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COMMUNITY HEALTH WORKERS - TRANSFER OF SKILLS AND KNOWLEDGE

(Paper presented by the Government of India)

India is essentially a rural country with 80% of the people living in about 600 000 villages with very unsatisfactory sanitary conditions and poor economic and educational standards. The high toll of deaths and ill health are mostly preventable. The three main causes of disease are:

(1) General malnutrition,
(2) Insanitary surroundings, and
(3) Ignorance.

Before Independence, the limited health services available in the country were scattered in towns and cities, and a small number of ill-equipped dispensaries in rural areas located at long distances. The Health Survey and Development Committee (1946), popularly known as the Bhore Committee, gave shape to health services and a generalized infrastructure for rural areas. The Committee recommended the establishment of primary and secondary health units to cater to the needs of the rural population.

In a concerted drive to extend health care to the rural population as many as 5 372 primary health centres and 37 775 sub-centres have been set up since Independence, serving a population of about 500 million in 5 247 community development blocks.

The first three five-year plans concentrated on creating the basic infrastructure for rendering more effective health services. By the end of the Fourth Plan, an effective base for rural health care had been created by strengthening the primary health centres. Family planning has also become an integral part of the general health services from 1963 onwards. The curriculum approach has changed, and this changed the family planning message. Services are taken to the homes of the people. There was greater emphasis on integration of health and family welfare and maternal and child health services, and population education was introduced for the first time in some schools and colleges.

During the Fifth Five-Year Plan, the strategy was changed and the movement has been given a thrust towards increasing the accessibility of medical facilities in rural areas, raising the number of primary health centres at the rate of one per Block and one sub-centre for every ten thousand of the population, intensification of efforts to control and, if possible, to eradicate the major diseases, promotion of preventive medicines through improved environmental sanitation, proper disposal of wastes, water supply, immunization, nutrition and health education, placement of the full complement of medical and paramedical personnel at all primary health centres and correction in the shortest possible time of the existing rural-urban imbalance.

Experience gained during the last two decades in the provision and development of health services has revealed that paramedical workers should be so trained and oriented as to be fully useful in carrying out a diversity of health programmes. The earlier concept of deploying uni-purpose workers has, therefore, been replaced by one of using multi-purpose workers who would be more suitable for delivering the package of health services to the community. Under this scheme comprehensive health and family welfare care will be provided through a team of two workers (one male and one female) at the sub-centre level. It is now envisaged that by the end of the Sixth

Five-Year Plan period, there will be a sub-centre for every 5 000 of the population, with a team of a female and a male worker. However, taking into consideration the existing male and female health workers and the workers that will be available by the end of the Sixth Plan period, it is envisaged that there will be one female worker for every 8 000 and one male worker for every 5 000 - 6 000 of the population. In addition to their duties of providing health and family welfare and nutrition education, these workers will also be responsible for providing first-aid and treatment for minor ailments.

We have about 600 000 villages in our country served by 5 372 primary health centres. A primary health centre covers a population of about 100 000, and has one or two doctors plus 40 paramedical staff. No concerted or adequate effort has, however, been made to involve the community in taking care of itself and seeking assistance when needed. As a result, the community has to become servile and depend on assistance as and when it is provided.

The first assistance that any community needs in the form of health services has to be provided in the community itself. It is necessary that all these services are provided by professionals trained in public health. Some other services may be provided by fully trained professionals who are self employed. It is, however, erroneous to assume that these services should be provided only by these few categories of professional staff. At the community level what is needed most are professional experts who are nearest to the community, enjoy its confidence, have rapport with the people, are willing to assist, can spare the time needed and entail a low cost. It is, therefore, necessary that some of these services should be provided by the members of the family itself and also trained part-time para-professionals who operate on a self-employment basis. Various steps will have to be taken to organize a large number of para-professionals who will be needed in every community to provide simple day-to-day health and medical services. The aptitude for such work is developed within the family itself through participation in the provision of such services or by attending on sick persons.

The emphasis on the creation of a large number of professionals and part-time health workers in the community itself will bridge the gap between the sub-centre and the community.

The Government of India has formulated a scheme which seeks to organize para-professionals trained from the community to work on a part-time self-employment basis to supplement the multi-purpose workers with the object of involving the community in its health care.

According to the scheme, every village or a community with a population of one thousand should be asked to select one representative who is willing to serve the community and enjoys its confidence. He/she would then be given training in simple and basic health services. This will mean a programme of getting about 600 000 people selected from within the community in the rural areas and training them within a period of two years. The people to be selected should be from the village in which they are to serve, and the selection is to be made by the *Gram Sabhas* or other representative organizations within the community. The

selected candidates should be non-controversial. In case of female candidates, only married women should be selected for the training, as unmarried girls are likely to leave the village after their marriage. There should be no political base for the selection of community health workers. The detailed criteria and method of selection will be left to the State Governments. The community health worker should be mainly concerned with the preventive and promotional aspects of health and should be provided with a suitable manual to enable him to discharge his duties efficiently. Limited curative knowledge may also be imparted to him. It would be preferable to select a man or woman who is below 30 years of age. To be able to absorb the elements of human science, the person selected should be literate and be able to read and write fluently. It would be preferable if he/she has had formal education of at least up to matriculation. The educational qualification may, however, be relaxed in tribal areas where it may be difficult to select candidates with such an educational background.

After the above training, these workers will be given practical training in batches for a period of three months in the primary health centre to which they belong. It would be possible to train, in this way, the target of 600 000 workers in two years' time.

The contents of training for community level workers will include the basic elements of the broad dimensions of health care delivery. It will include the fundamentals of health science, measures of maintaining health, hygiene, treatment of common infectious diseases, assistance in immunization programmes, maternity and child care including nutrition, treatment of common ailments, providing first-aid in emergencies, family welfare, and environmental sanitation.

On completion of the training, they will be given a test and awarded a certificate. They would then return to the villages after being provided with a kit and also with a simple working manual provided in regional languages with simple diagrams, etc. The kit would consist of common remedies belonging to the modern system and also the traditional system in vogue in that part of the country.

Periodically short courses will be organized at the primary health centres to refresh the knowledge and skill of the community health workers. In such courses, the community health workers will be informed, in simple terms, of the latest developments in the field of health and applying them in solving the problems.

The community health workers will thus work not in isolation or in competition with multi-purpose health workers at the village level, but rather as members of the health team which shares a common, unifying goal; as such they will co-ordinate their activities with multi-purpose health workers and each will help the other in the delivery of health care services.

The community will be responsible for their working within normal bonds. Technical supervision (education and guidance) in their health activities will be provided by the medical officer of the primary health centre and other primary health centre and sub-centre staff, i.e., health

assistants and multi-purpose health workers, both male and female. The primary health centres' staff and the community will have to be alert to see that the community health workers do not indulge in undesirable practices beyond their area and competency and that the accessibility of their work is maintained.