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Work Profile of Community Health Extension Workers in Cross River State and implications for achieving MDG 4 and 5.

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KEYWORDS

Key household and community practices, community health extension worker

ABSTRACT

INTRODUCTION

The goal of significant reduction in maternal and child mortality could be achieved if national health services de-emphasizes vertical public health programs and services and strengthen community services[9]. Community based service are usually directed toward identification of at risk groups in the community such as pregnant women and children U5 years and provide them services not only in the health centers but also in the home. Studies have shown that those at greatest risk of high morbidity and mortality are least likely to make use of health services. A survey of caregiver knowledge of 19 key household and community practices in selected communities in Cross River showed that high proportion of mothers and caregivers lack appropriate health knowledge to correctly manage their sick children in the home[7].

OBJECTIVE

To identify where community health extension workers work and what services they are providing in primary health care

METHODOLOGY

One hundred and forty one questionnaires were distributed among community health extension workers in two local governments in Cross River State. The instrument was simple structured self administered questionnaire.

RESULTS

The study showed that most of the community health extension workers (91%) were fully engaged with activities in the health centres (Table 2) The study showed that community health extension workers were responsible for immunization, growth monitoring, antenatal and pregnancy care, and curative care (table 3). Although majority of the community health extension workers were aware that they should be working in community but when asked why they did not, their reply was that there was insufficient number of staff in health centers. (Table 4)

CONCLUSION

Nigeria health system is concentrated on facility and curative based services. Community based health care is almost completely absent. The total involvement of community health extension workers in the health centres care rather than to work with mothers and caregivers will make the achievement of the millennium development goals for mothers and children as distant as it was 40 years ago when primary health care strategy was adopted for achievement of health for all in Nigeria.

It is recommended that community health extension workers should be recruited to work in the communities.

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INTRODUCTION

Primary health care workers who are also known as community health worker have been in existence for several years in many countries of the world. [1] According to studies by the World Health Organization,[1,2] the community health worker was introduced into the health system for various reasons. In some countries they were to meet shortages in health manpower. In other countries they were introduced for specific health programs or campaigns. In Nigeria community health workers also known as community health extension workers (CHEW) were introduced into Nigerian health system when the country adopted the PHC strategy to achieve the goal of health for all

Nigerians.

The community health extension workers in Nigeria were "to bring health care as close as possible to where people live and work, and would constitute the first element of a continuing health care process"[3,4]

The curriculum developed for the training of the community health extension workers specified that community health extension workers were "to spend 75% of their time in the community and 25% in the health centers".[5]

The job content for community health extension workers was also described in great details in the training curriculum. After more than 35 years of Primary Health Care in Nigeria, there have been no significant improvements in health of Nigerians. Life expectancy is 51 years; maternal mortality and child mortality are high and from preventable causes. A national survey of knowledge of key household and community practices among mothers and caregivers showed that significant proportion of mothers lacked knowledge of the common causes of childhood illnesses and how to prevent them.[7]

This study was to determine whether community health extension workers were working in the communities and according to their job descriptions, and what type of health care they were providing.[6]

RESEARCH METHODOLOGY

Study Area

This study was conducted in two local governments in Cross River state namely, Akpabuyo, Calabar south. Study population was community health extension workers who were in the employment of Akpabuyo and Calabar south local government.

Study Design

This was a cross sectional descriptive study. One hundred and forty one community health extension workers were interviewed using a simple 12 item structured questionnaire.

RESULTS

The survey showed that 71.6% of the community health extension workers were females and were married (77.%), (Table I).

Table I: Demographic characteristics of respondents (CHW) N=141

Demographic profile	Frequency (%)
Age	
25 - 29	5 (3.5%)
30 - 34	29 (20.5%)
35 - 39	60 (42.5%)
>40	47 (33.3%)
Sex	
Male	40 (28.3%)
Female	101 (71.6%)
Marital status	
Single	2.2 (15.6%)
Married	109 (77.3%)
Divorced	0 (0%)
Widowed	10 (7%)
Years of work as Community health worker	
<10	15 (10.6%)
10 – 19	62 (49.9%)
20 – 29	47 (33.3%)
>30	17 (12.0%)

Most of them were very experienced, 50% of them having worked in primary health care facilities for more than 20 years.

The study (Table II) showed that 91.4% of community health extension workers were working in health centers.

Table II: Place of work of CHEW, N=141

Work-place of CHEW	Freq. (percent)
Health center	29 (91.4%)
Home visiting	35 (24.8%)
Community/Village	24 (17.0%)
Other	(3.5%)

When asked what functions they were involved in the health centers they mentioned growth monitoring (77.3%), immunization (93.6%), antenatal care and delivery care (73.7%), and treatment of illness (78.7%) (Table III).

Table III: Activities by CHEW at work. N= 141

Job/work schedule of CHEW	Frequency	Percent
Growth monitoring	10 9	77.3 %
Immunization	1 3 2	9 3. 6 %
Home visiting	27	19.1 %
Health talk	40	28.3 %
Treatment of illness	1 11	78.7 %
Antenatal care,delivery	104	73.7 %
Sanitation duties	36	25.5 %

The community health extension workers knew that they should be working in the community but they (89.3%) reported that they could not because "the health centers did not have enough staff ".

Many of them (75.8%) reported that "staff had too many patients to attend to" (Table IV).

And although they were in health centers most of the time many of them were aware that they ought to be spending most of their time in the community.

Table IV: Reasons community health extension workers do not routinely visit the home. N =125

Reasons for not working in community	Frequency	Percent
Few staff in health center	1 26	89.3 %
Too many patients in clinic	107	75.8%
Lack of vehicles to use	4 9	34.7%
Lack of funds to transport into community	36	25.5%
Radio, Television and churches are already doing community work	20	14.1 %

When asked what functions they were involved in the health centers they mentioned growth monitoring

CONCLUSION

This study showed that community health extension workers were not visiting pregnant women and children in their homes to identify "at risk" individuals and families and thereby bridge the gap between the communities. To emphasize the importance of the work of the community health worker in the community a multi-country review of family and community component of Integrated Management of Childhood Illnesses in South and East African countries showed that child and maternal mortality was significantly reduced in each of these countries.[6] A survey of knowledge of key household practices such as hygiene and child care practices by mothers and caregivers in several communities in Nigeria[7] was found to be uniformly poor. In its document on the strategy to achieve MDG 4 and 5, the Federal Ministry of Health has identified packages of interventions to be provided at the level of the health center and at the level of the family and community.[8]

There is global recognition and consensus[9,10,11] that the health related millennium development goals will only be achievable through community health care services close to homes and community where people live and there is no need for the conflict between community care where lesser skilled health workers may be used and health centre care where higher skilled health workers are necessary. The WHO has made it very clear in its twin reports on PHC.[10,11]

The Federal and states ministry of health should invest more in community health extension workers and stop experimenting with so called volunteer health workers.

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