, if there are no well thought-out process activities, achievement of programme goals will be hindered. This is because the process level provides feedback information for programme implementers and assessors. It also encourages establishment of record keeping.

The Process Evaluation provides information to detect or predict defects in implementation, provide information for programme decisions and to maintain the record of procedures as it occurs. Under the process level, the following are the process objectives: to assess the effectiveness of the procedure for establishing the Development Committee in Villages, Selection of Volunteers from within the Community for training as Health Workers, to examine adequacy of materials for record-keeping and equipment for transportation, to check the accounting system for the Drug Revolving Scheme, to assess the quality of the various training workshops such as those on Water, Food and Environmental Sanitation, Mass Immunisation Campaign, Maternal and Child Health, and Family Planning, Selection of appropriate drugs as required by the Essential Drug List, Storage of drugs, and organizing Continuing Education Programme.

Product Objectives

The day-to-day monitoring and analysis of the activities and other efforts cannot be meaningful, if there is no way to measure the impact of the programme or determine the achieved outcomes. The product objectives are to provide information on the achievement of the programme. Just as the programme objectives are critical in programme evaluation, indicators that are usually derived from programme objectives

ed for measuring achievement are important. These indicators are, the extent to which the National Health Guidelines of the FMOH for VHWs are complied with, the adequate number of the VHWs to serve the population of the LGA, the level of involvement of VHWs in Mass Immunisation activity and their utilization for other services including control of childhood communicable diseases, maternal health, environmental care Food Demonstrations, Water and Sanitation.

APPENDIX VI

PHCM Checklist for the supervision of Village Health Services by Facility Supervisor

Review the Health Services being performed by the VHW/TBA. and Management Supports provided for these activities in the village. Collect information by reviewing record, talking to VHW/TBA. Development Committees and by personal observation

PHC Management and Organisation

Primary Health Care Services	Yes	No	Rema
Are the following health services available daily?			
• Maternal And Child Care			
• Family Planning			
• Immunization			
• Growth Monitoring			
• Food Demonstration			
• Protection of Water Sources			
• Environmental Sanitation			
• Provision of Essential Drugs			
• Treatment of Endemic Disease			
• Health Education			
• Home Visits			
• Referral			
B Personnel			
Are the following personnel available			
• Village Health Workers			
• Traditional Birth Attendant			
• Junior Community Health Extension Workers			

C Resources

- Are the VHWs/TBAs provided with kits?
- Does the Village Development Committee provide funds for drugs?
- Are the VHWs provided with Standing Orders?
- Are Essential Drugs Provided?
- Is the Drug price list available?
- Has the community provided an equipped health post?
- Are the VHWs/TBA Records of Work available?
- Are Monitoring and Evaluation Forms provided?
- Does the community provide food items for demonstration?
- Are the 2-way referral forms provided?
- Is the VHW/TBA provided with health education materials?

D Management Support

- Is supervision provided to VHW/TBA on regular basis?
- Is logistics support for VHW regular?
- Do communities make transport available to VHW for patient's referral?
- Is information on health activities available to Village Development Committee and the community?
- Do the Village Development and the Supervisors give feedback to the VHW/TBA and the community?
- Are periodic reviews and evaluation of VHW/TBA activities carried out regularly by Village Development Committee and Supervisor?
- Is the Village Development Committee functioning?
- Has LGA/DHB/RCI provided necessary support for Village Development Committee?
- Has the village Development Committee opened a Drugs Revolving Account?

- Is Drug Revolving Account and Cash Flow adequate?
- Does the Community provide facilities for outreach services by health team from health facility e.g Immunisation and Growth Monitoring ?
- Are the VWH/TBA kits well stocked and clean?

E Village Health Worker Facilities

- Is the working area/Health Post clean and well maintained?
- Is equipment well maintained?

F Village Health Worker Performance

- Does he/she communicate adequately with patients?
- Can the Village Health Worker prepare salt, sugar, and solution?
- Are mothers taught how to prepare and administer salt, sugar, and solution (SS)?
- Supervisor (i) Test 3 randomly selected mothers on preparation and administration of SS(ii) Select 3 houses to check water purification methods (To be performed by the Supervisor)
- Is Mid Upper Arm Circumference strip used to assess nutritional status of children
- Does VHW/TBA give advice to pregnant women and mothers of pre school children?
- Does VHW/TBA perform family planning services effectively?
- Does the VHW/TBA give health message accurately?
- Does the VHW/TBA mobilize and motivate Villages for health actions?

G Immunization

- Does VHW/TBA identify pregnant women and children requiring different immunization at appropriate time?
- Does VHW/TBA screen children for immunization
- Does VHW/TBA visit homes for trace immunization defaulters?
- Does VHW/TBA prepare venue and community on immunization days?

II Water and Sanitation			
• Does the VHW/TBA ensure that pit or VIP latrines are adequately maintained?			
• Does the VHW/TBA supervise proper protection of water sources by?			
• Fencing or other means of isolation of water from contamination?			
• Keeping people and animals away?			
• Protection of family wells and checking for proper covers and aprons?			
• Does the VHW/TBA supervise proper method for waste disposal?			
I Monitoring and Data Control Activities			
Is village based VHW/TBA record of work up to date?			
• Are drugs issued, and money collected and recorded correctly?			
• Are the home-based record place?			
• Are the clinic master cards completed?			
• Does the Village Development Committee received feedback on monitoring and evaluation at every meeting?			
• Are the following records updated and displaced on the well			
• Community Demographic Profile?			
• Community Pregnancy Profile?			
• Community Family Planning Activities?			

APPENDIX VII

QUESTIONNAIRE FOR THE VOLUNTEER HEALTH WORKERS

Indicate YES or NO by marking the sign of YES or NO in your answer Jeki idahun re ko je BEENI tabi BEEKO nipa ti fu ilaa BEENI tabi BEEKO niwaju iheere kookan

(1) (i) Name(Oruko uyin) (ii) Sex (Okunrin/ obinrin) (iii) Place of Residence(Abule/Ileto lon ileghee (iv) Educational Background (Ile-eko ti e lo gbehin) (v) Occopation(Ise ooju uyin)

(2) How did you become a volunteer worker in the village? (Bawo ni e si di alapon ilera?)

(a) Selected by the Village Head (Olori abule lo yan mi)

(b) A friend invited me (Ore kan lo pe mi sii)

(c) After the programme of Onchocercial Eradication (Leyin eto igboguni aran oju)

(3) Were you trained in any of the duties of VHWs? Yes/No (Nje awon koo yin ni awon ise alapoti bi? Beeni/Beeko

(4) If yes, what are they? (Bi beeni awon wo ni eyiti won ko ti won ko yin?)

(i) Treatment of common ailments (itoju lin awon aisan peepeepeee)

(ii) Mobilization for Expanded Programme on immunisation (EPI) (abere ajesara)

(iii) Water and Sanitation program (WATSAN) (imototo omi ati ayika)

(iv) Food Demonstration (Onje wiwa)

(v) Family Planning (lifi eto s'omo ibibi)

Do you consider that it worth it, being a VWH? Yes/No (nje o je ohun iwuri koju nyin lati je alapoti ilera?

(5) If yes why? (Bi beeni, kini idi re?)

a I am being respected for it (iyi wa nibe)

b People come to me for health matters (awon eniyan a wa sodo mi fun iranlowo)

c I have more friends within the community (oje ki ng ni ore l'adugbo)

d I see myself as a "small doctor"(mo ri ara mi bii dokita onisegun kekere)

e. I am happy to see that a sick person coming for help (ayo ni pe alaisan wa si odoo fun iranwo)

(6) What is the purpose for which the VHW was established? (kini idi ti eto alapoti ilera fi wa?)

(i) To sell drug (Lati ta ogun)

(ii) To make money (Lati ni owo)

(iii) To form a political party (Lati da egbe oselu sile)

(iv) To make the community healthy (Lati jeki agbegbe wa ni ilera)

(v) To eradicate diseases in the community (Lati kese aisan nile)

(7) Which of the following have you handled or participated in before? (Ewo ninu awon wonyi ni e ti se tabi ba won se ri gegebi alapoti ilera)?)

(i) WATSAN (Ipese omi nimo ati imototo adugbo)

(ii) Mobilising for EPI (Ipolongo abere ajesara)

(iii) Treatment of common ailment (Itoju awon aisan peepeepeee)

(iv) Food Demonstration (eto nipa onje wiwa)

(v) Family Planning (nipa lileto s'omobibi)

(8) How often did the LGA staff come to you? (Bawo ni awon osise ijoba ibile se ng be nyin wo dede si?)

(i) Once a week (Eekan l''ose)

(ii) Once in two weeks (eekan l''ose meji)

(iii) Once a month (eekan l'osu)

(iv) Once in a year (eekan l'odun)

(v) No visit at all (ko si abewo kankan)

(9) Which of the LGA staff had visited you (awon osise ijoba ibile wo l'o ti be yin wo ri?)

(i) Nurse (nurse)

(ii) CHEW(olutopinpin alapoti ilera)

(iii) Pharmacy technician (apoogun)

10 Which of the following items had you seen or handled before? (they were shown for recognition) (Ewo nin awon iwe eto ise alapoti wonyi ni e ti ri?)

(a) Record of work for VHW's and TAB's (Akosile ise)

(b) Maternal Health Report (Akosile ilera alaboyun)

(c) CBD monthly Tally sheet (Iwe ti a nko oogun ati awon nka tita si)

(d) All of the above (ghogho awon wonyi)

(e) None of the above (ko si okankan nnu won)

11 How did you procure your drug? (bawo ni e se ng ri ogun un yin ra?)

(a) Travelling to Ibadan in the chemist shop (no nna ng wo oko lo si Ibadan loo raa ni kemisti

(b) In the patient medicine seller's shop (Ni ilee ita oogun)

(c) From drugs peddlers roaming the street (lati owo awon ti won ng ta oogun lati ojule d'ojule

(d) From the LGA pharmacy store (lati ile itaoogun ti ijoba ibile Lagelu)

(e) Brought to my door step by the LGA staff (osise ijoba ibile ni o ng ko awon oogun wa fun ni n'ile)

(12) Have you heard of Bamuku initiative before Yes/No (nje eti gbo nipa eto kanukara ti ongun gegebi ipade Bamako ti ka sile?)

(13) Either Yes or No, how do you finance the drugs you sell? (Bi beeni tabi beeko, bawo ni e se ng sin owo oogun ti e ba ra?)

(i) Pay –and-buy (cash down) (owo lowo eyin nile)

(ii) On credit from the LGA (awin, lowo ijoba ibile Lagelu)

(iii) Free (ofe ni no nghaa)

(iv) Bought on credit from a friend, and pay later (awin lati odo ore won si nsan owo lehin or'ehin)

(v) Borrow money from a friend (won maa nya owo lowo ore lati ra oogun ni)

(14) Which of the following are the factors that encourage you as a member LGA Volunteer Health Workers' Association (ewo nino awon wonyi ni awon nkan iwuri ayin gegebi omo egbe alapoti ilera?)

(i) Financial help (iranlowo owo)

(ii) Social functions e g naming ceremony etc ("A'ar'eni se tia".gegebi isomoloruko. Igbeyawo ati Isinku)

(iii) Base-line for forming a political party (o fi aaye sile fun dida egbe oselu sile)

(iv) Advising one another on business and family matters (ghigba ara eni niyanju lorii okoowo ati oro ebi)

(v) At time, settle quarrels among member (usually after the monthly meetings) (igbamiran,pipari ija laarin omo egbe paapaa lehin ipade olosoosu)

(15) What problems did you encounter as a VHW? (awon isoro wo ni e ni gegebi alapoti ilera?)

(i) finance/money (isuna/owo)

(ii) transportation (eto irinse)

(iii) Domineering members at meetings (awon abeni gan an ninu ipade)

(iv) Recovery of money on credit sales to some community members (awon ti won ura oogun ni awin lowo eniyan l'abule .sugbon ti won o kii fe owo san)

(v) Strikes by LGA staff (iyanse l'odi ti awon osisee ijoba ibile maa se)

(16) What do you think can be done to enhance your activity as VPW in the community? (nnu ero ti nyin,kini a la se ti o le je itesiwaju fun un nyin gegebi alapoti ilera ni agbegbe?)

(i) Financial remuneration (lifuni ni owo idakonu)

(ii) Provide Transportation (ipese ohun irinse)

(iii) Reduce cost of drug at the LGA pharmacy store (dinku owo oogun ku lati ile iko oogun si ti ijoba ibile)

(m) Domineering members at meetings (awon abenu gan an inu ipade)

(n) Recovery of money on credit sales to some community members (awon ti won ura ogun ni awin lowo eniyan l'abule .sugbon ti won o ku fe owo san)

(v) Strikes by LGA staff (iyanse l'odi ti awon osisee ijoba ibile nwa se)

(16) What do you think can be done to enhance your activity as VHW in the community? (nnu ero ti nyin,kini a la se ti o le je itesiwaju lori on nyin gegebi alapoti ilera ni agbegbe?)

(i) Financial remmeration (fifuni ni owo idakonu)

(ii) Provide Transportation (ipese ohun irinse)

(iii) Reduce cost of drug at the LGA pharmacy store (didin owo ogun ku lati ile iko ogun si ti ijoba ibile)

AFRICAN REGIONAL HEALTH EDUCATION CENTRE
Sub-Department of Health Promotion and Education
College of Medicine, University of Ibadan
Ibadan, Nigeria

February 9, 1999

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION AND APPEAL FOR ASSISTANCE

Rev. O.O. Nwoyeka is a postgraduate student in the Sub-Department of Health Promotion and Education, Department of Preventive and Social Medicine, College of Medicine, University of Ibadan. He is carrying out a research project on "An appraisal of the Activities of the Non-Formal Community Health Workers in Igbo-Ora in Community of Lagelu Local Government, Oyo State.

To this effect, he would need your assistance in the collection of some vital information which will be of help to the study.

Yours sincerely,

F.O. Oshiname
Supervisor & Ag. Head.

RECORD OF WORK

FOR

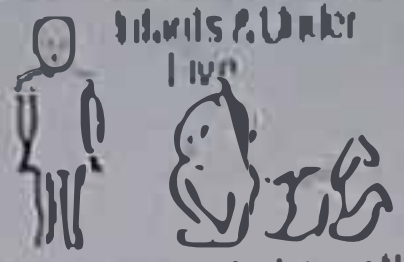
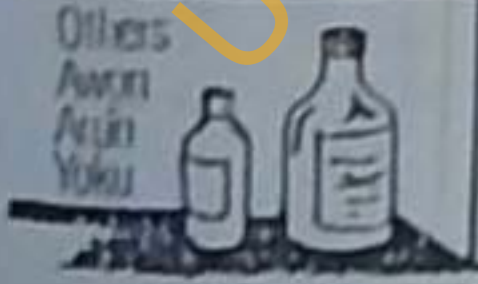
VILLAGE HEALTH WORKERS

AND

TRADITIONAL BIRTH ATTENDANTS

CBD MONTHLY TALLY SHEET

Field-work Reports Of TBAs & VHWs (Cards One)

	Adult  Agbalagba	School Child  Omo ile iwe	Infants & Under Five  omo owo. omo ti ko to ile iwe
Malaria  Ibà			
Cough  Iko			
Diarrhoea Igbe Gbuuru 			
Worms  Aran			
Anaemia  Eje Kolo Lara			
Dressing  Egbo			
Others Awon Arun Yoku 			

HOME VISIT (without treatment) but Health Talk
IBEWU SI ILE (Ibaifun ni Laisan) sugbon gbigba ni ni 'yanju nipa ile

	Live Births	Still Births	Maternal Deaths
			

0 - 11 Months	1 - 4 YEARS	Total	School Child (5-14yrs)	Total	Adult 15yrs +	Total