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Why do village health workers drop out?

A study in the Solomon Islands has revealed that training before the age of 20 and irregularity of remuneration are the main factors explaining why village health workers leave their posts. Other causes are dissatisfaction with levels of payment and promotion, lack of community support, and family concerns.

Although village health worker programmes are closely associated with primary health care in developing countries, there is little conclusive evidence that they have had any effect on health status. Evaluation of their effectiveness is fraught with methodological difficulties; this may explain why studies reflect monitoring processes but seldom give indications of quality. An important way of measuring the cost-effectiveness of these programmes is to examine attrition rates and the reasons why village health workers leave their posts. Valuable indicators for planning and the detection of problems can also be obtained in this manner.

Between 1978 and 1991, 335 such workers were trained. Operating on a part-time basis, they provide simple curative and preventive services, including the treatment of fever, malaria, diarrhoea and coughs, and the application of dressings. They are also involved in health education. On average they receive US$ 13.67 a month, the amount, source and method of payment varying between provinces.

It was reported that during the first three years of the programme 10% of village health workers had left their posts (1). In order to throw light on this matter a study was conducted by the Ministry of Health and Medical Services in collaboration with Save the Children Australia (2).

A survey was conducted among 64 currently working and 66 non-working village health workers, representing 50% and 32% of the respective categories. The samples were stratified with a view to obtaining equal numbers of each category in each province, as well as a balanced representation of the sexes and the years elapsed since training. Six of the selected working and four of the selected non-working individuals were unavailable for interview at the time of the

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survey. In order to validate the information given by village health workers and to gather the opinions of villagers, a male and a female observer from each of the 119 villages covered were also interviewed. The questionnaires were designed to compare the differences between the working and non-working groups so that the variables associated with dropping out and length of service could be analysed. Questions were also asked in relation to training, selection criteria, supervision, conditions of work, and the regularity and source of payment. The data were subjected to detailed statistical analysis.

**Attrition**

Of the 335 village health workers known to have been trained since 1978, 128 were currently active and the remaining 207 had dropped out, giving an average annual attrition rate of 4.8%; the provincial attrition rates for the 13-year period varied from 43% to 78%. In the literature, attrition rates varying between 3.2% and 77% have been reported (3–10), and volunteer health workers have generally been associated with the higher values.

Fifty-one village health workers had become nurse aides or their posts were upgraded to this level. Excluding these instances, the overall attrition rate was 47%. The rates of dropping out for males and females were not significantly different. The average period worked by village health workers was 4.9 years. Within five years of starting, 49% had dropped out; within 10 years the proportion had risen to 67%. Thus the annual rate of dropping out was higher in the first five years of service, averaging approximately 10%, as compared with 3.2% for the second five-year interval (see figure).

**Why?**

Multivariate analysis indicated that the principal factors accounting for attrition were training before the age of 20 years and irregularity of remuneration, the latter being significantly affected by the source of payment: 94% of workers paid by provincial governments were remunerated regularly, whereas this was true of only 47% of those paid by local councils; overall, 58% of the workers surveyed had been paid regularly. Village health workers who were paid regularly had been in their posts longer than those paid irregularly, the respective means being 5.7 and 4.2 years.

Many workers gave a range of reasons for leaving their posts, most commonly related to pay (38%), lack of community support (32%), upgrading of posts (26%) and family problems (23%). Of the 66 non-working individuals surveyed, half had left for reasons related to pay. It was considered by 92% of all the workers surveyed that their allowances were inadequate. On average they thought that US$ 27 a month, roughly double the current amount, were desirable.
Whether village health workers should be paid is a question affected by the historical, cultural and economic context. The payment of allowances has been an accepted feature of the Solomon Islands programme since its inception. Although the vast majority of village health workers said they were dissatisfied with the level of remuneration, no relationship could be demonstrated between this factor and attrition rates because of variations over time and between provinces. However, payment being an agreed part of the programme, it should clearly be regular at the very least if dissatisfaction is to be avoided. Local councils, which have a weak administrative and financial base, were responsible for the payment of village health workers' allowances in five provinces; this was significantly associated with unreliability of payment and an increased risk of attrition.

Although, in itself, unmarried status was not a significant factor, younger candidates for village health worker posts were less likely to be married and have children than older ones. If they married after training they were more likely to move away from their villages, seek other paid employment, or give up work to look after their families.

Communities in the Solomon Islands are often keen to see their relatively well-educated young people selected as village health workers. School-leavers with three or more years of secondary education are easier to train than people who are less well educated. Becoming a village health worker is often seen as a step towards full-time employment, particularly in the health field, and the young are the most likely to have ambitions to become nurses. This is a direct consequence of a system in which village health workers are perceived and are paid as state extension workers by both the authorities and the communities. In these circumstances it is difficult to uphold the concept of the community health worker.

Communities often aspire to having village health worker posts upgraded, and retraining or promotion frequently leads to the creation of nurse aides. This has been accepted in the Solomon Islands as a natural development that should improve the quality of health care. Restrictions on this avenue of promotion could induce more village health workers to drop out.

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The establishment of a database of village health workers is relatively simple. The monitoring of attrition requires accurate maintenance of records and retrospective reviews. Information on the causes of attrition is important in the planning of manpower requirements and the defining of selection criteria. These need to be clearly articulated and understood by communities and programme organizers. It should be borne in mind that the attrition rate is comparatively high among young single candidates. Finally, if village health workers are to be paid, a strenuous effort should be made to ensure that payment is both adequate and regular.

References
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Women and tobacco

In the developed countries, smoking by women was socially unacceptable for many years. However, by the mid-20th century, in most developed countries, smoking by women had increased rapidly. As the health hazards of tobacco became apparent, the prevalence of smoking among men declined in some developed countries. Prevalence rates among women did not begin to decline until later and then only in a few countries; the two rates are currently converging in several countries. Today, in many developed countries, smoking is predominantly a practice of young women, women with limited education, and women of low socioeconomic status.

In the past, cultural norms were a powerful deterrent to women's smoking in the developing world, although there have always been areas in which women have practised traditional forms of tobacco use. Currently, in the developing world, smoking is linked with a cosmopolitan and affluent life-style. With increasing urbanization and career-oriented education, and increasing spending power, many young women who aspire to this life-style have taken up smoking. There is grave concern that these aspirations, fuelled by aggressive tobacco marketing, will result in increased prevalence rates among women in developing countries, further compounding their present difficulties.