

THE POLICY AND PRACTICE OF THE VILLAGE HEALTH TEAM IN NIGER:

A SOCIAL ANALYSIS

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I. Niger's Rural Peoples

This project focuses on all of Niger's rural peoples; therefore it would be useful to have a brief overview of them. Eighty to ninety percent of the country's estimated 5,000,000 people live in the rural areas. Most of these are sedentary or semi-sedentary farmers who live in 9,000 villages. The rest are pastoral nomads. They live in two ecologically different zones: the farmers live in the cultivatable zone in the south and west, and the nomads live in south central Niger just above the cultivatable zone. Farmers grow millet and sorghum as a staple crop, but also grow a variety of vegetables, corn, ground nuts, cotton and cassava. Nomads raise livestock mainly for dairy purposes, but to a lesser extent raise them to sell on the meat markets.

Neither the farmers nor the nomads are ethnically homogeneous as the following table reveals.

<u>SEDENTARY FARMERS (80%)</u>		<u>PASTORAL NOMADS (20%)</u>	
Hausa	60%	Tuareg	50%
Djerma	25%	Fulani	40%
Beri-Beri	10%	Tubu	10%
Gourmanche	5%		
	100%		100%

The Hausa farmers live in the Southern zone although some have migrated to towns throughout the country to work as traders and laborers. The Djerma farmers live in the West, and many live along the Niger River as fishermen and rice farmers. The migration patterns of the Tuareg keep them mostly in the central part of the country, whereas the more unpredictable ones of the Fulani diffuse them throughout the

pastoral zone and even into the sedentary zone during the dry season.

II. The Village Setting

If a Hausa scholar can say that there is no such thing as a typical Hausa village (Hill 1974-7), one can say all the more that there is no such thing as a typical Nigerien village. Beneath a superficial air of homogeneity in structure and activity, lie complex differences in age, ethnicity, wealth, occupation, class and kinship. Nevertheless, there are a few aspects which directly influence the operations of the Village Health Teams that can be described and analyzed in order to identify the directives, incentives and constraints on these operations. What follows is a brief discussion of these aspects as they relate to Hausa and Djerma villages; finally analogous remarks will be made to the nomadic variant of the village.

The most striking aspect of Nigerien villages to a visitor is the compact formation set in the vast Sahelian land scape. The villages range in size varying from small hamlets of less than 100 persons to large, complex villages of well over 1,000. Surrounding the village are millet farms which may or may not have livestock on them, depending on the time of the farming year. Some villages are walled; others are not. Some contain rectangular or square houses with thick mud or brick walls with flat roofs; others contain round mud huts with conical thatched roofs and cylindrical walls of mud or bricks plastered with mud. As the visitor approaches the village he is overwhelmed at what appears to be a maze of huts and granaries separated by mud or millet fences with narrow paths winding through the labyrinth in no apparent order. On the periphery are fenced gardens to keep out the small herds of goats

and sheep which wander about aimlessly and unattended. As he walks along these paths of varying size he notices groups of men conversing under a tree and hears the perpetual pounding of millet by women with their mortar and pestal behind the walls.

Beneath this seeming disarray, however, is a definite order founded primarily on the basis of kinship. The visitor notices the basic architectural unit is a walled concession consisting of a mixture of huts, some large and rectangular, others small and usually round. The dwellings may surround a sort of court yard or be dispersed in it. The concession contains the basic unit of village society - the household or extended family. Ideally, this consists of a patriarch, his wife or wives, his sons and one or more wives for each, and numerous children. There are numerous variations on this ideal, however, depending on the number of in-laws and children in the concession, and one study of a Hausa village found that out of 205 households only 66 were polygamous (Faulkingham 1970: 151).

The household, then, is the basic living unit and the primary one for food production with the household head controlling the farm plots. Household units are grouped together according to close kinship ties to form a loosely, defined descent group whose members are likely to assist one another in labor exchange or provide grain for those who have none. Combinations of these loosely defined descent groups, then, combine to form a ward or quartier which becomes more like a neighborhood of consanguines and affines related in varying degrees of proximity. Each quartier is usually demarcated by a path and the numbers vary from 7 to 10 depending on their size and the size of the village.

In sum, a village consists of the household unit (patri-local extended

or joint family), which combine to form a loosely defined descent group (patri-clan), which in turn combine to form a more loosely defined quarter based on descent and marriage. The quarters combine to form a village, whose members are mostly related in varying degrees of proximity.

Kinship relations extend beyond villages so that individuals from different villages have mutual obligations to one another. Villages are not isolated units and this regular contact between them gives them a form of identity. Groups of villages, then, interlink to form a canton.

Each of these units ~~has~~^{has} a formal leader whose power and prestige corresponds to the size of the group. They correspond as follows:

Household	- patriarch (<u>chef de famille</u>)
Descent Group	- most respected patriarch of the households
Ward	- ward chief (<u>chef de quartier</u>)
Village	- village chief (<u>chef de village</u>)
Canton	- canton chief (<u>chef de canton</u>)

For each village the ward chiefs combine along with the village chief to form a village council which meets formally 2-3 times a year. The council and the canton chief influence the selection and operations of VHT members, and this will be discussed below.

Most farmers tend their millet or sorghum and garden plots as a part or full time activity. In addition, some have a few goats or sheep to tend, and during the dry season when there is no farming there are other things to do such as to dig or repair wells, construct or rebuild walls and roofs. Women pound millet daily for 2-3 hours, and along with children, draw water from the wells, gather fuel, (a time

consuming task in the Sahel) and look after domestic chores. Many farmers are specialists, as well, who perform basic crafts in the village for themselves and others. These include well diggers, tanners, blacksmiths, weavers, tailors, barbers, hawkers, carpenters, etc. Naturally, the larger the village, the more the specialists, some of whom work full time at their trade. In addition, villages are often ethnically mixed with "minority" groups living in their own ward.

This suggests that what appeared to be a collection of simple farmers is more complex and that villages are differentiated by status and class. This is in fact the case and the basic determinants of the differentiation are two: ascribed and achieved characteristics. Important ascribed characteristics are kinship (how close one is related to a chief or village founder), ethnicity (is one a member of a dominant or minority group), and age (among the Hausa "men under 30 are considered youths and treated as status inferiors (Charlick 1974:123)"). Important achieved characteristics are occupation, education and wealth. Ultimately, however, one's status, which might loosely and simplistically be defined as high, medium and low, is determined by a combination of these two types of characteristics. That is, one may attain a high status because he comes from a prestigious family and is of the right age; but he must maintain his status through performance which lives up to the expectations of other villagers. This principle influences directly the selection and tenure of the VHT members as will be discussed below.

Also of importance to the functioning of the VHT is how they fit in the village web of politics. At the center of this web is the chief. The following model focuses on the performance of a Hausa chief as observed by Faulkingham (1970), but closely resembles that of a Djerma chief as reported by Stoller (1977).

A village chief reinforces his office and maintains the support of his villagers by discharging his basic duties according to the expectations of the villagers and by validating the core values of the community. Basic duties consist of adjudication, tax collection, festival leadership, and brokering between villagers and outsiders (e.g. government officials, visitors, etc.). Basic values in a Hausa community consist of "openness/frankness," "group solidarity", "conservativeness" and "resignation/fatalism". The chief carries out his duties through the manipulation of significant people in the village, and, these are likely to be the marabout (Islamic holy men), teacher, merchant, temporarily resident functionaire, or an important specialist, e.g. well digger. (These can also be Village Health Team members,)* That is, he tries to convince them first of his innovative or controversial plans or decisions before taking them to the villagers; or he supports their actions as a form of investment so that they will support him at a future date.

A successful chief is one who is qualified, holds his office by gaining support of the villagers, especially key persons, and performs according to village expectations. In effect, he reinforces both ascribed and achieved status criteria as a norm for the village; he qualifies because he comes from a chieftan clan, but performs well through careful politicking and decision-making. By reaffirming the underlying values he maintains village harmony, and a continuity with the past. It is a similar set of conditions and criteria in which VHT members must function as will be shown below.

*Village Health Team will be referred to as VHT from now on.

Turning to the nomads, the term "village" becomes inappropriate. By definition, nomads migrate as they follow their herds, and so their organizational units are small and flexible when compared to farmers. The maximal residential unit is the campement and consists ^{of} a few families (la tente) each of which manages the herd for both Tuareg and Fulani.

The campement as a cooperative unit enables herders: (1) to assist one another in times of crisis; (2) to guard their animals more effectively; and (3) to release family members for millet farming or wage labor in urban centers.

Usually, a leader known for his experience and good judgment is chosen by consensus among campement members to lead the unit. The camping... unit is not a permanent, corporate structure, for its composition may expand and contract during a migration or in the next year. There is, however, a core of families that migrate together, and if the families do ~~disperse~~ ^{disperse}, they reassemble later on. The camping unit, then, is the largest, most stable unit of the nomads during migrations.

Tuareg migrations tend to be more predictable than those of the Fulani. The general pattern of migration for both is a southward movement during the hot dry season in search of water and pasturage and a return movement northward late in the cooler rainy season in search of surface water and renewed pasturage. The Tuareg are more likely to migrate between relatively fixed-points in a north-south direction while the Fulani radiate out in many directions in a general southerly direction.

For both, migrations of camping groups are punctuated with delays, deviations, dispersions and reassemblies depending upon changes in climate. Discussions within and between camping groups at wells and along migration routes, forming a "pastoral telegraph", determine whether a group will

maintain or change direction of its movement.

Beyond the camping group, Tuareg society is more integrated than that of the Fulani for it is stratified into three classes which function as status groups. The Fulani, however, are basically egalitarian with considerably less class differentiation. The Tuareg camping groups comprise more inclusive tribes or "fractions", and then tribes make up the more inclusive groups (le groupement). Each tribe and group has its respective chief. For the Fulani, however, the lineage is the next inclusive group above the family led by a chief with limited authority. Beyond this, Fulani social units are more symbolic than corporate.

This social structure has strong implications for health interventions. Since the flexible social structure of the Fulani enable them to disperse in more directions than the Tuareg, they are more difficult to contact. The more integrated social structure of the Tuareg enable them to assemble more easily, and this observer witnessed a gathering of 30 Group Chiefs with Nigerien ministers at an annual gathering in the north, the salt cure, where the chiefs represented an estimated 25,000 people. No meeting of this scale was heard of among the Fulani by the observer. Moreover, the Tuareg tend to be more dependent on the market economy than the Fulani and thus are more accessible for health (and other) interventions.

The annual salt cure in the north is one time when significant contacts are made between the government and Tuareg and Fulani. The nomads lead their herds to this area to be restored with salt and other nutrients which are accessible in August-September because the rains have restored the pasturage. Members of tribes and groups meet at designated places to renew kinship ties and to partake in ritual and recreational festivities. During these meetings, government officials politicize the nomads through

informative and exhortative talks about development policies. Also, large mobile health units come to vaccinate the nomads against small pox, polio and measles and treat them for diseases, wounds, or other health problems. In general, however, the operations of these units are unrelated to those of the VHTs.

III. Village Traditional Health Care

Nigerien villagers, like people everywhere, have always had a system of beliefs, concepts and practices for understanding and curing sickness and mental and physical health. One could hardly say it is "scientific," based on a germ theory of disease. In fact, it is a blend of common sense observations explained ultimately by supernatural causes. It is logical if one accepts the premises, and in their eyes the practices seem efficacious. Most important, the health care agents in each culture convey a strong emotional charge in their dealings with the afflicted, and this personal relationship no doubt has a *relaxing* and possibly accuring of the psychosomatic effects on the afflicted.

In general, sickness and death are perceived to be a result of two factors: natural and supernatural causes. Natural causes are not really explained; rather sicknesses are associated with natural phenomena or climatic changes. For example, riverain villagers believe that when the river is high from November to March, the water is clean, and that drinking it will not cause sickness; but when the water recedes during the hot season, the water becomes dirty and drinking it causes meningitis and gastro-intestinal problems which do, in fact, occur at this time. Malaria is signified by the same people as the "result of the harvest" which occurs in October at the end of the rainy season when the mosquito population is high (Stoller 1977). Similarly, the Tuareg recognize the symptoms of such diseases as tuberculosis,

malaria, syphilis, measles, etc. which are widespread in Niger and, in some cases, associate them with natural events.

The underlying element in all this temporal association with disease incidence is a sense of fatalism, a core value at least among the Hausa as mentioned above. Why does one person get sick and another does not? Why can one person drink polluted water and eat rotten meat and never be sick? It is the "will of God". Stoller reports that during a cholera epidemic, a Tillaberi resident once asked whether he would continue to drink river water, despite the risk to his health. He stated he would continue to drink the river water for "if God decides it is time for one to be sick or die, so be it (1977)".

Supernatural causes basically fall into two categories: spirit intervention in human affairs and sorcery. Generally villagers believe in the existence of the devil, witches and evil spirits, and the actions of these forces are responsible for illnesses such as fevers, prolonged lethargy and especially mental illnesses. The Hausa attribute these incidences as well as child mortality to the vengeance of "Allah's henchmen", the bori, who have been offended by a human wrongdoing (Faulkingham 1974: 105). In a country with so many and widespread diseases, it is readily understandable that malevolent forces would be the basic cause. Sorcery, or the manipulation of spirits for evil purposes by humans, is also widely believed and practiced among villagers, and this is suspected as a cause of illness and death. Suffice it to say that supernatural causes of physical and mental diseases among Nigerian villagers is widely and deeply held and will continue to exist despite large interventions in modern preventive medicine.

Just as there are deeply held traditional beliefs about sickness and

death among Nigerien villagers, so is there a deeply held trust and use of traditional curers. These are of two types: Islamic and non-Islamic. The Islamic curers are marabouts, or Islamic holy men; the non-Islamic curers are of many types, the most numerous being male healers, or guerisseurs, and the traditional female midwife, or matrone.

Marabouts have existed in Islamic West Africa for centuries and are more respected than non-Islamic curers. They are literate in Arabic and are usually familiar with Arabic literature on curing, ranging from pharmacology to witchcraft cures. They treat both psychological and physiological problems, and their cures often consist of a consultation with the afflicted and giving him a Koranic verse written on paper ("gris-gris") to carry with him. Most every village has a marabout, whose prestigious position puts him in the center of village politics, as mentioned above. Often, he is the only literate person in the village, and in some cases, has more power than the village chief. In addition, he may become quite rich by village standards and payments may be in animals, grain or cash.

The non-Islamic guerisseur is more likely to treat physiological problems, although these are usually attributed to supernatural causes. Unlike the marabout, however, he has little supernatural aura about him and is perceived as a craftsman. An unexpected death, a prolonged illness or sudden pain is interpreted as the spirits taking vengeance on the afflicted either for his wrong doing or as a result of someone's sorcery. He attempts to appease the spirits and recommends ritual procedures or the taking of herbs or potions by the afflicted. Each village usually has more than one guerisseur each of whom is much in demand and well remunerated for his services though not as much as the marabout. Examples of their services and payments are given in Annex 1.

The matrone assists the delivery of babies and also serves a therapeutic function for the anxious would-be mothers. It will be brought out later that she has a firmly entrenched role in the village and that modern training of the matrone is additive to this role.

Some of the traditional treatments are perceived by medical personnel as beneficial and the Nigerian Ministry of Health is considering research of these treatments and the inclusion of successful ones as part of the secouriste-matrone repertoire. For example, guerisseurs treat hemorrhoids among the horse-riding Hausa by applying a certain oil on the anus which is perceived to be efficacious. Other treatments have neutral, and even harmful effects. Examples of the forms are drinking sugar water for a fever among the Tuareg ^{BERNUS} (~~BERNUS~~ 1967:5), and of the latter are the placing and mixture of faeces and mud on the fallen fontanelle of a baby suffering from diarrhea. This treatment is believed to raise the fontanelle. No attempt is made to catalogue these treatments here; suffice it to say that it is an important area for research and for incorporating selected traditional practices into a modern health care system.

Traditional curers also practice preventive medicine. The most famous is the amulet or "gris-gris" mentioned above. This is believed to protect the person from witches and sorcerers. Guerisseurs may give a ^{charged} ~~charged~~ ring, herbs, or parts of animals to protect a person from sickness, witchcraft or sorcery.

Generally, those objects which have Koranic writing on or in them are more valuable, thus, heightening the prestige of the marabout. While these preventions are ineffective from a scientific view, they do give the bearers a sense of security, thus, fulfilling a psychological function. This reason alone assures that beliefs in the efficacy of these practices will not die

quickly despite accelerated development and modernization.

IV. Village Health Team Policy

Beginning in 1964, the Nigerien Ministry of Health (MOH) has tried to "add on" to the traditional village health system. A health team, generally consisting of a male health worker, midwife and two administrative members, are selected and trained in basic modern techniques of curative and preventive medicine. The villagers themselves choose the team and after the training, the team returns to the village to practice what they have learned. Team members receive no salary and, officially, they are to give their services freely, finding reward in their sense of service and the prestige of having been chosen by their kinsmen and neighbors. They are supervised periodically by health officials and after two years are re-trained in the same basic techniques. In this way the MOH attempts to work through the existing health agents (curers and midwives) who ideally can diffuse basic techniques of modern medicine to villages in terms which they can understand.

There are approximately 1300 Village Health Teams operating throughout Niger at this time, and they are on the "front lines" between the urban based MOH and the villagers. The first dispensary (Poste Medical) which usually consists of a certified nurse (infirmier certifié), trained midwives (matrones) and a laborer. In a few dispensaries there is a certified midwife (sage-femme) and a health educator (educatrice sanitaire). The dispensary is small with only a modest supply of medicine and facilities.

These dispensaries are located in large villages and serve that village; but they also support satellite villages where there are VHTs. This support consists of serving as a referral base for sick cases which the VHT cannot handle or as a relay point to send serious cases to a large dispensary or hos-

pital. In addition, the nurse and certified midwife (where they exist) are to visit a VHT in the village once every two months to supervise them and replenish their medical supplies. Presently, there are 163 of these dispensaries to support 1300 teams, at a rough ratio of 1:10.

At the arrondissement level, there is a medical center (Centre Medical) which consists of a dispensary, a maternity ward with 2-3 rooms and a hospital ward of 3-4 rooms. The central dispensary serves the arrondissement town as well as villages nearby. It also receives patients from the smaller dispensary unless they have been evacuated directly to the urban hospital. The staff consists of a head nurse, who has had three years of training (infirmier d'etat), in addition to a greater number of the same personnel who staff the rural dispensaries. The facilities and medical supplies are also greater than those of the rural dispensaries, and there usually exists one or two vehicles.

There are 37 medical centers in each of the arrondissement centers in Niger. Like the nurses at the rural dispensary, the nurses at the medical center are supposed to supervise each VHT in villages surrounding the medical center once every three months and the state nurse tries to visit each VHT twice a year.* Most important, these nurses train and re-train the VHT's at the center throughout the year.

*Reports were inconsistent. In Niamey Department, certified nurses are to visit each VHT once every three months and the state nurse to do so once every six months. In Maradi Department, the frequency for the respective nurses are once every month and once every two months.

The selection of a VHT follows a standard procedure. A village is selected generally according to three criteria: (1) size; (2) proximity to a dispensary; and (3) existence of a school. The corresponding reasons are: (1) a larger village is considered better than a smaller villager because the team members can serve more people in their village yet travel to smaller satellite villages; (2) the closer a village is to a dispensary, the easier it is to supervise the team, to supply it with medicine, and to refer or evacuate more serious cases; and (3) teachers in a school can help the team members write and review their records as well as offer informed leadership during preventive medicine campaigns.

The election procedure is also standard, at least apparently so. A member from the Rural Animation Department (Service d'Animation Rurale) and a certified nurse come to the village and talk to the villagers at a meeting arranged by the chief at a public area or at a gathering of the Village Council with the entire village present. They "sensitize" ("sensibiliser") the villagers about the importance of curative and preventive health through explanation, discussion and exhortation. They return at a future date to supervise the election by the villagers of 4 team members: a secouriste (health worker), a matrone (midwife), and two administrative members (comite de gestion) president and a secretary-treasurer. After the election, they explain how they will be trained. They return a third time and follow up the previous discussion and finally exhort the villagers to cooperate with the VHT.

The recruitment criterion is for each team member to have the trust of the village as being responsible, reliable, and capable. The animator and nurse emphasize this before the election and tell villages that the team must work voluntarily, so team members must be service oriented.

The training lasts for 10 days for the secouriste and 15 days for the matrone although this figure varies with each arrondissement. It is basic and kept to a simple level for the illiterate members. Lessons consist of a combination of lecture, demonstration, discussion, and most important, application. The curriculum consists of the symptoms and causes of the most common diseases in the region, and the use of the medicines and techniques to treat these diseases or accidents. In addition, the secouriste and matrone receive a very short literacy training, especially numerical skills in order to keep track of records.

Each secouriste and matrone is given a medicine box which contains the appropriate medicines and is shown how to use it. See Annex II for a description of the curriculum and contents of the medicine box.

To facilitate the record keeping, the secouriste and matrone are given charts which have pictures on them, each representing the different diseases and the appropriate medicine. They are instructed how to note in each box the incidence of disease and distribution of money. In addition, they are given a price list of the pills (anti-malaria pills and aspirin) and are shown how to note down the money paid.* Each team is retrained at least once every two years in much the same fashion.

*Villagers must pay a very small amount for the pills (equivalent of US \$.05 per pill). MOH believes that they will respect the medicine more than they would if it were distributed freely. Because of the peculiar situation of the nomads, discussed in the next section, they are given all medicines freely.

The roles of the VHT members are as follows;

Secouriste:

Curative Duties

- 1 - treat wounds
- 2 - distribute simple medicines according to specific symptoms of the diseases (See Annex III for a list of the diseases and their appropriate medicines)
- 3 - refer serious cases to the dispensary

Preventive Duties

- 1 - teach sound concepts of body and environmental hygiene
- 2 - organize the construction of garbage pits, latrines, and animal enclosures
- 3 - warn dispensary nurse of epidemics
- 4 - conduct malaria prevention through the distribution of anti-malarial pills
- 5 - conduct nutrition education

Administrative Duties

- 1 - record number of patients treated and for which disease
- 2 - record the number of medicines given out
- 3 - note type of sanitary facilities constructed
- 4 - monitor medicine supply
- 5 - serve as liaison between other VHT members, villagers and the dispensary nurse.

Matrone:

Curative Duties

- 1 - insure births are hygienic
- 2 - administer care to the newborn

3 - monitor and care for the mother who has recently delivered

Preventive Duties

1 - visit homes and conduct public sessions to teach sanitary
body and environmental habits

2 - monitor pregnant women to identify high risk of pregnancies

3 - monitor the progress of newborn infants

4 - identify cases of malnutrition

Administrative Duties

1 - record number of pregnant women, births, deaths, and live
and still births

2 - maintain an adequate supply of materials

3 - serve as liaison between other VHT members, villagers and
the dispensary

President:

1 - supervise and coordinate team's activity

2 - support the secouriste and matrone especially in their deal-
ings with villagers

3 - oversee the medicine stock

4 - insure that the medicines distributed balance with the amount
of money paid for them

Secretary-Treasurer:

1 - keep an account of the sickness recorded by the secouriste
and matrone

2 - keep an account of the payments received.

Finally, all four members are to cooperate and communicate with each
other. This is especially important regarding the sharing of medicine when

one member lacks some, and they must borrow from one another. If a secouriste or a matrone decide that ^a patient must be evacuated to a hospital facility, they notify the president who in turn notifies the chef de village. He, then, dispatches someone by camel, horse or foot to the dispensary to obtain a land-rover.

MOH considers supervision of the VHTs as high priority. During the field visits to each team, the state or certified nurse, and sometimes the animator try to meet the secouriste and matrone. They check the medical stocks and replenish those which are needed. While they do this, they also review with the team the use of each medicine. In addition, the nurse and animator review the records and take the money received. If there is a shortage in the money received and the team cannot explain it, then the supervisors notify the chief about the problem who in turn discusses the matter with the team and the villagers in order to resolve the problem. If they cannot, then the supervisors will take back the medical kits. The point of this is to force both the team and the villagers themselves to be responsible for their medicine, its distribution and its payment, thus, encouraging participation at the local level.

Among the nomads, the VHT concept has been adapted to fit within their more flexible structure. The "village" unit in which the VHT operates for the nomads is the campement. It was mentioned above that this is the most permanent unit even though it is mobile. It averages in size between 20-30 people, and so because of the small adult population only the secouriste and matrone are selected for training. After training, they return to their campement to administer the medicine which is free because the MOH recognizes that they have less cash than farmers. The teams are given an identity card, which they present at the dispensary to replenish their medical supplies when

they return from their migration. They are also retrained at the same dispensary where they were originally trained, usually a rural dispensary. There is virtually no supervision when they are migrating.

V. Village Health Team Practice: Strengths and Limitations

This section reviews the actual operations of the VHTs in the context of the three main sections discussed above: the village structure, traditional health care, and the VHT system. This review addresses itself to the three basic social soundness questions:

- 1 - How does the VHT system fit socioculturally within the existing structures, processes and values in the village?
- 2 - Will the VHT system be likely to spread from 1300 to 5000 villages successfully?
- 3 - Will the villagers benefit from the VHT system in the way they are intended to?

A. VHT in the Village Structure

Generally, the VHT recruitment and operations fit into the basic social structure of the village. It was noted above that the chief and other important village personalities attain that position because they meet certain ascriptive and achievement criteria. They belong to a chief-tain clan; but they perform in that position through a careful manipulation of agents and by carrying out their duties successfully. The matrone and securiste also operate under ascriptive/achievement criteria. Even though they are elected openly, it is generally known before hand that the chief would like person A or B to be elected. If it is a large village, the canton chief may even have some say on the matter. Invariably, the team members are closely related to the chief, or another important person in the village. In a number of cases, the chief himself may be the securiste

or the president, or his wife may be the matrone. In fact, in one sedentary Tuareg village visited by this observer, the two secouristes were the chief and the marabout! This is understandable for the villagers are asked to elect someone whom they respect and trust, and usually, the chief and his relatives are those people. And if they don't perform, the villagers have the right to replace them with others (although no cases were reported to this observer where this actually happened).

In addition, the operations of the team reinforce the existing power structure of the village. It was noted above that the chief needs agents to help him legitimize his position.* In most cases, he works with the team by exhorting people to follow their advice on preventive medicine, by attending teaching sessions, and most important, by assisting in the referral operations. In two reported cases, the chief gave the use of his horse to enable a courier to carry a message to the dispensary. In another case, it was the marabout who wrote the message for assistance. By doing this, the chief not only supports and improves the performance of the team, but he also reinforces his own position. This is why animators and nurses make sure they have the full support of the chief before they begin their sessions. Generally, chiefs want to have a team for the obvious reason of improving their health facilities, but also because they know it will strengthen their position by giving prestige to the village. Just how the introduction of VHT among the Tuareg and Fulani would reinforce the existing structure was not investigated.

*Legitimacy here is defined as "a form of support attaching to a person, action, or status on the basis of a positive connection to values which the supporters share (Faulkingham 1970:176)".

Most likely, it would function in the same way for the chef de campement and chef de tribu. Certainly it would be necessary to gain their support.

It is difficult to see how the team can become a threat to the existing political structure. Possibly in the future, as educated and better trained secouristes are elected they might be seen as "petit fonctionnaires" and try to achieve their own power position. But the values of 'conservativeness' and respect for elders, noted in Hausa villages above, do not die easily, and even today the teacher and merchants assist in the actions of the team by counting the money taken in, reviewing records, and writing notes. In one observed village the teacher assisted the interview with the matrones (secouristes were in the fields), and it was apparent that his knowledge of the team's operations indicated he was involved with them.

There is a problem regarding compensation for the team's efforts. Essentially, the members are caught in a dilemma. On the one hand, gift-giving has a tradition as a form of establishing and validating dyadic relationships in Nigerien villages (Faulkingham 1970:159), and this specifically applies to healers as was shown above; on the other, MOH has stipulated that the team should receive no gifts (cadeaux) because the service is voluntary and the reward should come from the prestige associated with the position. There is cultural support for the service being voluntary as well, especially in the value of "solidarity" mentioned above for the Hausa. In addition, Islam reinforces donating goods and services, for the donor will get his reward later on because "God sees what you are doing" ("Iri coy go no" - Djerma expression).

The secouriste and matrone, especially the former, suffer from the above dilemma. The problem came up repeatedly from team members as well

as MOH personnel. One interviewed secouriste complained that he had been a secouriste for 3 years and after receiving 3000 CFA from the villagers when he first started, he has received nothing since. Another, when complaining of the lack of compensation, was asked why he did not quit. He replied that he felt an obligation to help his fellow kinsmen. The problem is less severe for the matrone who has a traditional role in village society and has always received, like the curers and marabouts, a "cadeau" for her services. Most likely, both secouriste and matrone receive "cadeaux" though neither admits it openly because of MOH policy. In addition, the matrone receives more than the secouriste. One chef de village said that he helped the secouriste by asking villages to reciprocate services to the secouriste such as gathering firewood or repairing his home. This might be one way to alleviate the problem.

Finally, the roles of the president and secretary-treasurer do not seem firm. In the villages which were visited about half had one or two of these positions, and in some cases they were assumed by the secouristes and matrones themselves. Reports collected on VHTs from Niamey and Maradi Departments listed no "administrative committees" (Comité de Gestion). The DDS in Maradi said there were numerous teams in his Department which had no committees. Perhaps, this is because there is no reward for the effort, the roles have no tradition in the village, or the secouriste and matrone do the record keeping themselves.

For the campement among the nomads there is only the secouriste and the matrone. The relatively small size of this unit as compared to the villages makes the role of the committee superfluous. Curiously, it is easier to recruit and train secouristes than matrones as the following figures for Agadez Department which began the program in 1976 indicate:

	<u>Secouriste</u>		<u>Matrone</u>	
	<u>1976</u>	<u>1977</u>	<u>1976</u>	<u>1977</u>
Agadez	19	12	8	12
Bilma	14	15	8	-
Arlit	18	-	10	-
		<hr/>	<hr/>	
	78		38	

The reason given for this is that Tuareg women are reluctant to accept anyone outside of the family (la tente), which make up the campement to assist in the delivery. It is always the grandmother in the extended family who assists and is preferred to an outsider even if she is a trained matrone. Among the sedentary Tuareg villages which were visited, there were no trained matrones.

B. VHT Operations in the Traditional Health System

There is no question that villagers want a VHT in their village. When asked the question "What do you want from a rural health care system?", the inevitable reply was "medicine". They fully realize the efficacy of modern medicine, especially such pills as aspirin, Nivoquine -flavoquine and paragoric - in that order - and advice as to disease treatment. When the secouriste were questioned as to the frequency of distributing medicine the average reply was 3 times per day. This included all medicine. Ideally, they would like to have a dispensary in their village, but realize that this is impractical. The nomad informants were less enthusiastic about this for it does not fit into their migratory way of life. They would like to see, however, more dispensaries in the countryside along their migration routes, and of course, for the secouriste to have a greater variety of medicine, especially for the treatment of syphilis which is more common among them than sedentary villagers. In addition, they would like to have the medical

supplies replenished more regularly.

However, there are some constraints which inhibit to some extent the villagers making full use of the VHT's services. These have to do with (1) the villagers' perceptions of the VHT, and (2) relationships between the VHT and other healers.

1. Villagers' Perception of the VHT

With the exception of the nomads mentioned above, the villagers, in general, perceive more clearly the role of the matrone than that of the secouriste. The matrone has a traditional role in Nigerien village society.

In fact, most of the matrones interviewed had traditional roles as matrones before training, and it is logical for the villagers to select them. They are respected and take their job seriously. They do not leave the village and so are readily available. Hence, they perform their duties pretty much as expected.

The secouriste, on the other hand, has a slightly ambiguous role. There are many secouristes who are well integrated into the village health system and are quite effective, but there are others who are partially so and as a result are less effective. Often the secouriste is younger than the matrone - the former ranging from 20-40, the latter from 40-60 - and it was noted above that at least, among the Hausa, that a male is not fully respected as a male until age 30. Why do villagers elect them if they do not afford them full respect? Possibly because in some cases, the village chief wants his son or younger relative to fill the job and influences the election procedure to do it. (One interviewed secouriste, who was the chief's son, was 17 years old!) Moreover, to some extent, the services of the secouriste in the eyes of the villagers are in competition with those of the guesisseur and this will be discussed below. In effect,

the role of the secouriste is somewhat new to the villagers and not fully understood by some.

As a result, some secouristes have less commitment to do their job than the matrone, especially in light of the lack of compensation as noted above. He is liable to leave the village and migrate to Nigeria or Libya during slack periods of the farming season. This observer spent the whole day searching for a Tuareg secouriste in the Ingall area only to find out that he had gone to Libya. Also, the secouriste may render services inadequately because he has competing business to attend to in his own household. One resourceful secouriste said he got around this by having "office hours" from 6:00-7:30AM every day. Also, he may be less likely to cooperate with the matrone to exchange medicine or to give demonstrations in preventive medicines together.

The ^{tenuous} position of the secouriste is probably a function of the novelty of the role, competing roles, and his age relative to the matrone.

In some cases, villagers may perceive VHT members as being socially distant from them. The secouriste and matrone are selected and then go off to training at a "government" institution, the Centre Medicale. This is prestigious for they are in a very slight way identified with the government. They return to the village prepared to treat and teach people about preventive medicine. Villagers are further impressed with them. Then the VHT begin their work. Most do it successfully, but a few begin to appear a bit haughty, pushy and aloof. To the villager, they are becoming "anasara"* or different from them and the villagers begin to resent them.

*Djerma term for white person, hence different, aloof, even haughty because they were the Colonial rulers.

In one case, the matrone said when she asked a village woman to clean up the faeces in the concession, the latter replied "Who are you? My concession has always been this way, why change?"

This lack of reinforcement from the villager, then, frustrates the VHT worker who in turn may become alienated from villagers, and he or she may actually think they are better than the villagers because of their "government" training.

When one matrone was questioned as to whether she ever used traditional medical practices, she laughed and said "never". She was never taught to use them in her "government" training and that if she did, villagers would lose respect for her as a trained matrone. Thus, the modern training may reinforce a slight disidentification, thus, confirming occasional haughtiness of the VHT member in the villagers' eyes.

How widespread is this problem is impossible to tell. Probably not very. Nevertheless, some villagers do not follow the advice of the VHT worker, especially regarding preventive medicine, to be discussed below, and this perception may be responsible for widening the social distance between the VHT worker and villager, thus, reducing the motivation of the latter to practice preventive medicine.

Further, the villagers' belief systems regarding sickness, disease and death, influence in varying degrees their relations with the VHT workers in at least two ways: (1) their decision-making process regarding the use of traditional or modern medicine and curers; and (2) their less than enthusiastic response to preventive medicine which the VHT attempt to introduce.

It was noted above that most villagers have no conception of a

germ theory of disease and believe that natural and supernatural phenomena are responsible for disease. Exactly which phenomena are responsible for which diseases is a rich subject for research, and would have practical implications regarding why and under what conditions^a/villager will choose to use a VHT worker for curative purposes. He can choose to use an array of healers: the marabout, guerisseur, diviner, barbier, and secouriste. Naturally, only the matrone will be used for birth assistance, except for the Tuareg where there appears to be suspicion of non-family members helping a delivery.

Unless more is known about the villager's disease etiology, one can only speculate on his decision-making process. Determining variables might be:

A. Whether the villager compartmentalizes the function of each of the healers according to certain symptoms and diseases. Ex. Is the secouriste good for aspirin for a headache, but the guerisseur good for a potion for nausea?

B. Expediency. Whether one healer is available and the other is not.

C. Kinship ties to a healer. If a guerisseur is a close kinsman to a villager, he may be more likely to use him than the secouriste and the inverse is also likely to be true.

D. Acculturation level of individual and village - The more contact and experience, especially schooling a villager has had with urban-based forces, the more likely he will use the secouriste; the less of this, the more likely he will use a guerisseur or diviner. Faulkingham reports, however, that some villagers see the diviners as fakes (1970:106). The marabout will always be sought out because of his religious prestige. One

Tuareg group chief reported that the Tuareg would seek out the marabout for most any illness first, then the dispensary nurse. No doubt difficulty of travel is a factor here.

E. Reputation of the respective healer - If any one of the healers has a reputation of being efficacious, he will be sought out more than those who do not.

F. Multiple usage - Villagers may try two different healers just to be sure to be cured. One expecting mother sought the matrone for prenatal care and the marabout for encouragement to insure a safe birth. This suggests that introducing modern techniques through a traditional system may not be fully possible, because in the eyes of the villager they are different systems for meeting different needs, and to some, these systems may even be mutually exclusive.

Villagers want to be cured; they are less interested in learning how to prevent diseases from occurring. Again, their beliefs make it difficult for them to see the relationship between faeces in the concession, flies, and infantile diarrhea, or to stagnant water, mosquitoes and malaria. They may and do listen to VHT workers' advice, demonstrations and instructions, but they are less likely to practice them. This is not to say VHT workers are not successful. In many observed cases they were. Concessions were clean, goats were penned up in the village, women were making the recommended porridge to wean their infants, etc. Obviously, a long-term study with participant-observation would be necessary to confirm this, but opinions of Peace Corps Health educators, nurses and VHT members concurred that some progress was being made in this area.

VHT workers conduct preventive medicine in a number of ways. They gather 15-30 people together under a centrally located tree, usually after the chief has summoned them, and he may attend as well, thus, legitimizing the VHT workers' status. The secouriste and matrone may conduct the meeting together or separately, and generally follow the outline noted in the above section. Interviewed VHT workers said the meetings lasted 15-30 minutes, and they try to have them at least once a month. Also, they work with the chefs de quartier as they rotate their talks around the village. They also give individual instruction or advice when meeting someone who has recovered from an illness or when dispensing medicine.

Some VHT workers, especially the secouriste, admitted they did not teach preventive medicine techniques as much as they should, and that they emphasized curative medicine. They knew also that some villagers were not following their advice. The reasons are understandable. Villagers' disease etiology, as mentioned above, is not congruent with the assumptions behind modern preventive medicine. The VHT workers themselves are illiterate and have only a shallow understanding of causes and prevention of diseases. Hence, traditional and modern preventive medicine do not inter-link as intended. In addition, VHT workers are busy people and must tend to their own affairs at the expense of introducing preventive medicine.

2. VHT workers and other curers - There are points of cooperation between VHT workers and the other curers. It was mentioned above that in a few cases a marabout became a secouriste. This appeared to be more prevalent among the nomads than the villagers (where concurring estimates were that only 1-2 out of 10 secouristes are marabouts). There was no reported incidence, however, of a guerisseur becoming^a secouriste. There were a few incidents where the marabout helped the VHT by authorizing a referral

case to a dispensary or by sending a patient who came to him first to the secouriste. One Tuareg marabout legitimized the status of the secouriste by calling people in front of his own tent to have the secouriste conduct preventive health lessons which the marabout said was done once a week. Finally, some DDS and Chef de Centre Medicale said they believed that the marabout and even the guerisseur refer patients whom they cannot cure to secouristes. This became dramatically evident to this observer when he met a CCM on the road just outside of town. The CCM was on his way to visit a famous marabout who summoned him to treat his hypertension.

But, testimony was also obtained whereby the VHT and the traditional healers operated in "two separate worlds" and could not cooperate. It must be emphasized that the guerisseur and marabout are firmly entrenched in the village, as noted above. Moreover, they have no intention of yielding their position for not only is the prestige rewarding but they receive substantial payment. To a certain extent, they do operate in compartmentalized worlds which do not conflict. But the secouriste could be a threat to them, especially to the guerisseur, who is a craftsman with no religious aura about him. For the immediate future, it is likely that a more effective VHT system, especially in terms of the influence of the secouriste, could erode but not displace the power of the traditional healers who will continue to fulfill a psycho-therapeutic function for the villagers, especially the older ones. In the long run, it is inevitable that modern medicine and related techniques along with other modernizing forces, such as schooling, cash product agriculture, communications, etc. will undermine if not displace the power of these traditional personalities.

C. VHT Operations in the MOH System

So far in this section the VHT has been viewed from the "bottom-

up" -- from the organizational and medical perspective of the villager. Despite the limitations within the VHT and the constraints placed upon it by organizational and belief systems of the villagers, the VHT system functions satisfactorily. Moreover, conditions exist on the local level to receive the VHT system where it does not yet operate. This section focuses on the limitations which MOH confronts in the diffusion of the VHT system throughout the country.

The VHT system began in Maradi in 1964, and so it is there where it operates most efficiently in terms of team stability, the distribution of curative and preventive medicine, and supervision, training and support by Dispensary personnel. It started later in the West and operates less efficiently there. However, Niamey Department has intensified the effort recently, especially with the close supervision of a small but mobile Dutch team of doctors and nurses who monitor in the field the activities of the secouristes and matrone.

The program is weakest in the north among the nomads and only began in Agadez Department in 1976. Supervision is difficult and almost non-existent as the mobility and dispersion of the nomads present formidable problems for training, retraining and supervision.

The following statistics illustrate the disparities in the three main areas:

	<u>Secouristes</u>	<u>Matrones</u>	<u>Comites de Gestion</u>
Maradi	578	487	
Niamey	246	129	Incomplete data
Agadez	78	38	

There is no question that the MOH intends to expand the VHT system and that the villagers want it. There are some limitations, however,

within the support system which will impede this expansion.

The most formidable one is general supervision. It was pointed out above that the VHT members are in some cases slightly "removed" from village life because of their mild acculturation and status as innovators. Their roles are also slightly ambiguous, especially in terms of their rewards. This applies more so to the secouriste than to the matrone. They need to have support from nurses and animators in order to feel more secure. This was articulated many times by MOH administrative personnel. Just the fact of a nurse riding into a village in a land rover and talking with the VHT members in the presence of the village chief, marabout or teacher confirms their importance in the eyes of the villagers. When this observer accompanied nurses on a supervisory trip, a crowd always gathered around the VHT and nurses to watch the inspection of the medicine box and records and to listen to the advice given and questions asked by the nurses. The secouriste and matrone need this validation of their status. Naturally, this means an increase in the number of vehicles, small dispensaries and trained nurses. In addition, when a physician accompanies a supervisory team occasionally, this not only intensifies the validation but enables him as an important administrator to know more about the realities and problems of the VHT.

The next major limitation is the spread of the VHT system among the nomads. After they are trained at a dispensary or medical center they are rarely if ever supervised. Moreover, their medical supplies run out during the migrations, and they have no chance to replenish them until they return to the dispensary where they were trained. The vast distances, difficulties of travel, especially during the rainy season, and the shortage of vehicles and staff make supervision difficult, if not impossible,

among the small campements of dispersed and mobile nomads.

MOH has tried to work within nomadic patterns by training a secouriste for each campement and by mass vaccinations during the annual gathering of the nomads, or the cure salé in August. Currently, the nomads pay no taxes, their medicine is free, and they are less suspicious than they used to be about government intrusions into their way of life. However, there ought to be a linkage between the mobile health teams' activities which occurs all year round, not only during the cure salé, and the supervision and support of the VHTs in the campement. Unless the migration patterns and schedules are known more fully and they actually occur as predicted, then it is difficult to expect MOH personnel to contact the campements.

In addition, supervision and support by the MOH of Agadez Department, where most of the nomads live, is inadequate, administrative control and innovation within this vast department is too difficult, and instructions, assistance and monitoring should improve between the Central Ministry and Agadez.

A third limitation is one of monitoring payment of medicine by villagers to VHT members. The means of control, outlined above in section IV, is reasonable because it encourages villagers themselves to solve the problem; but nurses and animators need to keep a closer watch on payments. In addition, VHT members make mistakes inadvertantly because they have not learned to balance their accounts adequately in training. As a result, one observer reports that villagers may be suspicious of the prices charged and how the money is handled by the VHT members (Stoller 1977). Moreover, there is no nationally broad^{cast} listing of medicine prices.

A final problem is that of training. It is too short, focuses

too much on techniques and not enough on understanding disease conditions, symptoms, and causes. In addition, the literacy section is not sufficient, for some trainees get nothing out of it according to nurses interviewed who conduct the training. Nor is any aspect of traditional medicine discussed during training. MOH officials recognize that there are useful traditional techniques and medicines from herbs, plants, roots, and leaves, and Dr. Daya, the DDS of Maradi, is putting together his own research on the subject. By incorporating discussion and use of these medicines in training, not only would the VHT worker be able to use readily available medicine which the villagers understand and accept, but he himself would be less likely to disidentify with the traditional health care system, a problem noted in the above section.

VI. Suggested Recommendations

The following are areas for alternative action. They flow from the discussion above, and are written from the view of improving the sociocultural fit between the VHT system and village structure, diffusing the benefits of the system, and insuring that the villagers in fact receive the benefits intended for them.

1. Recruitment of VHT Members:

(a) Clarify as well as possible the criteria of VHT members. To a certain extent this is being done by animators during their initial meetings with villagers. This could be extended through radio broadcasts which cover generally the Health efforts, and attention could be devoted to specifying the kind of person who can be a VHT worker. Also, tapes from villagers, who have successful VHTs could be broadcast to articulate implicitly how model VHT workers operate.

(b) Monitor the elections carefully. This must be done gingerly

and depends upon the tact of the nurse and animators and the rapport developed between them and villagers. Where possible, Government personnel, who know the local climate, should be the ones sent to monitor these elections. It is important that an attempt be made to enforce the achievement criteria for recruiting VHT members.

(c) Seek support from/^{village}leaders. The village chief, marabout, teacher and specialists should be sought out and encouraged to help the activities of the VHT members, especially those related to preventive medicine. It appears that where VHTs are successful, they have the support of these leaders.

(d) Investigate the background and personality characteristics of successful VHT workers. Opinions from villagers who are served by VHTs and MOH personnel, who supervise them, should reveal "successful" and "non-successful" VHT workers. Then, a survey of their background characteristics should reveal which ones contribute to their success or lack of it.

2. Supervision

(a) Provide incentives for nurses to spend more time in the field. A combination of monetary or promotional incentives could be employed to encourage nurses to supervise VHTs more closely and regularly. The effectiveness of their supervision would have to be monitored by the chief nurse and through talks with VHT members and villagers themselves.

(b) Train nurses to be more systematic in their dealings with VHT members. They need to know what questions to ask, what to look for in the village, and what advice to give in terms of curative and preventive practices. In training, they could be given practice in interviewing and provided with a check-list of questions to carry with them in the field.

(c) Sensitize nurses more carefully to local cultural *patterns*.

This is especially important for Hausa- or Djerma-speaking nurses who deal with the nomads. This has been done in Ghana in order to narrow the social distance between health workers and villagers.

(d) Monitor more closely payments for medicine. Nurses and animators should look into this more carefully in the field, and public radio broadcasts of medicine prices should be announced over the radio.

(e) Reinforce VHT activities nationally through radio broadcasts on their activities, on preventive health practices and how villagers can cooperate more effectively with VHTs.

3. Nomads

(a) Link Mobile Health Teams with the VHT system. A mechanism already exists for supervising and supporting nomad VHTs, and the Mobile Health Teams should have some responsibility for doing this. During the annual salt cure, VHTs should be encouraged to contact the teams/as to^{so} replenish medical supplies and receive advice.

(b) Seek closer cooperation from tribal chiefs. MOH needs to get their support in order to install VHTs in campements. In addition, the chiefs can provide some knowledge on migration patterns so that MOH personnel can contact nomad VHTs more easily.

(c) Investigate the apparent reluctance of Tuareg women to become trained matrones.

4. Training

(a) Lengthen training for secouriste and matrone to 21 days. This should improve their understanding of disease causes and preventive techniques. Visual aids and recorders with informative talks on cassettes could be used both in training and by VHT workers in the field, with villagers. Retraining should also be strengthened in the same way.

5. Research

- investigate intensively and extensively process and effectiveness of VHT operations in order to identify ideal qualities of a VHT in terms of personalities, village structure, relations with villagers and supervision.

- collect and catalogue traditional health techniques and medicines to find out which ones can be successfully used by VHTs.

- investigate disease etiology of villagers to construct a taxonomy of terms and concepts.

- introduce discussion and use of known, effective techniques employed in traditional medicine. This should not only link the two medical systems more closely but also should diminish the VHT workers disidentification with the traditional system.

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