

TRAINING COMMUNITY HEALTH WORKERS – WHERE DO WE STAND?

INTRODUCTION

As noted in the report titled "Training Community Health Workers"¹, "Training is only one element in the implementation of primary health care, and much of its content and methods must reflect the programme as a whole. Some training designers become overly engrossed in tangible implementation details rather than in broad policy and resource questions – yet the latter are often more critical."

Further the report notes, "Planners must resolve training issues for themselves. They must understand how training fits into their program and decide how much effort to invest, given competing priorities. It is easy to be didactic about training ideals, but a more difficult task is to adapt ideals to field situations and to balance training with management and technical support, provision of supplies, and all the other elements which make primary health care effective."¹

While Community Health Worker training has been going on at different scales and in different programmes over the last few decades, and has more recently started at the national level as part of the National Rural Health Mission, there is a need to look at certain issues that go beyond the traditionally discussed issues of content, methodology and human resources and indeed influence and shape these critical aspects of the training process. This paper attempts to raise some of these questions in the light of some accepted principles and guidelines and some potential new approaches and relationships.

LINKING TRAINING TO OVERALL PROGRAMMES

Post the 1960s "technology transfer" phase of development thinking, and learning from its failures, building up community participation and capacity have been central strategies for most programmes attempting to facilitate development. This move has been reflected in the health field as well with numerous community based projects mushrooming all over the world including India during the 1960s and 70s. The main aim of these programmes has been strengthening the people's capacity in planning and implementing development programmes.

As part of this overall strategy of increasing community involvement most programmes have adopted strategies that included the training of an individual from the community to act as a 'link worker' or 'extension worker'. This was done with the expectation that such workers would help in translating 'expert' knowledge and interventions into culturally and socially acceptable forms to increase community acceptance and thus increase community ownership of programmes. While the many programmes saw participation as merely one way of increasing the efficiency of systems, more radical interpretations saw

community involvement as a process that was essentially empowering and that ultimately led to a redistribution of power and control over resources.

In the health field numerous approaches to community health worker based programmes have been tried. While many projects have adopted an extension approach where health workers are trained in preventive and curative medicine to 'fill-the-gap' as it were, other programmes saw health workers as activists, who by challenging medical hierarchies and demystifying medicine and its interventions would facilitate mobilization and organization of communities to demand health as a human right.

The World Health Organization has defined Community Health workers as workers who live in the community they serve, are selected by that community, are accountable to the community they work within, receive a short, defined training, and are not necessarily attached to any formal institution (WHO Study Group, 1989).

Training of community health workers, regardless of the ultimate perspective of the programme is obviously a crucial aspect of any community based health programme and necessarily reflects the overall philosophy of the programme managers / initiators and also to a large extent defines the overall and ultimate outcomes and impacts of the project.

Given the complexity of such social processes and the status-quo challenging nature of most such programmes, most demonstration and learnings / innovations from such projects are necessarily context specific. Thus while such programmes have been extremely creative, the generalizability and scalability of many of these have always been questioned.

While the challenges of programmes attempting to create change agents have included the transference and sustenance of vision, social analysis, organizing capacity, leadership skills and negotiating skills to the health workers, the challenges of programmes that have conceptualised their workers largely as service providers are demystification of medicine, teaching diagnostic and therapeutic skills, standardizing approaches and maintenance of records, and quality control. Obviously the two approaches need not be exclusive. However the methodology for each of the knowledge, skill and attitude components are very different and require very different competencies on the part of the trainers and are very sensitive to the context within which they are taught. They obviously also require very different monitoring, support and evaluative skills.

SOME ISSUES

Three conceptual issues are raised here:

1. One of the crucial issues and one that need to be raised constantly is

regarding the approach to training taken by the programme managers / initiators. Is training seen as a charity doled out, or is it seen as an enabling process that helps redistribute power and control over resources and infuse confidence into communities? Even if it seen as an empowering process we need to look carefully at the definition of empowerment we are using. Are we defining empowerment as enabling people to negotiate the dominant system better (a so called status-quo non-challenging empowerment) or to challenge and transform the system?

2. George Foster notes, "The striking thing about these questions is that almost all assume that effective health care can be achieved only when members of traditional communities change their health behavior (so that they accept whatever is offered to them by health bureaucracies). Rarely, if ever, the question is asked: "How can anthropologists help to change bureaucratic behaviour that inhibits the design and operation of the best (people centered) health care system" ² (brackets added).

This is an important question for the approaches to all aspects of training including content, methodology and human power and logistics. The ultimate choice of each of these depends on whether we are trying to manipulate people and communities to change behaviors to suit the developed technologies or are we inviting communities to organize and demand technologies that are in line with their values and priorities?

3. There seems to be an underlying assumption that we are 'teaching' the people something new – something without which they can't 'develop'. Something that is crucial for their overall development. It is almost as though we are doing them a favor. However clearly 'training' is not a 'favour' to anybody by any stretch of the imagination (as is sometimes argued by those arguing for voluntary workers) – given the fact that it is the people who are subsidizing both training and research of / by professionals – it is their right that this knowledge / benefits of the knowledge reach them.

These questions are not merely theoretical exercises but will be the foundation upon which the whole approach to training is based.

PRINCIPLES AND LEARNINGS

While there have been many programmes training community health workers the following are some of the common lessons learnt / principles that are followed.

It has been well recognized that while training community health workers one has to follow the principles of adult learning. As per a recently published module by CEDPA³ they are as follows:

Adult learning occurs best when it:

- *Is self-directed*

Adults can share responsibility for their own learning because they know their own needs.

- *Fills an immediate need*

Motivation to learn is highest when it meets the immediate needs of the learner.

- *Is participative*

Participation in the learning process is active, not passive.

- *Is experiential*

The most effective learning is from shared experience; learners learn from each other, and the trainer often learns from the learners.

- *Is reflective*

Maximum learning from a particular experience occurs when a person takes the time to reflect back upon it, draw conclusions, and derive principles for application to similar experiences in the future.

- *Provides feedback*

Effective learning requires feedback that is corrective but supportive.

- *Shows respect for the learner*

Mutual respect and trust between trainer and learner help the learning process.

- *Provides a safe atmosphere*

A cheerful, relaxed person learns more easily than one who is fearful, embarrassed, or angry.

- *Occurs in a comfortable environment*

A person who is hungry, tired, cold, ill, or otherwise physically uncomfortable cannot learn with maximum effectiveness.

Apart from the above, experiences in various other training programmes have come up with many accepted principles of teaching adults and especially teaching them to take on the roles of a change agent as well as a service provider. An example of such a set of principles is that developed by the SEARCH⁴ programme,

1. Training is not only for “knowing more”, but is also for “behaving differently”. Our focus is not upon information, but is upon attitude and skills.
2. Training must be meaningful to trainees, it must start from where the trainees are, and must respond to their evolving needs, both as individuals and as a group.
3. Effective learning comes from personal experience.
4. To be effective as an agent of change, the individual should have experienced change himself.
5. The processes, the issues, the forces and the learning in the group under training are similar to those in other groups, in a community and in society at large.

Thus to sum up – methodology is experience based, open ended, individual and group centered and largely here and now.”

Similarly in a review⁵ of the various projects that have been reported in the Anubhav series the following has been noted as far as training is concerned.

- Aim not only to impart skills, but also to change attitudes, and do so through novel ways of communication, such as street theatre and use of symbols, so as to include even illiterate women in community participation.
- Acceptance of the need for local health workers brought with it need for ‘innovative training methods.’
 - For a primarily illiterate group of trainees simplified systems of training, testing and monitoring had to be devised like in CHDP-Pachod.
 - Intensive and repeated training
 - Quality of training is a major factor for success.
 - Short, simple and imaginative training courses at various levels and varying intervals.
 - Pre-job, on-the-job training and refresher courses.

Some of the projects took over the existing government staff in an area retrained them.

- The worker is as good as his or her training.
 - In the 12 case studies of Anubhav series the workers have been trained in different aspects of maternal and child health, preventive and curative care, and their repeated in-service training.
 - Training is functional not didactic and in-service training and supportive supervision helps to further develop existing skills.

There have been two major community health worker trainers' conferences in the past in India; the more recent one in 1990 ended with the following 'Statement of shared concern and evolving collectivity'¹¹ from which the following sections are quoted⁶:

"GOALS – considering the goal of health for ALL the policy for education for health must

- See health as a constituent part of human development and as an integral instrument of building a just and equitable society.
- Aim at building up and sustaining a health system that,
 - is people oriented, helping the people to cope with their problems in health;
 - is available and accessible preferentially to the poorest sector;
 - strives to enable and empower them to participate in their own health care by sharing in decision making, control, financing and evaluation with regard to their choice of health system;
 - is in consonance with the culture and traditional practices, when these are constructive and beneficial;
 - uses the resources better, with appropriate technology which serves the people.

"TRAINING STRATEGIES – Education for health should be community -oriented and people-based so that the health professional / worker is able to equip and enable the people to cope with their health problems.

Competence based learning. The health personnel at different levels should be trained with appropriate skills attitudes and knowledge to function effectively in the area of work, encouraging competence based learning.

Opportunities should be provided for learning outside the training institution or organisation in the health care delivery system at various levels. One way of achieving these objectives will be through the greater use of electives in the community with government and voluntary health and development projects.

Value Orientation. The training programmes at all levels should lay emphasis on values and ethics including conduct and relationships at the personal level and right to health and distributive justice at the social level.

Health and Culture. All training programmes should take into consideration the way of life of the people and their practices, learn from it and build on it. Both trainers and trainees must approach this area with an attitude of learning.

Governmental and Non-governmental programmes. It is the primary responsibility of the government to provide health care services, while the NGO sector also has its increasing role. To achieve the optimum mix, with respect to numbers, types and qualities of health workers and effective training programmes, all efforts should be made to have interaction between governmental and non-governmental sectors, learning from and supportive of each others efforts.

Systems of Health care and Medicine. All training programmes must take into consideration peoples' health culture.

What ever be the focus of the system of health care and medicine, in a training programme, there is need for generating awareness of the plurality of health systems and traditions in the country and encourage a healthy respect for all systems.

Evaluation. All training programmes should be evaluated for their effectiveness to achieve their goals, including

their cost effectiveness. The process of evaluation should encourage evaluation by the trainees and the people themselves.

Training of Trainers. There is a need for improving training of trainers for community based, people-oriented health care. The trainers should be role models for the trainees. For all formal courses, the trainers should devote their full-time for the training.

Methodologies of training. Different methodologies of learning and training, appropriate to the situation should be used. To the extent possible, all training should be more experiential.

Innovative programmes. To meet the requirements of health for all, innovative training programmes should be encouraged and supported, whether in the governmental or voluntary sectors. National institutes set up to function as torch bearers of innovation should be accountable to the people in this role.

Networking of individuals / institutions involved in promoting relevant innovations in training should be encouraged and strengthened.

The very process of training and gaining knowledge and perspectives that are usually beyond the reach of the average rural woman is itself a very transforming process. It greatly increases the recognition of inequities, social analysis and aspiration and confidence. In fact one of the common refrains that is heard from programmes all over the country is that, "if nothing else, at least we have 'x' number of confident and transformed women".

Thus the content and methodology of training as well as the very fact of going outside the home to learn new knowledge and skills are great transforming events. However in terms of overall goals of training, the ultimate impact is aimed at the community that the health worker serves and not only the individual and the family.

This translation of individual transformation into community level empowerment is dependent not only on a set of unique skills that the health worker may have, but also on certain systemic and community wide processes. Merely giving inputs to a particular individual, without any systemic and community level facilitation will be totally non-productive and community mobilization, organization and empowerment will be left to random events to trigger off. Moreover this sort of individual training can lead to the creation of new centers of power, rather than facilitating the redistribution of power as originally intended. This risk is well reflected by Paulo Friere when he says⁷, "As soon as they complete the course and return to the community with resources they did not formerly possess, they either use these resources to control the submerged and dominated consciousness of their comrades, or they become strangers in their own communities and their former leadership position is thus threatened. In order not to lose their leadership status, they will probably tend to continue manipulating the community, but in more efficient ways."

TRAINING AND THE LARGER CONTEXT

Apart from these there are several issues regarding the changing context within

which training programmes are now being implemented that have a bearing on the overall approach chosen and the effectiveness of the training imparted. A few are highlighted here:

1. The changing context of the community health field. These include changes in the local level and national level like increasing urbanization, increased industrialization, a marketization of the economy, fracturing of the community along newer faultlines, fluctuating political will, and internationally by the move towards increasing globalization, increasing powers of the multinational corporations and homogenization of economies and cultures.
2. The pressure towards sustainability and scalability as crucial components of any programme.
3. Renewed interest shown by governments to start statewide / nationwide community health worker programmes.

As noted above the context within which training occurs has changed quite radically since the early programmes of the 70's. It is very important to re-look at our approaches and experiences in the light of these changes.

CHW TRAINING: DEVELOPING INNOVATIVE WAYS TO WORK ON AND AT SCALE

Training is well recognized as a crucial input into any programme, while the principles of training and approach to training are broadly accepted, the actual translation of these inputs into content, and linked to this, methodologies has till now been, and is of necessity extremely context and programme specific. With the initiating of the NRHM and large-scale national and state-wide programmes, there is an urgent need to reflect on past experiences and critically develop ways to improve the design and implementation of such programmes. In this context, some of the important questions that need to be asked include:

- Is there a possibility of coming up with guidelines and processes for development of content, methodology and the planning of human power?
 - What can we adapt based on learnings from past experiences and in what ways can we develop new methodologies for training CHWs in large-scale programmes?
 - How can a large-scale programme ensure the creation of high quality and sensitively contextualized training content?
 - In large-scale programmes, who are the trainers and how should they be selected, trained, mentored and supported in their critical roles as facilitators and participants in processes of health empowerment?
- Is there potential to come up with methods to make the program learn as it is implemented and to incorporate these learnings as we move along?
- Is there a method by which the different stakeholders can create new

paradigms of engagement and partnership and together focus clearly on facilitating a people's movement?

THIS WORKSHOP

This workshop is an attempt to initiate a dialogue between the various stakeholders who are deeply engaged in developing and implementing CHW programmes across India. It aims to bring together representatives from NGOs, national and state governments, funding agencies, and researchers to share various experiences as well as re-examine them from both the specific perspectives of scaled programmes, as well as in the changing context of the 21st century. In doing so, the workshop attempts to go beyond the dichotomy of innovation and upscaling, towards evolving instead a process of "innovating at scale," in which the creativity and sensitivity of a rich history of community-based health experiences is combined with the historic imperative and opportunity to ensure access to health across the vast geographies and social contexts of India.

We also hope that this dialogue, in the context of the evolving National Rural Health Mission will provide a space to begin to forge new paradigms of engagement between the various stakeholders in the field of health.

REFERENCES

1. Training Community Health Workers. Information for action issue paper. UNICEF. 1983
2. George Foster. 1982. Applied anthropology and international health: Retrospect and prospect. Human Organization. Vol. 41, 3, 189-97. As quoted in Banerji D. 1986. Social sciences and health service development in India. Lok Paksh. New Delhi.
3. Training Trainers for Development. The CEDPA Training manuals series. Volume 1. CEDPA. Washington USA.
4. Staley John 1982. People in development. A trainers manual for groups. SEARCH Bangalore.
5. Pachauri Saroj, Reaching India's Poor: Non-Governmental Approaches to Community Health, Sage Publications, 1994
6. Community Health Cell, Community Health Trainers Dialogue – Towards an Education Policy for Health Sciences, Bangalore, October 1991, mimeographed report.
7. Friere Paulo. Pedagogy of the Oppressed. Harmondsworth: Penguin, 1972

