Primary Health Care

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Community health workers—an evolving force

An assessment was made in Indian villages of the performance of community health workers in primary care projects supported by funding agencies. In general these workers were neither adequately trained nor properly integrated into the programmes to which they were attached, and the results left much to be desired. Nevertheless, valuable experience was gained and it has been possible to draw up guidelines for organizing future programmes in which community health workers should be able to realize their full potential.

In India, several voluntary organizations supported by funding agencies have striven towards the extension of health services to remote areas and the introduction of village-based health workers. Oxfam gave considerable support to the training of such workers during the mid-1970s, and in the early 1980s decided to study the training of community health workers and the impact of what they did in service projects. The objectives were to:

- assess the training efforts and the supervision structure of the community health worker programme;
- assess community participation in and understanding of the programme;
- provide profiles of the community health workers (age, class, caste, marital status, understanding of their role, attitude to the community, etc.);
- assess the socioeconomic and political status of client groups;
- assess changes in infrastructure related to community health goals;
- assess the impact of ancillary programmes on community health programmes.

It was felt that it would not be possible to work out criteria for the assessment of the technical performance of village health workers, since little or no suitable data were likely to exist at project level. Furthermore, other factors besides the community health workers might have led to the improvement of the people’s health status. Evaluation was approached with an awareness that every...
proposal and every new action was bound to contain seeds of conflict. It was thought worthwhile to try and understand the process by which voluntary groups developed or abandoned their work. An attempt was made to combine the available quantitative data with qualitative observations in order not to be misled by projections based on purely numerical evidence. On interpreting the work of each group, more weight was given to the development process than to progress or performance.

The project organizers were contacted and it was explained to them that the ultimate purpose of our study was to assist decision-making. Neither Oxfam nor the projects had a clear idea of the exact role of the community health workers. It was assumed that their usefulness lay in the fact that they themselves were villagers, able to understand the local culture and to act as a channel for health education and as a link between project staff and the people.

It was not obvious why the projects or existing institutions accepted the whole community health package sponsored by Oxfam. The possibility existed that the community health workers were welcomed as an additional element but that there was merely as front-line servants of the system of hospitals and health centres?

In addition to the limited data that were available we relied on:
- field observations;
- discussions with management;
- interviews with field staff;
- interviews with community health workers;
- interviews with beneficiaries, including health committees;
- project reports, annual reports, and interim evaluation reports.

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Health priorities for action and training: community versus planner preference

Community preference
• Community participation in various activities like construction or cleaning may be forthcoming if health priorities respond to felt needs.
• Health workers are more respected if they respond to felt needs.

Planner preference
• Ascertaining community preference is time-consuming and must be done before training starts.
• Communities are aware of the diseases but not the causes.
• It is not always true that the people know what they need.
The projects selected for study were located in the States of Tamilnadu, Karnataka, and Andhra Pradesh. They differed from one another in various ways and their coverage ranged from 5 to 110 villages.

Unfortunately, health education consisted of repeating the same messages irrespective of specific situations or problems. If the workers had been taught to spread the message of the importance of caring for children aged under five years and if this had been followed up by regular under-five clinics, it would have been clear both to the workers and the people in the communities. A transfer of knowledge and skills would have occurred from professionals to lay people, thus providing the basis for a community health programme and acceptance of the need for rational health behaviour.

The health workers were found to adopt an approach that was mainly individualistic and family-orientated. No impact had been felt at community level. Their training was not usually designed to produce people who could meet new challenges. The minimum expected of the community health worker was assistance while mobile clinics were being held, and the imparting of health education during home visits. Some projects went a little further, involving them in record-keeping, e.g., noting the weights of children. In only two projects was it realized that they had the potential to be responsible for selected curative services. In some projects the community health workers organized people to cope with their own problems, and in one the workers had learned how to carry out laboratory tests.

Role

In concept, primary health care is community-orientated, but in practice it often turns out to be project-orientated. In concept it is an outcome of the felt needs of the people but, in reality, felt needs are far from what the planners of primary care would wish them to be. In concept, primary care should grow with the support of the health care infrastructure, but in reality it may grow in a vacuum. Very often it is expected to be based on self-sufficiency but this expectation may amount to unbridled optimism. Moreover, primary care is supposedly a fruit of multisectoral collaboration, but in fact this is seldom attained. The role of a community health worker is easy to define if primary care is community-orientated and an outcome of the felt needs of the people. Where it is project-orientated, however, the community health worker is merely grafted onto a situation in which role expectations and performances do not match.

In principle, primary care implies a reduction of the widening gaps between those who have access to resources such as income, food, employment and education, and those who do not. It requires a redistribution of resources and strong self-reliance. Yet this has seldom been understood by those implementing health programmes. The role of the community health worker in all the projects we studied was reduced to two main functions: that of acting as a link between the main programme and the people, and that of health educator.

If teaching materials are produced locally they are better understood because they reflect community health problems, their causes, and cultural influences.
Selection

The selection of community health workers is a complex issue involving the community, local leaders, trainers and project sponsors. Community health workers should be broadly representative of the people they serve and acceptable to all subgroups. In most of the projects examined it was considered that community health workers should be locally resident middle-aged women who were free of domestic ties, had adequate spare time and were willing to render service regardless of caste, and that it did not matter if they were illiterate. The people’s health committees usually chose the community health workers. There was no clear explanation of the preference for selecting women, and indeed in one project men were trained as community health workers and provided the necessary services in maternal and child health programmes.

In India a village is usually a collection of socially stratified communities with vested interests. Very often the danger exists that health committees will consist of members of the dominant caste and that their selection of community health workers will serve narrow interests. Where a handful of leaders strongly influences decisions, community participation is a sham. Under such circumstances one can be sure that minority groups will not participate and the project team is faced with having to rectify matters. In some projects, names were proposed by the committee but the final selection was through a formal interview.

Training

The effectiveness of training depends greatly on who does the teaching and what methods are used. In typical training sessions there was an attempt at imparting knowledge on the causes of disease, preventive action, remedial measures, and simple diagnostic methods. Flash cards were used in most projects but in two the programme of lessons was periodically upgraded. In some projects, chapters from the book Where there is no doctor (1) were used as lessons. Teaching took the form of lectures and only very rarely were the community health workers involved in dialogue.

Guidelines

- Funding agencies should be highly selective in their support for need-based primary health care programmes.
- Funding agencies should support community health programmes that are a part of the total development of the people.
- Training that requires remote control should not be undertaken.
- The needs of programmes should be identified before expertise from outside is offered.
- Professionals can help health workers in projects to improve and learn new skills.
- Projects should be helped to evaluate their work objectively; the framework for adequate supervision and training in record-keeping is lacking and this gap should be filled by expertise from outside.
- Self-sufficiency in health care is a myth, especially if the focus is on disadvantaged and exploited sections. Funding should be ensured until local resources become adequate.
Some projects demonstrated that it was possible to teach skills to illiterate community health workers, e.g., the giving of injections, monitoring the growth of children, preparing oral rehydration fluid, dressing wounds, and dispensing simple medicines. These workers also learned how to solve problems and make decisions, especially those related to diagnosis, referral and treatment.

In at least five projects the training of the community health worker was initiated by Oxfam. The training of health workers was invariably seen by the projects as a way of ensuring funding from Oxfam rather than of meeting a need. In some programmes it was found that, whatever the initial training, subsequent training was very poor.

The only knowledge transfer between trainers and health workers occurred at monthly meetings. In many programmes the health workers’ field training was inadequate. Nevertheless, in some instances the workers were keenly aware of the sociopolitical background to health problems. This was directly related to the skills acquired from project team members. Unfortunately, many projects did not have suitable training personnel and made no provision for in-service training.

Manuals and teaching materials were scarce in many programmes and those used were sometimes considered inappropriate. It was not clear whether there were practical difficulties in obtaining health education materials suitable for local situations. If teaching materials are produced locally they are better understood because they reflect community health problems, their causes, and cultural influences. On the other hand, producing materials locally needs the investment of professional time and a good understanding of the communication of health messages, two elements that were generally unavailable in the projects we studied. Innovative methods like the use of role-playing and singing were used very rarely. Little attention was given to practical skills and appropriate technology.

It was often observed that community health workers were very willing to offer assistance to patients and fellow-workers. They had a good grasp of theory and technical detail and were fully capable of performing allotted tasks. However, most of the projects lacked any system for evaluating the community health workers and consequently there was very little scope for upgrading their skills.

The following questions should be answered before the start of a training programme for community health workers

- Is the programme need-based?
- Does it include both curative and preventive services?
- Is it part of an overall development plan?
- Are the health services integrated with the overall development input?
- Is the programme compatible with existing health services?
- Is a referral system envisaged?
- What training facilities are there?
- Are sound baseline data available?
- Who are the beneficiaries and does the programme identify them?
- Is there a system for keeping records and reporting?
In one project, young girls whose literacy was of high-school standard were recruited; they were evaluated by means of written and practical examinations. In another the continual involvement of community health workers in a variety of skilled activities enabled them to raise their status, and attendance at monthly meetings helped them to assess their problems. Some of the projects provided support systems whereby the workers referred cases in need of special attention to clinics and the coordination of immunization and other programmes was effected.

The performance of community health workers may be the best available measure of health impact, but standardized methods of assessing it are not readily available. A potentially useful method consists of determining its effect on community health, knowledge and practices, especially in connection with the prevention and early treatment of diseases. Direct measurement of changes in health status can be costly and time-consuming and it is usually difficult to know whether a particular programme is responsible for any changes detected. Measurement of the infant mortality rate or of other sensitive indicators requires a rigorous information system, which is seldom found in projects.

Conclusion

The varied approaches to and understanding of health and development showed that the concept of community health was still evolving. The overall analysis indicated that the community health workers were not properly integrated into the programmes in a way that would increase people's autonomy in health care. The role of the community health worker was limited to a large extent by professional bias, fear of quackery, and an unwillingness to take risks. In most projects the development of training methodology was approached in a very amateurish manner. There was a tendency to assume that the training of community health workers and the imparting of health education were ends in themselves.

In general, many questions concerning community health workers remain unanswered. What is their role? To whom are they accountable? How does one keep a balance between their technical training and the social and other aspects of their work? Who supervises them? Are they accepted by the community? What priority do health projects have in local development?

The role of the funding agencies, which introduced the idea of the community health worker to the projects, deserves careful consideration. Initial training was undertaken by persons from outside the community. Subsequent training and the development of the role of the health workers were neglected. When the agencies grafted the concept of the community health worker onto particular institutional set-ups they made little or no effort to create frameworks for adequate training, record-keeping and supervision. Many of the projects did not possess the required skill and, as a result, there remains a vacuum in this sphere. To believe, therefore, that the programmes have become self-sufficient after a brief period of funding would be erroneous. In many cases the programmes have come to a standstill after the withdrawal of support in the forms of training and funds. Funding has led to programme changes but seldom to a change in perspectives.

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Reference