WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

SHS/HMD/84.1
ORIGINAL: ENGLISH

COMMUNITY HEALTH WORKERS

A Report of the World Health Organization Inter-Regional Study and Workshop
4-8 July 1983, Manila, Philippines

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

SHS/HMD/84.1
ORIGINAL ENGLISH

INTER-REGIONAL STUDY ON COMMUNITY HEALTH WORKERS

A Report of the World Health Organization Inter-Regional Study and Workshop, 4-8 July 1983, Manila, Philippines

CONTENTS

Preface

The eleven participating countries who attended the Manila Workshop, 4-8 July 1983, are grateful to the World Health Organization for this opportunity to continue sharing learning experiences in order to improve their country programmes. It is during such scientific meetings that we can debate the strengths and weaknesses of our programmes and develop alternatives to improve our health delivery systems.

The participants are particularly indebted to the Regional Director for the Western Pacific Region and his staff for organizing such a meeting; to the Philippine Urban Primary Health Care team, and to the consultants for their active participation and valuable contribution to this Workshop.

The participants also wish to thank their respective governments for giving them the opportunity to attend the meeting.

Manila, Philippines, 1983.

INTRODUCTION:

Following the WHO/UNICEF sponsored International Conference in Alma Ata in 1978, the Primary Health Care (PHC) approach was unanimously accepted by the member states as the most effective way of achieving "Health for All by the Year 2000."

One of the guiding principles in this approach was the utilization of Community Health Workers (CHW) to extend health services to the population, to support the community in identifying their own health needs, and to take the necessary actions to solve their own problems. This innovative concept of involving the community gave a new dimension to the management of health care, and provided member states with a baseline for rethinking practical means to deal with their respective situations.

The Conference also stressed the need to clarify and define the functions, define the required training, establish the remuneration and other related aspects of the Community Health Worker so that countries could put them to use in promoting and improving primary health care programmes. Recognizing that the health needs and health delivery systems differ in the various countries, the conference underlined the importance of a comprehensive exchange of experience and information in order to avoid previous mistakes. The first workshop organized to that end was held in Jamaica in 1980, and was attended by 13 member states. The result of this workshop was an extensive list of "guiding principles" which could be used as a reference for the development of community health worker activities in different countries. However, it was felt that a more in-depth evaluation of some of the key issues on CHWs was also needed. Thus, as a follow-up to the Jamaica workshop, an initial framework which was prepared in 1981, covered 3 main issues, as regards the position of the Community Health Worker, namely: his/her community; his/her training; his/her support. This framework would serve as a model structure for a multi-country research and development activity on CHWs. Eleven countries (Bénin, Botswana, Colombia, India, Jamaica, Liberia, Papua New Guinea, Philippines, Sudan, Thailand and Democratic Yemen), were invited to a consultation in early 1982 to review the framework and the methodology proposed for such an activity.

The participants, who were designated as Principal Investigators, began to implement the research and development activity in their respective countries. They adopted the working-team approach in order to benefit from mutual experience, thus providing added information and dictating further action and study. The working teams were composed of health workers, volunteers, sociologists, students and other personnel from participating agencies, thus demonstrating intersectoral collaboration in the Primary Health Care approach.

In the course of 1982, the country research and development activities were implemented and, by the beginning of 1983, reports from the various countries were submitted to WHO. These were then tabulated to summarize the main descriptive aspects of CHW activities in the different countries. An analysis of the key issues was added forming the basis of a meeting involving the Principal Investigators of the member states, which took place in Manila from 4 to 8 July 1983. The objectives of this meeting were: to identify the problems facing CHW programmes and recommend alternative measures for action through a learning-by-doing process; to investigate alternative processes for a periodic revision of CHW activities and their impact at the national level; to agree on follow-up activities providing exchange and dissemination of effective innovative experiences.

This report presents a summary of the discussions held (Chapter 1), with the major recommendations deriving from these discussions. Chapter 2 deals with several technical aspects of the CHW's responsibility, namely nutrition, immunization and control of diarrhoeal diseases. In Chapter 3 is included a description of a field trip to an urban Primary Health Care project in Manila, to observe and learn from the management of the community by the community. This trip provided a rich and tangible experience for participants, from which they could learn, compare and relate aspects of the programme to their own demands and thus, strengthen their country programme by improved leadership and motivation. Chapter 5 presents a summary of the expected follow-up activities for study and improvement of CHW programmes.

CHAPTER ONE

OUTCOME OF COUNTRY EXPERIENCES

THE COMMUNITY HEALTH WORKER

Due to the extensive requirement and use of CHWs by communities, it is important to choose CHWs in function of those characteristics which would contribute to their maximum effectiveness, such as the type of person who should be selected; the tasks they would be expected to perform; would CHWs be full-time or part-time workers. The various contexts of cultural, political and geographical realities and the size of the population are also to be considered when selecting these CHWs. It was suggested that either a programme be established to provide guiding criteria for selection, or that such decisions be left to the community Support Group (SG).

Despite the different experiences of the represented countries, it was generally felt that the final decision on CHW selection should be made by the SG, (or, as in the case of Bénin, by the entire village), although in some countries such as the Philippines, this is a joint decision to be taken with the health sector.

As regards the sex of the CHWs in the study countries it was reported that out of 11 countries, one of them (Jamaica) had all female CHWs; 3 of them (Botswana, Colombia, Philippines) mostly female; 5 mostly male; another (India) had mostly male CHWs but the requirement has recently changed to female; and the last country (Bénin) has 2 CHWs of whom one is female and the other male or female.

In India, an interesting development was observed. When the CHW programme first came into action, the sex of the CHWs was not mentioned in the criteria, thus allowing communities to select both male and female workers. In fact, very few women were selected. After programme implementation was under way, an evaluation of the effectiveness of the female CHW showed that, in general, they were performing much better than their male counterparts. On this basis, the selection criteria were modified to encourage - but not require - each community to select a woman. The proportion of women then selected increased slightly, without, however, reaching 10% of the total number. A second effectiveness-evaluation was carried out, and again the results were in favour of female CHWs. Once more the selection criteria were modified to require the selection of a woman unless "a suitable woman candidate is not available or not willing to work".

According to the different country reports, the tendency is to use somewhat older CHWs (from 35 to 55 years), as shown by the more effective - less effective scale established in countries such as the Philippines, Thailand, India, and Jamaica. Based on empirical evidence, it has been found that most of the other countries agree that older individuals tend to perform more effectively. However, no decision was reached as to whether a minimum of 25 or even 30 years of age should become a requirement or only a recommendation to SGs. Colombia and Papua New Guinea on the other hand, consider a younger age group of CHWs (17 to 25 years) to be preferable.

The level of education of CHWs ranges from no education at all to college graduation, although both extremes rarely occur. In general, the educational level of CHWs is equal to or slightly higher than that of their community. The various reports generally agree that this is appropriate and should be maintained.

Opinions vary considerably about the selection as CHWs of traditional birth attendants (TBAs) and practitioners of traditional medicine (PTMs). The existing situation differs considerably from country to country, ranging from cases such as Thailand where TBAs and PTMs are virtually non-existent to cases such as Benin where several operate in nearly every village. Although it was generally felt that TBAs and PTMs should be encouraged to become CHWs, there are serious obstacles which can hinder this process. In Botswana, for example, attempts to enlist PTMs have proved virtually impossible, due to both the secretive and lucrative aspects of their positions. In India, an earlier positive view of PTMs has been altered, and villages are currently discouraged from selecting them because "it was found that their own interests were in conflict with the objectives of the CHW scheme."

TABLE 1. CHW BASIC DATA

Country	Title of CHW(s)	Fulltime (FT) or Parttime (PT)	Coverage	Sex	Duration of pre-service/ basic/initial training	Paid(P) or Voluntary(V)	If paid, by govt.	If paid, by project	If paid, by community	Notes
Benin	Traditional Midwife (TBA)	two PT 1-4 hrs. per day: one-am other-pm	500-1000 av. (1000-2000 by two TBAs)	F	4 weeks	P+V			✓(but some do not pay)	If CHW is paid, it is a small amount, not fixed, may be either in cash or in kind. Funds are given on an individual basis as payment for service but is strictly voluntary (non-payment would have no effect on the quality of service).
	First Aid Worker	two PT 1-4 hrs. per day: one-am other-pm	500-1000 av. (1000-2000 by two FAWs)	M or F	4 weeks	P+V			✓(but some do not pay)	
Botswana	Family Welfare Educator	FT	500-1000	mostly F	11 weeks	P paid very well	✓ (local gov't - but not same as community			Paid by local gov't authorities, with funds from the central gov't.
Colombia	a) Health Promoter b) Responsible for Health	Health Prom-FT Resp. for Health-PT	750-1000 (max. travel: one hour)	mostly F	urban/rural - 13-14 wks. indigenous- 8 wks.	Health Prom - P Responsible for Health-V	✓			
India	Health Guide	PT	1000	mostly M but now F required	200 hrs in 3 mo. (c. 33 da)	P - but much lower than 'real' salary	✓			In some States, funds come from the community. In most instances, funds are from central and/or state gov'ts. About 10-20% of programmes are supported by voluntary organizations.
Jamaica	Community Health Aide	FT	2000	F	8 wks	P	✓			
Liberia	CHW/VHW	PT 2-5 hrs. per day	100-1000 (15-150 house holds)	mostly M	6 wks	P - but much lower than 'real' salary	✓			
PNG*	Aid Post Orderly	FT	50-1000	mostly M	2 yrs	P	✓			
Philippines	varies - mostly Barangay (Village) Health Worker	PT	500-1000	a) F+M b) M+F c) F ***	a) 2 wks b) 4 wks c) 1 da/wk x 15 mo. ***	some P, others V	✓ (if paid)	✓		Gov't or private agencies pay in some projects; others are voluntary. Some also profit from village drug store.

TABLE 1. CHW BASIC DATA (continued)

Country	Title of CHW(s)	Fulltime (FT) or Parttime (PT)	Coverage	Sex	Duration of pre-service/ basic/initial training	Paid(P) or Voluntary(V)	If paid, by govt.	If paid, by project	If paid, by community	Notes
Sudan**	CHW	FT	settled - 4000 nomadic - 1500	mostly M	1 year	P - about twice minimum wage	√			
Thailand	Vil. Hlth. Volunteer	PT	500-1000	mostly M	15 da.	V				CHWs receive free medical care. Some also make a small profit from village drug cooperatives.
	Vil. Hlth. Communicator	PT	50-100	mostly M	5 da.	V				
Yemen	Health Guide	PT	250-300 actual 300-1000 plan	mostly M	3 months	V				

*The general consensus was that the Aid Post Orderly in PNG is more comparable to a health centre paraprofessional than to a designated Community Health Worker. The two-year training period would certainly not be sustainable if APOs were to be introduced into every village. In fact, PNG is currently beginning a small scale tryout of another type of worker - with much shorter training - who is more of a designated CHW.

**Sudan also has a Trained Midwife who would qualify as a Community Health Worker by the definition used in this study. However, information on this category of worker was not included in the country report; they receive a small salary.

***Philippines: a, b, c refer to three different projects.

All countries agreed that sufficient time be allocated for such a process. The length of time varies according to the receptiveness and existing level of knowledge of each community, from one week to six months - too broad a range for meaningful planning.

If decision-making is left to the communities, one logical and inescapable conclusion is that they should have the right to reject the programme completely. In such cases, however, it was felt that health centre staff should continue to keep the option open, rather than view the community's rejection as final. Such communities might for example be encouraged to develop alternative approaches for the achievement of the same goals, or might even be encouraged to visit an effective CHW in another community and then reconsider their decision.

In addition to the preparation of community leaders, it was felt to be important to try and help the entire community to understand the programme even before CHW selection. This is currently being done in the Philippines via meetings of the village assembly - a gathering of all village adults/elders. A number of reasons were given in favour of approaching the whole community rather than only the leaders. It was felt that the health sector personnel was better placed to present the programme to the villagers than the leaders who had just been introduced to it themselves. The personnel could assist the leaders in understanding the programme by bringing about a confrontation between themselves and the villagers and allowing the leaders to benefit by attending this interaction. Approaching the entire community would stimulate the villagers' motivation and acceptance, as well as incite people other than leaders to formulate their ideas and questions. Such an approach would also ensure that all potential CHW candidates are fully aware of the programme.

CHW's JOB DESCRIPTION, TASKS AND COVERAGE

Job description:

CHW job descriptions should be reasonably accurate guides as to what they are expected to do. As such, it is extremely important for support group members as well as health sector personnel to be familiar with these job descriptions, and to use them as a means of assisting and assessing their CHWs. It was also suggested that SGs review those descriptions periodically, both as a source of information for a revision of the national or programme-wide job-description and as a basis for modification of their own CHW's tasks, in conjunction with the local health staff, in order to deal with the specific needs of the community.

Number and types of tasks:

The major tasks CHWs are expected to perform are listed by country in Table 3. There is great consistency from one country to another, as shown by the fact that 14 out of the 23 tasks are carried out in at least 10 countries. However, there appears to be a slight difference between programmes with part-time CHWs (with an average of 17.7 tasks) and those with full-time CHWs (19 tasks).*

Certain tasks require CHWs to take action more immediately, rather than just inform or advise, namely: give first aid treatment in case of accidents or minor illnesses; dispense drugs; deliver babies; take care of nutrition; give injections; distribute family planning supplies; start dealing with communicable diseases. Of these tasks, full-time CHWs perform an average of 5.2, while part-time CHWs perform only 3.7, thus accounting for 2/3rds of the difference between full-time and part-time performance of workers.

In general, it was felt that CHWs were asked to do too much, especially the part-time workers. It should be possible to decrease the number of tasks according to the priority health problems, the distance to travel, the terrain and the technology available.

*Tasks which are performed "irregularly" or "occasionally" are also included, since CHWs would still need to be trained to perform them.

TABLE 3. CHW JOB DESCRIPTIONS

TASK SUMMARY	BENIN	BOTSWANA	COLOMBIA	INDIA	JAMAICA	LIBERIA	PNG	PHIL	SUDAN	THAILAND	YEMEN
1 - First aid, treat accident and simple illness	√	√	√	√	√	√	√	√	√	√	√
2 - Dispense drugs	√	√	√ (incl. injections)	√	√	√	√ (incl. injections)	√	√	√ (VHV only)	√
3 - Pre, post-natal advice, motivation	√	√	√	√	√	√	√	√	√	√	√
4 - Deliver babies	√	X	√	X	X	X	X	X	X	X	X
5 - Child-care advice, motivation	√	√	√	√	√	√	√	√	√	√	√
6 - Nutrition motivation, demonstration	√	√	√	√	√	√	√	√	√	√	√
7 - Nutrition action (W = weigh children, maintain chart; F = distribute food supplements)	F	W	W	X	W, F	X	W	W, F	F	W, F	X
8 - Immunization motivation, assistance during clinic	√	√	√	√	√	√	√	√	√	√	√
9 - Immunization - give shots	X	X	√	X	X	X	√	X	√	X	X
10 - Family planning motivation	√	√	√	√	√	√	X	√	√	√	√
11 - Family planning - distribute supplies	X	√	√	√	X	X	X	√	√	√	X
12 - Environmental sanitation, personal hygiene, general health habits - motivation	√	√	√	√	√	√	√	√	√	√	√
13 - Communicable disease screening, referral, prevention, motivation	√	√	√	√	X	√	√	√	√	√	√
14 - Communicable disease follow-up, motivation of confirmed cases	√	√	√	√	X	irreg.	√	√	√	√	irreg.
15 - Communicable disease action (D=provide drug resupply; M=take malaries slide)	X	D	D, M	M	X	X	D, M	TB sputum smear	D	X	D
16 - Assist Health Centre clinic activities (i.e. not in village)	occasion-ally	√	occasion-ally	X	√	X	√	X	occasion-ally	X	X
17 - Refer difficult cases to Health Centre or Hospital	√	√	√	√	√	√	√	√	√	√	√
18 - Perform school health activities regularly	X	√	X	X	X	X	X	X	√	X	√
19 - Collect vital statistics	X	√	√	√	X	√	X	√	√	√	√
20 - Maintain records, reports	√	√	√	√	√	√	√	√	√	√ (VHV only)	√
21 - Visit homes on a regular basis	√	√	√	√	√	irreg.	√	√	√	√	X
22 - Perform tasks outside health sector (e.g. agriculture)	√	√	X	√	X	√	X	√	√	√	√
23 - Participate in community meetings	√	√	√	√	√	√	√	√	√	√	√

KEY: √ = task performed by CHW

X = task not performed

Two of the common requirements for SGs are activity planning and financial management. Both were considered to be essential tasks for an effective SG. Planning of community health activities is a creative task in which SG members, using simple methods, learn to study their community and evaluate existing activities, decide what the problems are, establish priorities and consider alternative actions, before developing a work plan. Financial management (wherever funds are raised by the community) requires decisions on how to obtain funds and an acceptable scheme for controlling the flow of funds and ensuring their accountability. If a SG is able to perform these two functions well, it is likely to remain interested, active and effective. Unfortunately, most SG members lack the skills needed to perform these functions adequately. None of the countries are currently doing this, but all agreed that major emphasis should be placed upon the need to provide training to SG members in each of these areas - an appropriate type of training, with each of the skills taught by a simplified, relevant and understandable method.

Another area in which it was felt SGs should be knowledgeable concerns more technical aspects of their role: health content and more general community development content which need greater attention during the preparation of a SG.

Finally, and perhaps most important, it was felt that many SGs lack the required motivation. In part, this may be due to a history of government paternalism in which health services have been handed down to the people, who thus have come to believe that it is unnecessary for them to take action. 'Social preparation' of the SG, or motivating them to recognize and accept the necessity of community participation in understanding and solving health problems is a basic pre-requisite to the success of these groups.

In the Philippines and Thailand, some CHWs operate community drug sale projects. In these countries, the SG plays an important role as monitor of the system, ensuring that the funds raised by the CHW are collected and used appropriately. However, in three other countries in which CHWs raise funds from drug sales - Benin, Botswana and Colombia - it was not considered appropriate to involve the SG in this process.

Relationship with the health sector:

Several of the points raised in the previous sections lead to one of the most repeated and most important conclusions of this report: the need to train SG members by the health sector, that is, usually by the health centre staff. This training should be given in such fields as social preparation/adaptation, activity planning and management, financial management when needed, specific related health topics, community development, drug sale management as required, planning and conducting of meetings. The SGs should also have some knowledge of the existing health services and of the functions and job description of the CHW within the programme. It was understood that priorities would be established for a series of short-term training/orientation sessions, as all these topics could not be covered during a single training course. No decision was reached as to the length of the series of sessions.

However, if health centre staff are to train SG members effectively, they themselves will require training. All countries felt an urgent need to provide training for health centre staff in the various areas mentioned. They also felt that it was necessary to publicize and inform the population in general of the value of preventive activities, of community participation, and of CHWs. As regards preventive activities, it was suggested that the distinction between preventive and curative tasks should not be underlined as yet, but rather that all the functions related to a specific disease or condition be integrated into a comprehensive approach. For each disease or condition, it was suggested that a very simplified presentation be devised - first, to ensure that health centre staff themselves have a clear understanding of the disease, its cause and prevention, then for them to convey this understanding to SG members.

Regarding community participation and the CHWs, several countries noted the difficulty of convincing health centre staff that the exercise of power and the performance of tasks by villagers should be viewed positively, as an enhancement rather than as a loss of their own influence. Greater involvement by health centre staff in the initial training of CHWs, as

well as the training/orientation of SG members, should help to improve health centre staff attitude; additional training of health centre staff by higher level personnel was considered to be equally necessary.

Another weakness noted in the relationship between health centre staff and the communities they serve is that health personnel tend to have an inadequate understanding of the cultural and economic implications of their various recommendations for the improvement of health. For example, recommending that mothers of malnourished children feed them certain more nourishing foods is not a helpful suggestion to a mother who cannot afford to purchase the suggested items. With a greater understanding of the life of the poorer people in the community, health centre staff are more likely to limit themselves to realistic, credible recommendations.

It was also suggested that health centres need to serve not only as medical, but also as multi-sectoral problem referral points. If, for example, a SG or a CHW needs information or materials for construction of a water system, and the health centre can serve as a link to other government or private resources, then the health centre's credibility in its major areas of expertise will be considerably enhanced.

Finally, another suggestion was for health centre staff to assist SGs in comparing their accomplishments and achievements to those of neighbouring communities. This could be done in 2 ways: either by consolidating data from different communities so that comparisons can be made readily; or by identifying the communities in which SGs and/or CHWs are performing better than average, and then helping other SGs to learn from them.

PREPARATION OF THE COMMUNITY

One of the weaknesses of many country programmes is that the selection of the CHW - although done by leaders of the community - occurs at a time when the community as a whole has no understanding of what a CHW is supposed to do, and the community leaders have only an unclear, preliminary understanding. As a result, the individual selected to become a CHW may not be the best possible candidate. Another consequence of this lack of understanding is a general lack of interest, expectation and involvement of the community in their CHW and in what he can do for their own welfare.

These problems could be considerably alleviated if more attention were paid by the health sector to the preparation of the community during the period preceding CHW selection. All countries felt this to be extremely important. Only one country (Benin), where "efforts are made to arouse the interest of the whole village, (to make the) whole population aware of the criteria for selecting the CHW and the conditions under which he or she will work" reported that the current process is adequate; in some other countries (e.g. Colombia, Botswana), this process is sometimes used, but in all countries it was felt that more emphasis should be placed on this social preparation stage.

Throughout the study, considerable attention was paid to answering the following questions: how to "sensitize" the population to the value of CHWs; how to spur interest in the programmes; what role should health centre staff be called upon to play.

It was agreed that it is essential for health centre staff to visit each village several times during this preparatory stage. Through a series of formal and informal discussions with community leaders, they can introduce the programme, then facilitate both an understanding of it and decisions concerning it by community leaders. Considerable emphasis was placed upon the importance of health centre staff not making decisions, but rather limiting themselves to providing technical advice while encouraging decision-making by the community itself. In this context, the Manila City Project which participants visited was cited as an excellent example: throughout a phased process of drawing up a questionnaire, implementing a survey, analyzing the survey results, then establishing the initial aspects of an action project, the health sector personnel has acted as facilitators and technical consultants, while the community provided most of the information and made the decisions; only after the community has developed an understanding of its health problems was the idea of a CHW introduced and discussed; and only after this lengthy process (two months) were the CHWs selected.

COMMUNITY SUPPORT FOR THE CHW (CHW Support Groups)

During the first phase of this project, one of the "guiding principles" which was suggested to promote the development of the CHW programme was expressed in the following terms:

> "Some form of viable community organization is necessary to establish operational relationships between the community and the government's developmental agencies including the health sector, thus promoting a new partnership between government personnel and the community."

Building upon this earlier consensus, the second phase of this project no longer questioned whether or not such community organizations or support groups were needed. Instead, it focused on their characteristics: what aspects, and what factors of the local organizations supporting the CHWs contribute to their success?

The basic structure of these SGs tends to vary, but in most instances - reference Table 2 - these either constitute the local village council or are part of a sub-committee on health. Since decisions about the framework and functions of the SG are so closely linked to the political structure of each country (thus placing the SGs beyond the exclusive responsibility of the health ministry), it was not considered necessary to seek alternative types of SGs. However, if SGs are not an integral part of the local village council, then strong linkage with this formal community leadership needs to be established and maintained. In Thailand for example, it was felt that one of the weaknesses undermining the effectiveness of the SGs, and therefore that of the CHWs, was the lack of proper representation of the Village community in the various SGs. In one other country, the SGs benefit from satisfactory organization; however, a proper backing from higher echelons at state level is missing.

The various country reports focused on 4 areas of importance concerning the SGs, namely, the question of membership, the frequency of meetings, the responsibilities and functions of the SG, and its relationship with the health sector.

Membership

CHW Support Groups should, undoubtedly, be representative of the communities they serve. However, as can be seen from Table 2, there are many different interpretations of what is meant by representative: among the criteria used are occupation (Benin, Colombia), caste (India), sex (Benin and India require that at least one woman be included; Colombia shows a 1:1 ratio in general; Botswana and Jamaica include a majority of women), religion (Benin, Philippines) and political affiliation (Yemen, Benin). Another representative member may be chosen on the basis of a geographical sub-unit of the community, although this was not a criterion taken into account by the member states as yet. It was generally felt that at least some of the members of the SG should be elected, either by the community as a whole or by a particular constituency. Election not only ensures adequate representation of the SG, but also serves as a valuable mechanism for educating the community about the functions of the SG and the CHW.

One of the more controversial aspects of SG membership is the role of women and of 'vulnerable' groups (the poor, the illiterate, certain ethnic groups or castes in some countries). The latter urgently require the services of the CHW among other needs, but tend to be badly represented at governing councils. The question was whether special efforts should be made to include them in CHW Support Groups. It was generally agreed that there could not be a single answer: in some contexts, requirement or encouragement for women and/or 'vulnerable' groups to be SG members may be feasible; in other contexts, however, alternative means need to be found to ensure that their interests at least are represented.

Also regarding 'vulnerable' groups, it was noted that if these occurred in urban areas, where the population is much more heterogeneous than in rural areas, there would be greater difficulty in involving them in the Support Groups.

TABLE 2. CHW SUPPORT GROUPS

	BENIN	BOTSWANA	COLOMBIA	INDIA	JAMAICA
Type of support group	- Village Health Committee - new group	- Village Health Committee - new group- 97% of villages had VHCs - VHC is sub-committee of Village Development Committee	- Community Action Board - Also, some communities have health committees, either subordinate to, or independent of CAB - Some have no SG	- Varies considerably from state to state mostly functioning poorly - Plan to establish Village Health Committee (remainder of this column refers to plans not reality)	- Either deriving from an existing group or initiated by health team - Affiliated with formal village council
Number of members	7-10	20	5-8	5	24
Type of members	- Should be: - Village delegate - CHWs - members: local revolutionary council - 3 members other groups - TMP representative - religious leader - extension worker - teacher - All VHCs include 1 woman - About half literate - Some are elected	- About 2/3 female - Selected by village as a whole with concurrence of chief - Many members have experience in other organizations	- Peasants - Manual workers - Housewives - Both M and F - Leaders of community	- 1 woman - 1 scheduled caste or tribe - 3 others members Once every 3 meetings, medical officer attends to "explain to the VHC action taken on the previous decisions of the VHC"	- Varies, but representative of entire community - Majority are women
CHW role in meeting	active	active	active	active	active
Frequency of meetings	monthly or quarterly	monthly or more frequently	monthly	monthly	monthly or more frequently
Responsibilities/ functions	- All the village's health problems - Does not select CHW- done by village assembly - Looks after CHW's land during training - Administrative supervision of CHW (schedule, identification of health problems) - Health programme implementation (e.g. construction of latrines) - Programme planning - Financial management (but not common) - VHC members work 10-20 hours per month	- Planning - Implementation - Keep community vegetable garden to feed malnourished children - Motivate community on environmental sanitation, etc. - Home visits for treatment, follow-up, elderly, destitute, handicapped - Evaluation - Vital statistics	- Coordinating activities/implementation - Supervising and promoting health - CHW selection - No financial responsibilities	- Support functioning of CHWs - Assess health needs of community - Convey VHC meeting results to medical officer	- Identify health needs - Develop/implement activities to overcome health problems - fund raising - maintenance of health centre - best-kept home competition - community health education

TABLE 2. CHW SUPPORT GROUPS (continued)

	LIBERIA	PAPUA NEW GUINEA	PHILIPPINES	SUDAN	THAILAND	YEMEN
Type of support group	- Where Village Council exists - Village Health Committee (sub-committee of VC) - Where no Village Council exists - Village Development Council	None	- Health Committee of Village Council	- Health Committee of Village Council or ad hoc Health Committee	- Varies. About half of SGs are not functioning - Some have MOPH VHDCs - Some have health sub-committee of Village Development Committee	- Village Council (People's Defense Committee) - Party unit also exercises some SG functions
Number of members	7-15	-	7-10	VC - 24 HC - 5-8	7-10	6
Type of members	- Some fairly evenly divided among men, women, youth - Others mostly older men or younger boys	-	- Chairman of Health Committee is member of Village Council - Teachers - Purok (sub-village) leaders - Representatives of local civic organizations	- Teachers - Headman - CHW - Others - Women: 25% of VC; they are usually represented on HC.	- MOPH-structured committees have only VHVs and VHCs (the two types of CHWs) - Other health committees usually do not include CHWs	- Secretariat of local PDC - Party representative - Representatives from agriculture, education, etc. sectors
CHW role in meeting	active (usually)	-	Active in Health Committee meetings, but not in Village Council meetings	active	see above	Active when topic concerns health
Frequency of meetings	Range from 2-12 per year. Considerable variety	-	1 per month and when necessary	3-4 times per year	3-12 per year	At least 1 every 3 months
Responsibilities/ functions	- Selection of CHWs - Review of CHW activities (esp. administration) - Planning - Implementing - Raising funds for development activities - Mobilizing people - CHW accountability	-	- Selection of CHWs done by varying mix of Village Council, midwife, community leaders, project leaders - Civic inspirational talks at training course opening and closing ceremonies - Collection, disbursement of funds - Admin. supervision - Planning village health programmes - Involvement in motivational campaigns - Review progress	- Collect funds - Construction, furnishing of Primary Health Care Unit - Admin. supervision - Logistical support - Maintenance - Active when a specific task needs to be done	- Participation in implementation of campaigns (nutrition, health education, sanitation, etc.) - Planning - Support (esp. fund raising) - Follow-up	- Overall development - Selection of CHW - Implementation tasks (digging wells, building health units, etc.)

Meetings:

The effectiveness of the SG is directly related to the frequency of their meetings. In general, it is reported that the more often the SGs meet, the more effective they are, as is the case in Liberia, Benin and Botswana for example. It was emphasized that SGs should be encouraged to meet at least once each month.

In every country the CHWs are reported to play an active role in SG meetings. It was suggested that, where they are not currently doing so, they be encouraged to propose topics for discussion during meetings. One way of doing this might be a CHW monthly report on the community's health status, the CHW's activities and problems. Ideally, the CHW, in addition to his/her role as information-provider during SG meetings, should also serve as a facilitator, helping to elicit and organize the ideas of other SG members. This is not, however, an easy role to play and the CHW will usually require outside assistance for training and supervision.

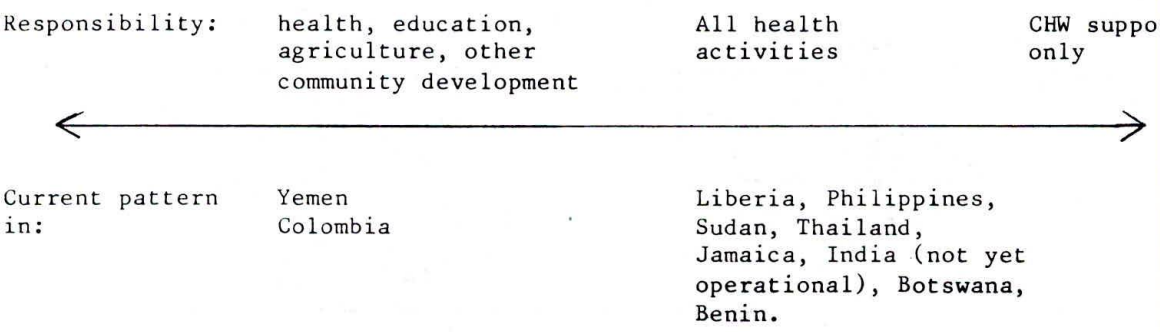
In Liberia, Benin, Sudan, the Philippines and Jamaica, it was noted that the atmosphere of the meeting was a democratic rather than an authoritarian one - and that this factor contributed to the success of SG meetings. Others tended to agree, although some cautioned that in many cultural contexts - especially in rural areas - this might prove difficult to implement.

Finally, it was suggested that in some cases the quality of SG meetings would improve if the SG leader could receive training on the preparation and process of an effective meeting.

Responsibilities/Functions

An overview of the responsibilities of a CHW Support Group suggests that they may range from broad community development topics - including but not limited to health - to the support of CHWs. Figure 1 presents the most common situation: an SG is responsible for all aspects of the community's wellbeing - including but not limited to the CHW's activities. It is interesting to note that in no country is the SG limited only to support of a CHW. (Such a limitation undoubtedly would prove objectionable to such an SG and would probably render it ineffective even for its limited goal).

Figure 1: CHW Support Group Responsibilities: A Continuum



In some instances, an SG, although not responsible for projects unrelated to health, nevertheless interprets its responsibilities broadly. In Botswana, for example, many of the village health committees maintain a community vegetable garden to help feed malnourished children.

In all cases but one, the SG's initial responsibility is the selection of the CHW - either solely or, as in the Philippines, in conjunction with health sector personnel. The one exception is Benin, in which the entire village assembly rather than the health committee alone selects the CHW - a process found to be very effective, both to identify better candidates and to inform the population.

One type of task (No.22), which requires the CHW to deal with aspects unrelated to health, and which is included in 8 of the 11 job descriptions of the different countries, was considered as a potentially constraining task. It was then suggested that CHWs not be expected to perform such tasks as gardening, maintenance of water supply, literacy classes, income-generating activities, but rather to limit their action to serving as a link between resources and to help coordinate the various activities. Another solution, if CHWs are to perform health tasks, would be to reduce the size of the population they are meant to cover.

Population Coverage:

CHW coverage currently ranges from 50 to 4000 people. In 4 countries however (Yemen, Liberia, PNG, and Thailand) the coverage amounts to less than 500 people per CHW. This issue was discussed at length, and two somewhat different approaches emerged: one side suggested that each CHW in a rural area be responsible for a maximum of 750 people and in an urban area, the maximum was to be a thousand; the other side preferred to distinguish between full-time and part-time workers, responsible for a maximum of 500 and 300 people respectively. However, the most important factor determining the number of people a CHW can cover depends on the kind of tasks he/she is expected to perform: the fewer or less time-consuming they are, the larger the population to cover and vice-versa.

TRADITIONAL PRACTICES AND DRUGS

The CHWs' position concerning traditional practices and drugs was one of the most puzzling aspects of this study. All countries agree that where a traditional practice is known to be harmful, it should be discouraged (Examples of this were placing cow-dung on a freshly-severed umbilical cord, denying liquids to a child with diarrhoea, the belief that a child who eats eggs grows up to steal). But often - as reported by Benin, Botswana and Jamaica - CHWs and health sector personnel themselves may not be certain whether a practice is harmful, harmless or helpful. It was suggested that it is unfair to instruct a CHW to oppose harmful practices without clearly explaining which are truly harmful. Anthropological studies might be conducted to identify the most common traditional practices, then a careful assessment of each of these conveyed to the CHWs.

A similar situation exists for traditional drugs. Currently CHWs are authorized to distribute them in some countries (e.g. Thailand), forbidden in others (e.g. Papua New Guinea) and neither authorized nor forbidden in most. Much more investigation is needed to determine which traditional drugs are useful, and which of these a CHW should distribute and how to obtain/prepare them.

Essential Drugs:

Table 5 lists an extraordinary range of drugs which CHWs may distribute - from 6 to 74 items. In all countries, CHWs do spend at least part - if not most - of their working time seeing patients and giving (or selling) drugs. It was generally felt that this is desirable, even if it is essentially a curative rather than a preventive or promotive task. It was suggested that, within the limits imposed by the health policies of the country, the influence of the medical profession, and the level of their training and logistics constraints, CHWs should be provided with drugs to alleviate certain high-priority problems, such as TB, yaws, malaria and other infections.

TRAINING OF THE CHWs

Trainers:

The performance of the community health worker is related to the type of trainers who conduct the initial training sessions for CHWs. As shown in Table 6, there is no consistent pattern for the recruitment of trainers for CHWs in the initial stages of the programme. In some cases (Botswana, Liberia, Papua New Guinea, Sudan), CHWs are trained in a

TABLE 4. CHW'S RELATIONSHIPS WITH TRADITIONAL PRACTICES AND PRACTITIONERS

	BENIN	BOTSWANA	COLOMBIA	INDIA	JAMAICA
Traditional practices to be overcome	- child who eats meat will become thief - child with diarrhoea should not eat - child with malnutrition should not eat eggs, fish, fresh meat - child with measles should not be bathed or eat fresh meat, fresh fish, ground nuts - pregnant women should not eat fruit as this will make labour difficult and cause dermatoses - pregnant women should not eat eggs, as this will harm her ovum. - etc.	- traditional drugs - faith healing - religious sects which oppose use of medicine - food taboos - use of cow-dung, ashes crushed egg shells on freshly cut umbilical cord - breast feeding only allowed if permitted by traditional doctor (following cured breast abcess, death of earlier infant) - disease causation		- disease causation - herbs, witchcraft to cure illnesses - other practices examples - mother fasting for recovery of sick child - denying liquids in case of vomitting, diarrhoea - massaging abdomen for abdominal pain	- bottle feeding - belief that some illnesses caused by witchcraft - non-use of contra-ceptives - selecting food for status rather than nutritional purposes - poor environmental sanitation - TBA practices
CHW's understanding of traditional practices	CHWs taught some traditional drugs, but extent of know-ledge of traditional practices not clear.	- CHW, as a villager, knows traditional practices. Not clear if she learns which are harmful/helpful		- As villagers, CHWs know traditional practices. In training they are taught which to: (a) encourage (b) discourage (c) ignore - CHWs also taught use of specific non-western drugs	- Not clear, but a module on ethno-medicine recently introduced in one supervisor/trainer training school
Pervasiveness, types of traditional prac-titioners (TBAs and PTMs)	- TBAs and PTMs very pervasive (av.2-4 per village), very influential	- Very pervasive - Faith healing is increasing		- Totally pervasive, including TBAs and practitioners of other systems of medicine (Ayurvedic, Unani, Siddha, Homeopathy)	- In about 30% of rural areas, 10% of urban areas
Relationships between CHWs and traditional practitioners (TBAs and PTMs)	- They cooperate only where CHW is more influential (about 2/3 of villages). Often their relationship is competitive.	- CHW does not promote or use traditional medicine, but neither does he condemn PTMs - CHW tries to educate PTMs - CHW not perceived as a threat to income or status of PTMs	- PTMs not an obstacle to CHW acceptability - CHWs provide training to traditional practitioners	- Competitive, but CHW position is stronger	- CHWs not expected to collaborate - PTM has little or no) influence on CHW

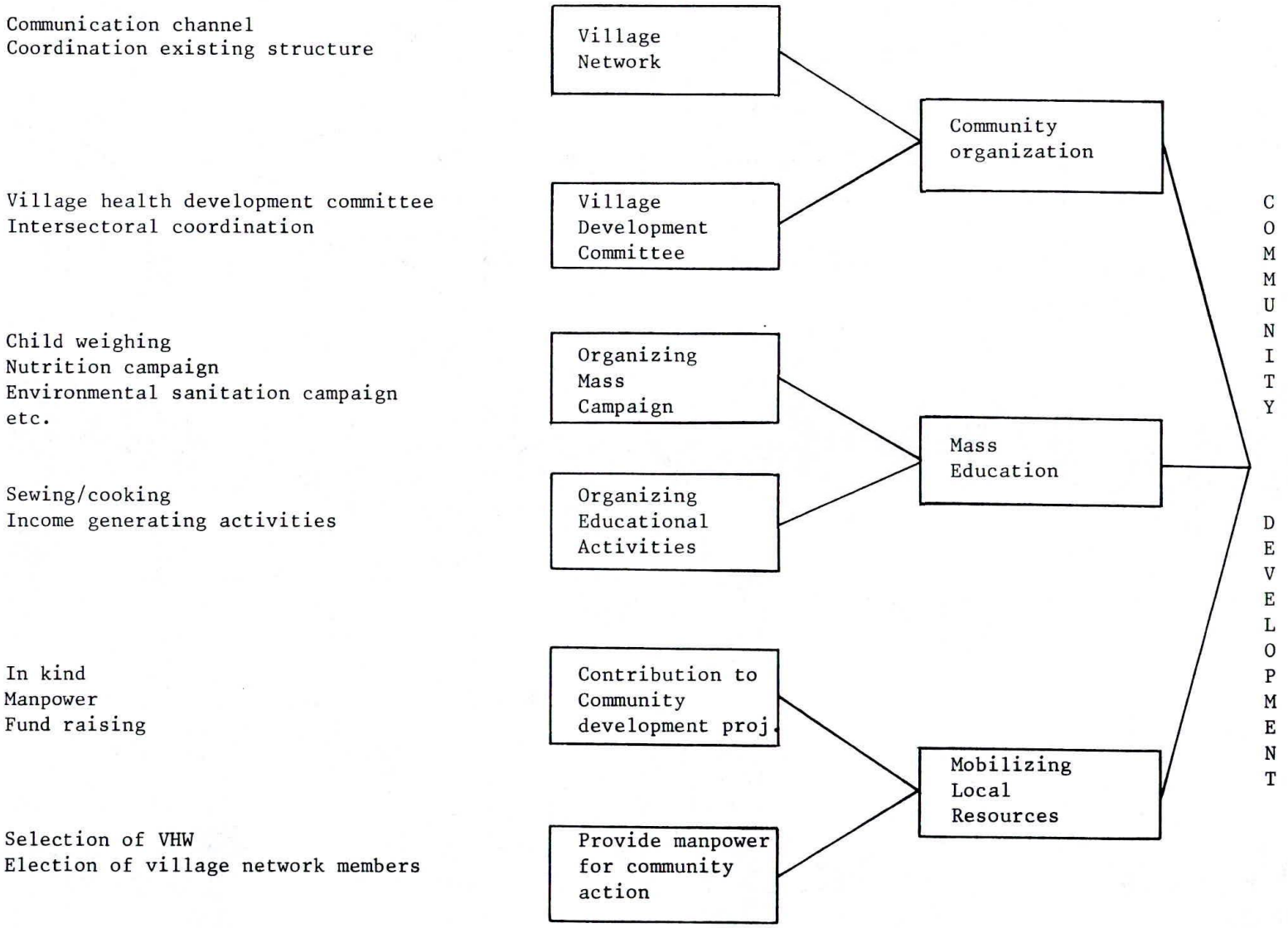
TABLE 4. CHW'S RELATIONSHIP WITH TRADITIONAL PRACTICES AND PRACTITIONERS (continued)

	LIBERIA	PNG	PHILIPPINES	SUDAN	THAILAND	YEMEN
Traditional practices to be overcome	- Pepper enema to children with diarrhoea - leaves, cow-dung on freshly-cut umbilical cord - child who eats eggs will be thief - child who eats meat will have worms - husbands should receive best part of any meal - measles caused by witchcraft - desire for many children - etc.		- harmful practices of TBAs, PTMs - food taboos examples - fish causes parasites in children - massaging pregnant women - eating fish after delivery makes breast milk smell bad	- female circumcision - food taboos - use of TBAs instead of trained midwives - wound treatment with cow-dung or soil	- cutting umbilical cord with a piece of bamboo - sprinkling holy water to treat diseases - food taboos	- treatimg hepatitis by cutting under the tongue - TBAs not tying umbilical cord - treating epistaxis by lowering and striking lightly the patient's head - belief that eating fish can make children forget their lessons
CHW's understanding of traditional practices	As they relate to a particular environment - but not taught		- As villager, CHW knows traditional practices. During training, they are taught which are harmful helpful	- As villager, CHW knows traditional practices and PTMs. - He is taught that certain practices are harmful	- Taught traditional practices during initial in-service training - Some traditional medicine (usually herbal) being included in standard drug list to be prescribed by the CHW	- CHWs are asked to report about the traditional practices then discuss with Health Centre personnel who explain which are harmful. The CHWs reports, however, cannot include all the traditional practices in their villages
Pervasiveness, types of traditional practitioners (TBAs and PTMs)	- Only 2 of 10 surveyed villagers had PTMs.	- Not very pervasive	- Becoming less common	- Wisemen, Wise-women - TBAs - herbalists - religious healers - bone setters All very pervasive	- Not so common - Western medicine preferred - Local druggist most common type but also injectionists, quacks, traditional doctors exist.	- TBAs only; others not common
Relationships between CHWs and traditional practitioners (TBAs and PTMs)	- Villages with PTMs among the most successful CHWs (not clear why)	No relationships	- TBAs' poor practices are being overcome via MOH training, so CHWs and TBAs do collaborate - Relatively few PTMs in surveyed villages	- Some CHWs mentioned frankly that it confuses them to be told to seek peaceful co-existence with traditional healers when they feel it is their duty to overcome their practices - CHW is threat to status and income of PTMs	- Presence of a PTM in village definitively has negative effect on CHWs effectiveness	- CHW is supposed to help and complement the functions of the TBA wherever needed and possible

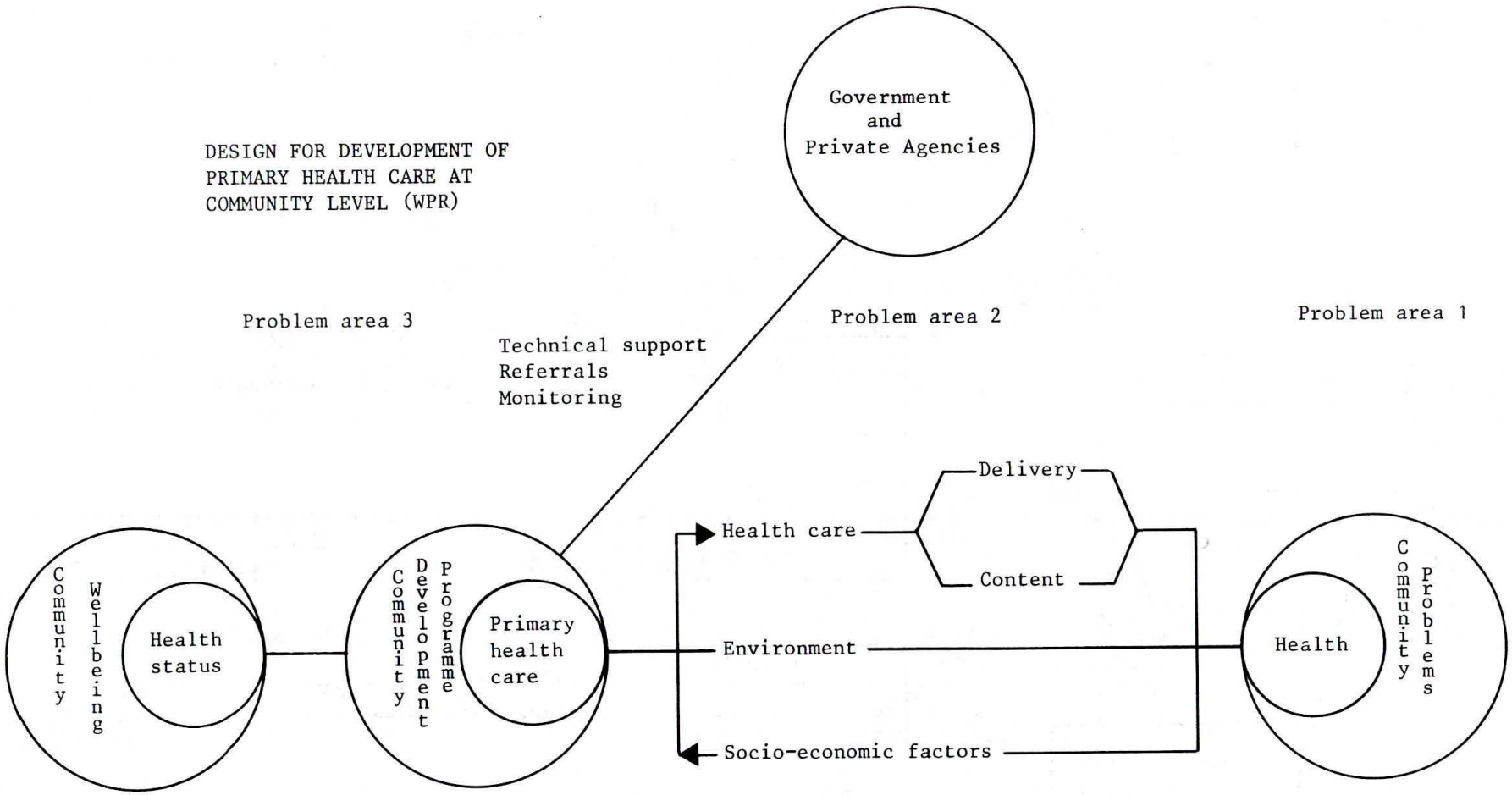
TABLE 5. DRUGS PRESCRIBED BY CHWs

BENIN	BOTSWANA	COLOMBIA	I N D I A	JAMAICA	LIBERIA
Nivaquine Aspirin Ganidan Multivitamins 90° alcohol Boric alcohol Iodized alcohol Sulfanilamide powder Argyrol Mercurochrome Methylene Blue Gomenol oil	Standardized list of drugs, but not specified in report. Some experienced CHWs also have sulfa drugs, antibiotics (including penicillin injections), malaria drugs	Anti-parasitics Anti-malarials Metronidazole Expectorants Aspirin Magnesium sulphate Papaverol Contraceptives Sulphones Anti-TB	A. Essential 1. Chloroquine phosphate Tablets 2. Primaquine Tablets 3. Iron and folic acid tablets (for adults and children) 4. Vitamin A 5. Dapsone tablets 6. Multivitamin tablets 7. Nirodh-Depot holder pack (in case "Depot holder free supply pack may be available, free supply provided) 8. O.R.S. Packets B. Optional (The list can be modified by the State Government as per their requirements. In case the list is modified, chapter No. 9 of the manual on the treatment of minor ailments, giving the detailed instructions about the use of these medicines should be modified accordingly.) a) For internal use 1. Lashunadi vati (flatulence, indigestion) 2. Jetiphaladi (for diarrhoea, dysentry) 3. Mahayograj Guggulu (body and joint pains) 4. Cina 30 (worms in intestines) 5. Calocymus 6 and Maghpos 6x (colic, abdominal pain) 6. Belladonna 30 and Merc sal 30 (dry cough with fever, toothache, swelling gums) 7. Kaolin pectan suspension (diarrhoea) 8. Paracetamol tablets (fever, headache) 9. Magnesium hydroxide tablets (constipation. acidity) b) For external use 10. Antiseptic ointment 11. Menthol and eucalyptus ointment 12. Sulfacetamide eye and ear drops 13. Zinc boric acid dusting powder 14. Gauze and bandages 15. Benzoic salicylic ointment 16. Benzyl Benzoate emulsion 17. Terramycin eye ointment List of medicines which may also be considered for inclusion in the medicine kit of the CHW. It is desirable that there be an ISM Physician who can guide the CHW regarding the proper use of these medicines. 1. Allopathic system 1. Antispasmodic tablets 2. Anti-histaminic tablets 3. A.P.C. tablets 4. Cough mixture 5. Anti-diarrhoeal tablets 2. Ayurvedic system 1. Lasmirhasa pata (for common cold, headache, influenza) 2. Ativisha Mishrani (infantile diarrhoea, digestive disorders) 3. Panchguna taila (for external use in burns, ulcers, wounds and skin infection) 3. Unani system 1. Qurs Mubarak (for fever) 2. Qura Tinkar (for constipation) 3. Arq Ajasb (for headache, earache, toothache) 4. Marham Khaxish (for external use) 4. Homeopathy system 1. Colorynth 12 and Magphos 6x (for abdominal colic) 2. Cina 200 (worms) 3. Nuxvomica 30 and Matphos 6x (for indigestion) 4. Chamomilla 30 and cal. Phos 6x (dentition trouble) 5. Arnica Montana 200 (after delivery) 6. Cantheris ointment (for external use in burns) 7. Calandula ointment (wounds and injuries)	Zinc oxide paste Savlon Aspirin Acriflavine Alcohol Supersan	Chloroquine Acetyl salicylate acid Triple sulfa Gentian violet Eye ointment

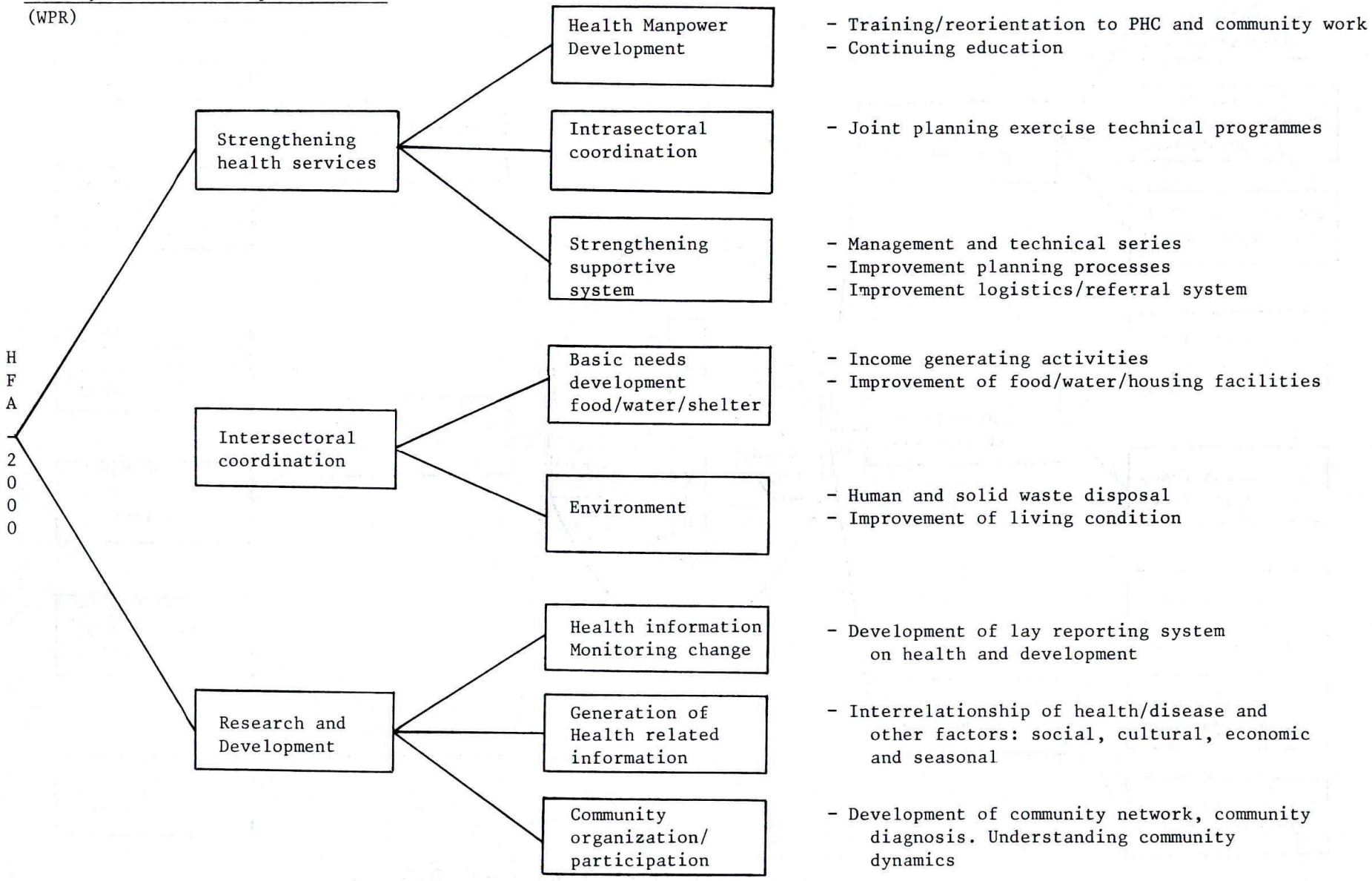
Primary Health Care as part of
Community Development (Philippines, WPR)



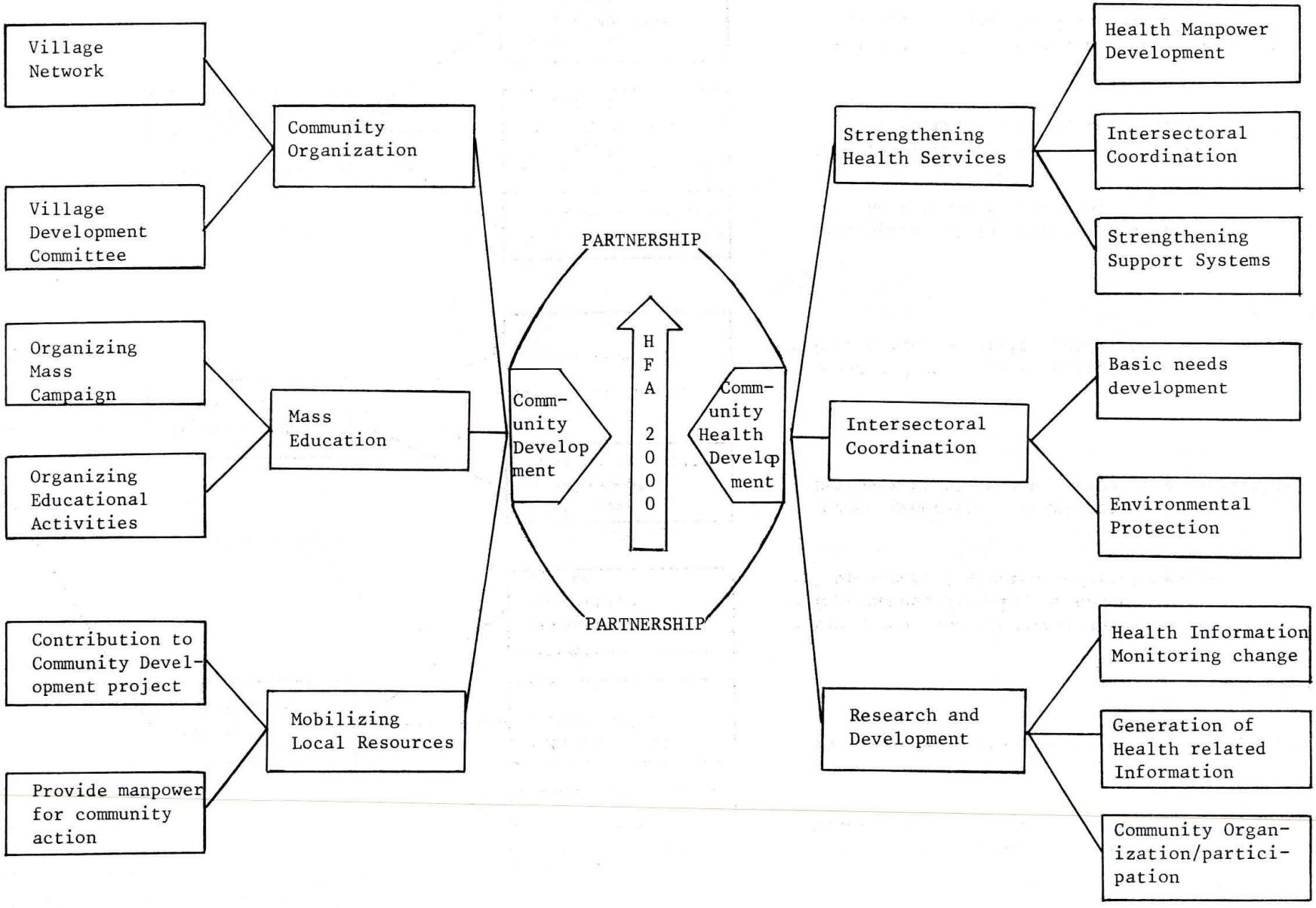
DESIGN FOR DEVELOPMENT OF PRIMARY HEALTH CARE AT COMMUNITY LEVEL (WPR)



Re-aligning Health Care System for Primary Health Care Implementation (WPR)



Process for Primary Health Care Development to achieve Health for All (Philippines, WPR)



2. For Session 6, WHO officers responsible for immunization, diarrhoeal diseases and nutrition programmes will be available to help participants to clarify the relationship between these areas and the CHW's job. These discussions will be initially conducted in small groups, then conclusions will be presented in a plenary session.

Annex 2

SECOND INTERREGIONAL WORKSHOP ON
COMMUNITY HEALTH WORKERS
Manila, Philippines, 4-8 July 1983

REVISED AGENDA

DAY 1: Monday, 4 July

a.m.		
9:00 - 9:30	1.	Opening session
09:45 - 10:15	2.	Review and adoption of the Agenda
10:15 - 12:30	3.	The Community Group Supporting the CHW
p.m.		
1:30 - 3:00	3.	The Community Group Supporting the CHW (continued)
3:15 - 4:30	4.	The CHW

DAY 2: Tuesday, 5 July

a.m.		
8:30 - 12:30	5.	The CHW's Job - Management
p.m.		
1:30 - 4:30	6.	The CHW's Job - Technical aspects of the programme

DAY 3: Wednesday, 6 July

8:00am - 4:00pm	7.	Field Trip. Departure at 8:00 from the Regional Office

DAY 4: Thursday, 7 July

a.m.		
8:30 - 9:30	8.	Learning experiences from the Field Trip
9:30 - 11:30	9.	Other health sector support activities
11:30 - 12:30	10.	Financing the CHW's activities
p.m.		
1:30 - 3:00	10.	Financing the CHW's activities (continued)
3:00 - 4:30	11.	Other National Policies and Actions

DAY 5: Friday, 8 July

a.m.		
8:00 - 9:30	12.	Follow-up Action : Regular review of national activities
9:30 - 12:30	13.	Follow-up Action : Specific improvements
p.m.		
12:30 - 1:00	14.	Closing session.

N.B. Coffee breaks at 10:15am and 3:00pm

Remarks:

1. For Sessions 3-5 and 9-11, the following general procedure is planned: First, in a plenary session, the basic national information concerning the topic of the session will be reviewed and problems identified. Then, in small groups, participants will exchange national experiences when dealing with each problem and develop possible solutions. These solutions will then be presented in a plenary session, discussed and finalized as recommendations for national follow-up action.

Annex 1

PHILIPPINES	Dr R.A. Estrada Associate Director Institute of Community and Family Health 11 Banawe Quezon City Philippines
SUDAN	Dr Ali Beily Director-General Primary Health Care and Rural Health Ministry of Health Khartoum Sudan
THAILAND	Dr Uthai Sudsukh Principal Medical Officer Ministry of Public Health Devavesm Palace Bangkok 2 Thailand
DEMOCRATIC YEMEN	Dr Ahmed Ali A. Lateef Director-General Primary Health Care Ministry of Health P.O. Box 4200 (Aden) Khormaksar Democratic Yemen

Consultant

Dr Don Chauls
Staff Associate
Training/Community Involvement
Management Sciences for Health
165 Allandale Road
Boston, Mass. 02130
U.S.A.

WHO Staff

Dr Sombhong Kutranon, SEARO
Miss M. Hamunen, EPI/HQ
Dr G. Oblapenko, CDD/HQ
Dr A. Pradilla, NUT/HQ
Dr D. Flahault, HTD/HQ (Co-secretary)
Dr A. Hammad, IAH/HQ (Co-secretary)
Dr Y. T. Kuo, HSD/WPRO
Mr H. S. Dhillon, CHR/WPRO
Dr G. Nugroho, PHC/WPRO

Annex 1

2ND INTER-REGIONAL WORKSHOP ON
COMMUNITY HEALTH WORKERS
MANILA, 4-8 JULY 1983

LIST OF PARTICIPANTS

Principal Investigators

BENIN	Docteur S. Raimi Osseni Directeur Provincial de la Santé du Borgou B.P. No.2 Parakou Benin
BOTSWANA	Mrs K.M. Makhwade Director of Nursing Services Ministry of Health Private Bag 0038 Gaborone Botswana
COLOMBIA	Dr R. Ruiz Medina Jefe, Division de Programacion y Evaluacion OPS/OMS Apartado Aereo 29668 Bogota Colombia
INDIA	Dr M.D. Saigal Deputy Director-General Rural Health Services Government of India Nirman Bhavan New Delhi 110011 India (Principal Investigator for study but unable to attend the meeting)
JAMAICA	Mrs Eugene McFarquhar Nursing Officer, Public Health Ministry of Health Caledonia Ave., Cross Roads Kingston 5 Jamaica
LIBERIA	Dr S. Benson Barh (Chairman) Primary Health Care Project leader Maryland County P.O. Box 1926 Monrovia Liberia
PAPUA NEW GUINEA	Mr Kelevi Atasoa APO Training School Butuwin P.O. Box 149 Kokopo East New Britain Province Papua New Guinea

PHILIPPINES:	Financing of primary health care Improving training methodology Expanding supervision Extending village organization
SUDAN:	Initial curriculum development and modular form for pre-service and in-service training Formulating job descriptions in conjunction with representatives of all levels and groups concerned Supervision and Community participation
THAILAND:	Extension of coverage of Primary Health Care activities by 1986 Programme review for improvement
DEMOCRATIC YEMEN:	Training methodology and contents Supervision and delegation.

Two topics are highlighted in nearly every country report:

- Community participation in view of the social preparation of both the SG and the community as a whole, and

- training of the health centre staff (who, in turn, train and/or supervise the CHWs) to help them to understand their job better and work with the CHW, the SG and the community.

Also, it was felt that countries should consider each of the following topics:

- financing of CHW activities
- supervision
- coverage.

Participants agreed to discuss the 5 topics mentioned above as well as other follow-up studies and activities with their colleagues. Within three months, they will each submit a plan to implement these activities - including, if necessary, requests for technical or other assistance from WHO.

Participants agreed that WHO should convene a follow-up meeting in approximately two years' time to report on the studies they will have conducted and improvements made in their CHW activities.

CHAPTER 4

RECOMMENDATIONS AND FOLLOW-UP ACTIONS

1. When deciding on a model for the involvement of the community in solving their own health needs and related problems, several options should be provided, and through the participatory approach and social preparation of the community, assistance should be given in choosing the most suitable solution given their situation, needs and resources. Support from established and well organized systems (e.g. training, supervision, communication, technology) should be readily available.

2. The Worldwide economic crisis is affecting the financing of Primary Health Care and is ultimately weakening the structure in which the CHW has to function. In order to remedy this situation, countries should be innovative and examine realistic and appropriate ways, within their own political, cultural and legal contexts, to generate the support and commitment needed for the continued promotion of health and welfare, particularly in aid of the rural population, the underserved and poor communities.

3. Countries should examine critically the issues related to training and supervision; review their own programmes and devise strategies which will inform and convince of the value of the CHW and the system within which he/she operates. These strategies should also aim at involving the community in order to provide the necessary support for the CHW to function at a highly motivated level. This level would be an indication of the competence of his/her supervisor/trainer and therefore of the effectiveness of the system as a whole.

4. The CHW job-description includes a number of tasks to be performed as part of the primary health care approach; however, this job description should be limited to the strict necessities of the PHC programme and should serve as the basis of training given to the CHW.

5. Countries should adopt an approach which would allow an efficient and effective management by mobilizing community-based resources, external agencies, and by resorting to the technical assistance offered by the World Health Organization.

In addition to the above recommendations participants identified areas which they believed required follow-up in their respective countries. These are:

BENIN:	Financing of Primary Health Care Community involvement and social preparation
BOTSWANA:	Community participation Training and review of job description Supervision
COLOMBIA:	Management of Primary Health Care Re-direction of job description to reflect the needs of urban sector as well. Community organization
JAMAICA:	Community participation Supervision
LIBERIA:	Primary Health Care to be dealt with at national level.
PAPUA NEW GUINEA:	Extending Community Health Worker coverage to rural population Training of trainers Supervision

Other health support services such as dental care, maternal and child health, sexually transmitted diseases prevention units are located within the health centres with lying-in facilities. This infrastructure was seen as an interesting option for solving many of the problems of Primary Health Care.

It was extremely encouraging to observe the team spirit, goodwill and cohesiveness animating the various members implementing the project, from the Medical Director down to the volunteer community health worker. This was seen as the main reason for the community's successful involvement and leadership for the fulfilment of the targets of PHC.

CHAPTER 3

URBAN PRIMARY HEALTH CARE

The Manila Field Trip

Participants from the 11 participating countries were given the opportunity of going on a field trip to the urban Manila Health Programme project at present being implemented in three 'Barangays' (villages) No. 865, 844 and 839.

The main purpose of the visit was to meet with the team of health managers and community leaders in order to discuss the programme, and observe the procedure of community organization, its response to the health needs of the community, the response of the community to the programme, and the ways of encouraging or improving community participation.

The various health centres are responsible for the 'Barangays' which are sub-divided into 'Puroks'(1). There is a very good communication and referral system manned by well-trained and well-motivated community leaders.

'Barangay' 865 has a population of 2,528; 'Barangay' 844 counts 2,818 individuals and 'Barangay' 839, 2,956. These barangays come under the supervision of 3 health centres responsible for 21 such 'puroks' between them, in the 4th Health District of Manila alone.

This programme was started as a pilot project to identify the causes of the only slight reduction in the morbidity and mortality rates despite an ever-growing number of health centres, greater manpower and extension of health services, and despite the variety of health delivery services and the concentration of medical practitioners and medical institutions in the city.

The project was started in 1981 and will continue to be implemented until their PHC objectives are reached. In 1982, the Health Department celebrated its 42nd anniversary with the theme: "Health for all Manilans through Primary Health Care".

The participants took great interest in the various activities in the Barangays such as the fund-raising projects and health-related activities (weighing and charting processes for a nutrition surveillance scheme carried out independently in each village). They noted the pride and confidence of the community in itself and its leaders. The proposals related to fund raising were being considered to increase the number of blood pressure instruments and to train some leaders to perform this skill so that they may later monitor such activities in the community under professional guidance.

The majority of leaders seen were women, and these seemed to be very influential in mobilizing the community. They knew how to evaluate correctly the problems and needs of their communities, and were able to provide the information required by the visiting participants. They were also able to explain the prevalence and incidence of diseases. Not only did they have the necessary data at hand, but they were also capable of interpreting and using it to relate figures to reality.

Social problems, such as large families, over-population, low income and poor environmental conditions were evident; but the highly commendable efforts displayed by the health staff backed by strong and effective community leadership and participation have kept this project viable dispite the existing social problems.

---

(1) Purok: zone - lowest political/administrative division of a village (barangay).

Control of Diarrhoeal Diseases

The activities relative to the monitoring of diarrhoeal cases are included in the job description of various countries. The newly introduced management schedule of oral rehydration salts (ORS) also assigns this task to the community health worker.

For this new task, the community health worker is expected to:

- evaluate the level of dehydration
- treat diarrhoea by ORS
- educate mothers/community on how to prevent dehydration and how to treat diarrhoeal diseases at home
- educate mothers on how to prepare ORS when necessary
- keep simple records regarding these actions
- encourage breast-feeding
- recognize the signs and symptoms of dehydration, that is:

    - reduced urine
    - sunken eyes
    - sunken fontanelle
    - loss of skin elasticity.

It was noted that cultural practises influenced the management of diarrhoeal diseases such as in India where mothers delayed breastfeeding during diarrhoeal bouts, and in other countries, (e.g. Colombia) where other cultural beliefs stop mothers from breastfeeding during the diarrhoeal periods.

Intersectoral collaboration and actions are needed in order to cope with the environmental problems but the community health worker can wield a positive influence by mobilizing the community to action and promoting health education regarding health practices such as refuse disposal, food hygiene and water sanitation systems.

Participants felt that several of the solutions are within the competence of the community health worker and that the community's response is crucial to the issue of control of diarrhoeal diseases.

FOLLOW-UP ACTION:

1. In the control of diarrhoeal diseases, the administration of oral rehydration salt against a salt and sugar solution needs to be reviewed, depending on supplies available.

2. WHO should be contacted through the regional offices when technical support is necessary and unavailable locally.

The problems of malnutrition are very complex. Although the CHW can participate actively in solving the problems arising from within the community itself (stemming from cultural practises, e.g. husbands get the best part of a meal, traditional/religious beliefs, ignorance, etc.), he/she would need another type of training to educate and inform the community of problems arising in areas such as adequate food production, employment, child diseases, etc.

Expanded Programme of Immunization

This programme is in progress in most countries participating in this study, and activities are at various stages, managed by the available human resources at country level. In some countries the responsibility of the community health worker for immunization was a single and/or participatory activity under the guidance of supervisors, in order to provide a balanced coverage throughout the country.

Participants expressed the desire to expand the immunization programme beyond the six diseases (Measles, Diphtheria, Tetanus, Poliomyelitis, Pertussis, Tuberculosis).

The decision was left to each country to see how many more diseases could be included in the programme according to existing means. However, it was vital that they use the same techniques when dealing with the additional diseases as with the initial six: they need to maintain effectively the "cold chain", adequate sterilization and supervision activities, the potency of drugs and learn about the side-effects of the additional diseases.

Malnourished children were one of the vulnerable groups who should be fully immunized to improve their chances of survival. This fact needs to be taken into account by professional staff as well as by mothers and families of malnourished children.

It is an accepted fact that for best results and effectiveness all children should be immunized within the first year of their life. One task of the community health worker in Colombia, Papua New Guinea and in Sudan is to give immunizations and other injections, regardless of their level of education and the stage of training they have reached. In one participating country, the community health worker operates from her own home when necessary, and this presents difficulties, as this worker is expected to perform duties out of working hours, consequently overloading her schedule.

Although practical experience in immunization techniques and uses makes up for 70% of the 12-hour training programme, (with supervision by professional hospital staff), the support for this activity during the actual implementation in the field is inadequate: the 'cold chain' cannot be maintained because of lack of transport and poor supervision.

The establishment and maintenance of the "cold chain" mechanism in the EPI programme is amongst the most critical issues to be reviewed by countries presently conducting programmes and or proposing to do so. Botswana has started a pilot project in which the Community Health Worker is taught to use immunization techniques, maintain the "cold chain," and care for the catchment population to make up for the infrequent visits of the mobile clinic.

In another instance, one participating country utilized the community health worker to give immunizations in the rural areas. In addition, veterinary officers entrusted the community health worker with some medications, and nomadic chiefs expressed the desire for their animals to be vaccinated against the common diseases in the district by the community health worker. Papua New Guinea reported that CHWs were supported by appropriate equipment and adequate drugs.

It was concluded that if the community health worker was adequately trained and competent in this skill, it is appropriate to assign CHWs competent in that task to remote areas where there is a lack of transportation, few or no health facilities or personnel. This is a way of utilizing available human resources with training to make up for the urban/rural imbalances in the provision of health care. In order to have a more equitable coverage, and given the acceptability of the community health worker, Sudan, is proposing to recruit and train more workers to serve the rural population in particular.

In the light of this discussion, the following facts emerged:

- the causes and effects of disease incidence are closely related, therefore the indicators for intervention and problem solving are similar.

- Decisions concerning policies, political influences and cultural manifestations determine the CHW's performance of these tasks in technical areas.

- The community should be mobilized to play an active role in the management of these technical schemes.

- The greater the CHW's competence in performing multiple tasks, the greater the number of links established between supervisors and CHWs, between CHWs with supervising capabilities and other CHWs, and CHWs and their community.

- The logistics of oral rehydration treatment were discussed.

- The methods of population coverage depend on the CHW and the number of tasks he/she can perform competently and effectively within a given context. The use of CHWs leads to a diversity of pre-training periods and nomenclatures; CHWs need to be incorporated into health systems and their various infrastructures.

- The "cold chain" should be established and maintained.

A more detailed summary about what has been said on the subject of technical aspects is given below:

Nutrition:

Most countries depend on the CHW for the presentation of health promotion and food demonstration activities. The CHW also demonstrates the varied uses and methods of charting, weighing and distribution of food supplements. In some of the countries, the different methods are used simultaneously, in others a single method is followed. 3 countries report a deficiency in the monitoring system.

The opportunity was given, during the workshop, to share the 'Thailand Experience' on nutrition, where the food supplement skimmed milk was not accepted by the community. As a result, an alternative activity was adopted with great success. The community was mobilized to provide food for a twice-a-week supplementary feeding programme for 3rd degree malnourished children. Village health communicators volunteered as health workers, and these workers were each responsible for ten households.

This limited coverage for each worker was a practical option in the problem solving approach by the community for the community and was undoubtedly the major reason for the success of this activity.

On the other hand, countries reported that weighing and distribution of food supplements were not tasks performed by the community health worker, and this aspect of the maternal and child health programme needed strengthening.

The use of the arm circumference measuring tape was not considered sufficiently sensitive as a method of identifying severe malnourishment within an overall monitoring system. However, it could still be used by the CHW in remote areas where it was difficult to use a scale. In Yemen, the arm circumference measuring tape was used to monitor malnourished children whose condition was precipitated by measles. Nevertheless, it was found that weighing was the most accurate method.

CHAPTER 2

TECHNICAL ASPECTS OF THE CHW.

There is a tendency among decision makers in primary health care to expand programmes without either preparing the community or the worker for the new tasks included or modified. Whenever this is the case, programmes are badly implemented. Sometimes, when CHWs are in fact trained to perform these new/modified tasks, then the training and other support systems are inadequate; in some cases, these systems are of such poor quality that the programmes themselves lose their viability. Successful programmes reflect good social preparation and acceptability of health workers and community alike.

It is vital to ensure that support systems are soundly established before assigning CHWs to primary health care programmes, especially in the technical fields such as Nutrition, Expanded Programme on Immunization (EPI) and Control of Diarrhoeal Diseases. Because of the fact that support systems and implementation of the technical aspects of programmes are so closely related, the CHW needs adequate support systems to be able to perform his duties efficiently. He/she should also acquire a basic knowledge of these technical aspects which are part of the curative/preventive approach of Primary Health Care. To illustrate this the following issues were discussed in relation to the role of the CHW in the implementation of three technical programmes:

1. Nutrition:

- Monitoring of growth performance with 2 major purposes:

  (a) increasing the awareness of mothers to health problems before children reach a critical stage of illness;

  (b) detecting special risk families and groups of families;

- Mobilization of the community to provide food for severe cases of infantile malnourishment.

2. Expanded Programme on Immunization:

- Identification of target groups in the community, e.g. high risk pregnant women and children under one year of age.

- Education and motivation of families in order to complete the immunization scheme which includes coverage for 2nd and 3rd immunization rounds.

- Recognizing the six EPI diseases.(1) Knowledge of the names given locally to diseases, information and referral system, definition of the role of the CHW as a support to the family when problems arise.

3. Control of Diarrhoeal Diseases:

Four strategies were adopted for a medium-term objective to reduce the mortality rate of children under five years old:

- case management, including oral rehydration;

- maternal and child health practices;

- epidemic control by rapid diagnosis of disease and prompt intervention; encouraging breast-feeding;

- developping environmental health conditions to include water supplies.

---

(1) Measles, Diphtheria, Tetanus, Poliomyelitis, Pertussis, Tuberculosis.

CONCLUSIONS AND RECOMMENDATIONS REGARDING THE COMMUNITY HEALTH WORKER AND HIS/HER COMMUNITY

In view of the discussions held during the Manila workshop on CHW's and if the target of primary health care, "Health for all by the year 2000" is to be achieved, several facts and propositions need to be explored in order to accomplish such a goal in poor and under-served countries and communities.

1. Among other measures, it was suggested that governmental resources be re-allocated to overcome local and regional imbalances. These measures would include free health care (government) schemes, and health insurance schemes. Thus a redistribution of the health budget to accommodate primary health care and implement health service delivery, would improve the CHW activities and increase support.

2. A detailed budget, allocated to primary health care, should be separate from the general one to enable adequate backing for the CHWs and for other essential support systems of the programme.

3. The community support groups should be provided with the necessary managerial tools to understand and utilize the principles of budgeting, accounting, planning, organizing, implementing and controlling, in order to establish practical and workable systems for an efficient utilization of funds. Those who will train CHWs and SG members should receive adequate training themselves for that purpose.

4. Community financing will increase community involvement and thus, increase their sense of "ownership" of the programme, provided that there is adequate social acceptability and preparation of the community, as well as strong support.

5. The community's transition from the status of recipient to provider poses many problems and the various attitudes of community members need to be taken into account. However, the learning experiences debated during the workshop served to encourage countries to carry out in-depth evaluation of their situation, and to help them adopt the established "guiding principles" in view of enabling them to make appropriate decisions concerning their welfare.

6. Some governments can no longer afford to finance the present CHW workers, or expand the programmes and give adequate support, because of economic difficulties. The implications of a change in the existing social order is also causing great problems. Therefore, options to suit their own policies and cultural situation need to be investigated.

7. In countries with economic problems, a new system was accepted considering the cost factor and the fact that primary health care reduces the workload to a minimum number of specialist cases for hospital-referral. This system is based on the withholding of the secondary care budget for 5 years (for example) and using the interest from that sum to finance primary health care.

These suggestions have to be carefully considered and would need confirmation at the political level of policy making in the various countries.

The method used to finance health care should be carefully selected, as it affects the social acceptability and economic effectiveness of the measures implemented. It should take into account the existing social structure. Participant countries were encouraged to benefit from the 'Chinese Experience' which showed that work and reward were respectively compatible with and proportionate to levels of production. It also suggested the establishment of a financial mechanism which would, among other things, "reward communities that are able to achieve better health care at lower cost"(1) and help the government "to promote a wider acceptance of what it considers to be in the best interests of the nation by subsidizing services that otherwise might not be demanded (e.g. immunization and family planning)."(1)

However, as it is impossible to define health care and financing in internationally applicable terms, there is no single expenditure system which would solve the problems of financial health care viability. It is crucial for the countries to review, modify and/or improve their programmes in order to increase the efficiency of the primary care approach and to further community involvement: this is the objective of this exchange of learning experiences, especially since countries report that the different communities are willing and able to assume the responsibility for their own health care. To this end, health behaviour needs to be modified, potential developed, and initiative encouraged towards productive ways of promoting health care. The participants stressed the importance of utilizing a uniform approach to financing PHC. This was especially the case for the difference in demands for payment made from rural and urban populations. It was observed that some countries, for instance, requested the rural community to contribute to the payment of certain aspects of their programme, whereas this was not the case for urban populations who by and large have greater access to health services. Whatever the decision taken, it should be applied nationally so that no special demands are made from certain population groups and not others.

The example of countries where the government contributes to drug costs should be emulated by countries where this expenditure is eroding an already minimal primary health care budget. In Botswana the cost is nominal; in the Philippines certain drugs are supplied free of charge, others are paid for by the community. In the Sudan, this type of community financing is being experimented with on a small scale.

(1) Primary Health Care - The Chinese Experience, Report on an Inter-regional Seminar, Yexian County, Shandong Province, China, 13-16 June 1982, WHO Publication 1983, p. 81

In most countries, the CHWs were paid from government funds. In Benin, the system of payment is based on both government and community funding. In Thailand, governmental salary is complemented by the profit from drug sales; in the Philippines it is increased by funding from external agencies.

The discussion of these systems raised critical issues concerning the loyalty of the CHW to the agency who pays his/her salary, the baseline of salary scale, and the implications and consequences of any system of payment (see table 8).

The salary scale does not seem to depend on any one constant: the full-time or part-time status of the CHW does not affect the size of the population covered, between 50 and a thousand individuals divided into households. In this manner, CHWs cover 15-150 households: these figures are indicators of payment. There are cases of very well paid CHWs (by the government) and CHWs who receive a salary much lower than average. No general answer could be given in relation to the salary scale as this is established according to the drug-sales possibilities and level dictates of each country.

As regards the loyalty of the CHW to its financing agency, two major reactions were discussed; that of the community, and that of the CHW him/herself.

Any system that prescribes community financing will have to provide options from which a scheme can be selected, e.g. Philippines and Thailand, and examine ways of helping communities to become financially self-sufficient for various health related activities, rather than depend so greatly on drug sales, as is the case in most countries. This decision would be taken according to certain priorities. In some of the countries funds were used not only for remuneration and drug supply, but also for the transfer of patients to health centre or hospitals, for the purchase of food supplements for malnourished children, and for the construction of wells and health facilities among other projects.

A community financing scheme which is introduced without adequate social preparation can diminish the interest of health workers and community alike. An example of this situation was reported in India. The participating countries felt that this was due to a deficiency in the infra-structure of the health system rather than in the payment scheme. If remuneration of CHWs were channelled through the Support Groups, the workers would have more loyalty to the group. In Liberia, it was reported that communities were willing to contribute towards a one-time-cost, but unwilling to share recurrent expenses such as CHW remuneration and drug supply.

The workshop provided a baseline for countries in order to strengthen a vital component of primary health care strategy: community participation.

Experience shows that any system of financing will have repercussions, be they on the government, the voluntary and/or external agencies and on the community itself. An analysis of country programmes indicated that among the reasons for deterioration or ineffectiveness of a programme were the following: lack of social preparation, lack of understanding and acceptance of the programme, lack of response to health measures as regards appropriate steps to be taken in consideration to health needs and community attitude towards such efforts, and lack of support from decision makers in order to implement such measures effectively. Since the socio-economic system plays such an important role in the financial viability of improving services, appropriate mechanisms must be established in order to deal successfully with social problems.

After considerable discussion and analysis of various country experiences, the participants agreed on a list of guidelines which they felt were important in view of social preparation. This preparation depends on: a) a "sensitization" to problems in general; b) a knowledge and understanding of the decision-making process; c) community diagnosis, community motivation and education; d) community awareness and knowledge of overall programmes, resources and implications; e) performance-check of the health system at national level; f) political preparation; and g) importance of governmental response to health needs, and attitude of communities towards health measures taken.

TABLE 8. COMMUNITY FINANCING

	BENIN	BOTSWANA	COLOMBIA	INDIA	JAMAICA	LIBERIA	PNG	PHILIPPINES	SUDAN	THAILAND	YEMEN
Does the CHW receive a salary or other payment from the community?	some yes some no	no	no	no	no	no	no	no	no	no, but can keep drug sale profit	no
Does the community pay for drugs?	yes	yes, but nominal amount	yes, but minimal	no	no	no	no	some drugs free; others paid by community	no, but being tried on small scale	yes, except drug cost can be reimbursed for low income people	only when not available from CHW or health centre
Method(s) of raising funds from the community	drug purchase	drug purchase	drug purchase raffle cultural event	-	agro-nutrition fair	local tax for development activities	-	income from village drug store: dance, lottery, raffle, donations from local organizations	drug purchase donation (both cash and commodities)	drug purchase drug co-operative	

The information collected can be either too abundant or insufficient. Both extremes are of little use. To remedy this situation, the participants discussed at length the various forms used for data collection and information (questionnaires, tally sheets, registers, cards, report books, etc.). The CHW finds himself swamped by the numerous, duplicate forms, some of which fill up with too much information, some of which are irrelevant and some useless. Countries were encouraged to review these forms, to check on their validity, their relevance and usefulness to the current health system.

Sudan is at present developing a Health Information System for primary health care and strengthening the support system, e.g. providing an acknowledged list of essential drugs.

In Jamaica, the Health Information System (HIS) is already developed, and is being reviewed and strengthened by the Health Management Information Programme (HMIP). Aspects of this system include computerizing health records, providing training in system management, supplying drugs and essential lists for each type of health centre, running transport and emergency services, and establishing referral systems between the primary health care centres at village, intermediate and national level.

The community health worker will accede to this information through adequate training and reports will be available when information is relayed back to the health centres, particularly the maternal and child health records (MCHR); however, interpretation, comprehension and relevance as monitoring tools need strengthening.

The community involvement component is weak, and is presently being tightened; however, formal relationships have to be developed at all levels to ensure participation of the community in order to fulfil the aim of primary health care.

The Manila Urban PHC project was given as an example of an informational approach closely involving the community to assist the CHW in monitoring the community-oriented activities. The Community Council evaluates the problems faced and then is responsible for the records, maps and other aspects of the country profile reflecting health conditions, problems, population, available resources and referral systems.

The types of records to be kept by the community health worker were not generalized nor standardized as these were dictated by individual countries in response to the various systems, taking into account the socio-cultural implications. This response provided a useful opportunity for retrospection and for monitoring situations. The information in record form is then available to community health workers and community for discussion and thus allows prompt and appropriate intervention.

PATTERNS OF FINANCING:

In all of the countries represented, financing of the CHW activities was based on a variety of systems, ranging from responsibility for financing by the local or central government or both, and payment by the community in cash or kind, to a joint funding by government and an external agency.

Several countries, in which the communities did not play a major financing role, nevertheless listed numerous important advantages of community financing. Two major arguments were presented in relation to community financing (for CHWs and drugs), one in favour, the other against: community financing will increase community involvement and the feeling of "ownership" of the programme; on the other hand, governments can no longer afford to pay for an increasing number of CHWs who distribute drugs subject to great price rises. Others indicated that their current programme is directed towards community-action for fund-raising for various purposes. However, existing constraints were difficult to overcome, such as lack of understanding of the role of the CHW, inadequate social preparation of the community, a strong belief that the poor should not pay for health services, and a history of paternalism according to which the government should be the sole provider.

Several suggestions for the improvement of supervision and coverage were discussed. The first of these was that, since the countries themselves were responsible for the training of supervisory personnel, a budget should be allocated for that purpose. The curriculum of the medical and para-medical schools should be revised to include basic social skills and effective supervision. A re-orientation of health personnel was also suggested, as a means of relieving them from responsibilities which can be entrusted to other competent staff, thus allowing for a supervision system which would be adaptable to local realities and change.

The question of incentives gave rise to an interesting discussion. These can be either moral or economic incentives. However, it was felt that job-satisfaction, moral support and acceptance by the community were greater incentives than short-lived, economic reward.

Finally, the participants felt that if the supervisors had adequate training in management, in the use of schedules and check-lists, they would be able to improve their performance for a better implementation of national policy programmes.

In several countries, it was reported that the Support Group would refer matters to the supervisors, especially when problems arose. No formal links were mentioned as existing in the community which acted as supervisor to the CHWs, but this was implied to a certain extent in those countries where the community participates in the assessment of the CHWs.

INFORMATION SYSTEMS:

Several issues on this subject were discussed, namely the use of information; the different systems used in the various countries; information as a tool for epidemiological charting, CHWs and village council records; and the differenciation between information and data.

Different systems were in operation in the various countries based on child health records kept by the mothers for nutrition surveillance; and monthly records from the community health workers; simple survey sheets for community diagnosis (Sudan); identification of maternal and child health and high risk curative cases (Jamaica); and feedback of information of crucial value to the Planning and Evaluation Unit at central level. In Thailand, voluntary community health workers are not required to report information, but to collect it. Supervisors compile reports directly from the community health workers records for use within the system. The importance of understanding, correlating, utilizing the epidemiological approach and feed-back was considered vital to the management of primary health care delivery.

The difference between data and information lies in the different forms in which the evidence is presented. If the data collected is not presented in a form that can be readily understood, analyzed and disseminated, then compilation of data is a futile exercise. Once date is presented informatively, then it can be used with effect, for example, to predict disease incidence and patterns. The CHW should be trained to understand and interpret this type of information in order to monitor curative and preventive activities, and thus control the disease. Before planning strategies for community mobilization, referring to intermediate and national level, and relating to other agencies, the CHW's first step is to consult this information. Various countries reported the need to further this methodology, while others decided to adopt it for the first time.

The information collected and made available should be credible. It is the responsibility of the supervisor to emphasize this aspect during the pre-service training and field activities. The CHW and other workers should be aware of the personal and job implications of relaying distorted information. Two countries in particular reported that records were often falsified to obtain a greater supply of drugs. This was harmful to the CHW's reputation.

TABLE 7. CHW SUPERVISION IN THE COMMUNITY

	BENIN	BOTSWANA*	COLOMBIA	INDIA	JAMAICA*	LIBERIA	PNG	PHILIPPINES	SUDAN	THAILAND	YEMEN
Is supervision done by Health Centre personnel?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Should be but is not	Yes	No, but was recently added to their responsibilities
Is there anyone who only does supervision?	No	Yes	No	No	Yes	Yes	No	No	Yes	No	Yes, plus training
How often is each CHW scheduled to receive a supervisory visit?	2-4 per month	monthly + fortnightly	1/month	2/month	about 1/ month	1/month	-	8/month		1/month	First year - 1/month Thereafter - 1/2 months (from teams of 3 supervisors)
How often do they actually receive a supervisory visit?	1-2 per month	monthly + fortnightly	1/month 44%; 1/month - 16%; 1/month - 41%	2/month	irregularly	1/month (80%)	-	2/month	2-3/year	1/2 months	same as above
Do supervisors regularly visit SG members?	Yes	Yes	Yes		No	Yes	-	Yes	Yes	Yes	Yes
Do supervisors have training in methods of supervision?	Yes	Yes (basic principles)	No		Yes	No	No	Yes	Some yes	Yes	Yes
Is lack of interest in supervision by supervisors a major problem?	Yes	Yes	Yes		Yes	Yes		Yes	Yes	Yes	Yes, but not a major one
Is lack of adequate transport a major problem?	Yes	Yes	Yes		No	Yes		Yes	Yes	Yes	Yes

*In Jamaica, the CHWs function in Health Centres; in Botswana, many of them work in Health Centres, despite the fact that they are not supposed to do so. This factor confounds many of the questions concerning supervision.

Country experiences show that one of the major weaknesses of most CHW training programmes is the omission of management topics. The CHW's job is a complex one which could be organized and conducted far more efficiently if the CHW knew how to use a few simple management tools. Precisely which tools to include in CHW training will vary from country to country, but those suggested as possibilities were: mapping, scheduling, problem-solving techniques and a reliable two-way information system.(1)

The only technical discipline specifically discussed in relation to training was drugs. It was noted that it is preferable to train CHWs to distribute drugs on the basis of symptoms rather than disease diagnosis (the implication of this is that the curriculum should include sections on cough, fever, diarrhoea, etc. rather than on leprosy, tuberculosis, cholera, etc.). In countries where CHWs are to be trained to administer a large number of drugs, this skill should be taught over a period of time rather than concentrated in one training session.

SUPERVISION:

This topic was discussed in terms of the type of supervision, the training and attitude of supervisors, the frequency of supervision, and the support system for that programme.

The majority of countries reported that supervision was done by Health Centre personnel except in Yemen, where this was recently added to their list of responsibilities. In Sudan, the supervisors who participated in training courses are responsible as trainer-supervisors for the Community Health Worker but very few are assuming this responsibility. This ineffectuality is due to their distance from the workers, the heavy work load, the lack of transport and expectation. This is a situation where a good programme is planned for an in-service Education, but, because of poor management, it is ineffective.

There is a general lack of interest in supervision by those designated for the job and this is a major problem. Supervisors expect special remuneration; the work-load is too heavy; they seem to under- or over-estimate their role; all these are constraining factors undermining the health and CHW programs. The lack of adequate preparation needed for their job causes them to become poorly oriented, unproductive and unmotivated workers, incapable of promoting and implementing health care and community development.

The effectiveness of supervisory visits seems to suffer from inadequate planning. A practical schedule should be established to be used as a means of monitoring activities and providing the necessary support for good performance, both of the supervisors and the trainees.

It was felt that the issue of social preparation within the community is directly related to the performance of the supervisor. A barrier created by hostile human relationships frustrates the efforts of the worker and discourages him/her. The participating countries felt that this issue ought to be reviewed.

Participants also thought that the experienced CHWs could be further trained to assume supervisory roles and perform their duties independently, thus enhancing their status and providing opportunities for career up-grading. This had proven successful in some countries. In other countries this system may not be accepted for cultural reasons, therefore research into alternative methods of supervision needs to be carried out in case CHW's have to be supervised and supported in isolated rural areas. Considering the needs and the system, a dual supervision programme is worth investigating.

(1) To that effect see "ON BEING IN CHARGE, a guide for middle-level management in PHC" WHO Geneva, pp.261-342.

allow the trainee to deal with his various tasks one by one as he/she keeps learning to perform them. In India and in one of the Philippines projects, this approach is currently being used. Colombia has experimented with both types of training and has reported that spaced-out training is more effective, but also more costly.

Community involvement during training was considered highly desirable, but it is not clear how this is best implemented. Spacing out the training programme is one approach, as it brings the trainees back to their communities and allows them to discuss problems during subsequent training sessions. Using sites within the proximity of the community to hold the training is another approach. Training at a health centre, for example, may include community-based activities. Another suggestion to elicit community involvement was to encourage financial support for training, especially if the training is conducted in a health centre or other site which is not equipped as a training centre.

The number of trainees per programme will depend upon many factors, some of which are unrelated to optimizing the quality of training. Participatory methods, such as small group activities and skill practice, are much more difficult to use in a very large training group; but these methods are usually felt to be more effective than others? Most countries viewed a maximum size of 20-30 per group of trainees as appropriate. Colombia recommended a maximum of 20, preferably even less. Liberia suggested a maximum of about 10 trainees.

Training methods

In general terms, the process of preparing a curriculum, developing training aids and lesson plans, teaching and evaluating CHW training is essentially similar to the process used for other health and non-health projects. In some countries (e.g. Benin), some of the trainees may be either illiterate or barely literate - a factor which would affect the teaching methods. But, with this exception, training of CHWs should only differ in content and not in form, from other training programmes.

Only certain elements should therefore be discussed. The approach of learning by objectives was emphasized, that is, that the whole process be geared towards teaching the CHW the tasks ultimately to be performed. These task-oriented objectives should also be used as a basis for developing assessment tools.

The most common teaching method in many training programmes is lecturing; it is also probably the worst, since it is ineffective at training people to perform practical tasks or to influence attitudes - the two main aspects of any CHW's job. Alternative methods were suggested: dialogue, demonstration, skill development, field trips, self-learning exercises, small group discussion, role-playing. A variety of teaching methods should be encouraged.

In the majority of the countries participating in this study, CHW training is conducted by people who are not full-time trainers - mostly health centre and district health staff. Training them how to teach was considered an essential first step. Beyond that, general opinion was that the Ministry of Health (or the central project unit) should be as generous as possible in the provision of the various written materials required to conduct a training programme: curriculum, training aids and evaluation tools; these should be provided to the trainers with as much informative detail as possible. However, this suggestion was not intended to imply that the trainers would not be free to make modifications where appropriate. The Philippines rejected this approach, maintaining that health centre trainers are sufficiently capable of developing their own training aids and other material, and that they did not need assistance in that area.

Content

The content of CHW training should, of course, derive from the job description. One major weakness (as reported by Liberia, but more broadly applicable) is the "lack of social preparation and clearly defined role of communities" as regards the content of many training programmes.

paraprofessional health training institution by the staff of these schools. In India and Thailand, they are trained by health centre personnel. In Colombia and Jamaica, CHWs are trained primarily by district-level health staff. In Benin and the Phlippines, CHWs are trained by both health centre and district health staff. Finally, Yemen has adopted yet another model: its CHWs are trained by units who deal only with Training and Supervision.

Clearly, there are advantages and disadvantages to each approach. In countries such as Papua New Guinea, where the duration of training is very long, it is virtually impossible to do anything but hold the training sessions in a separate training institution. But where the training is only a few weeks long, any of these approaches is feasible. The general opinion was that - if at all possible - CHWs should be trained by the same individuals who will later have the primary responsibility of supervising them. By such an involvement in training, the future supervisors will be aware of each individual's strengths and weaknesses. Thus, person-to-person relationships develop, which will help in an effective long-term supervision. In Botswana, where trainer and supervisor are two positions held by two different people, it was felt that this differentiation should be reconsidered in favour of one person responsible for both aspects of the Training and Supervision Programme.

Training staff might also consist of experienced, seasoned and efficient CHWs. It is clear that these are the people who are best placed to know what a CHW truly does. Thailand and Papua New Guinea both currently employ experienced CHWs as part of their training units and most of the other countries thought that this was worth emulating. Colombia noted, however, that removal of a CHW from his/her community to assist in the training of others would leave that CHW's area uncovered. It was suggested that a way of avoiding this problem was to use experienced CHWs as role models during field training; thus, the CHW would still be able both, to serve his/her own community, instead of going away to another health centre or training institution, and contribute to the training of other CHWs.

To optimize collaboration with other sectors, it was suggested that qualified staff from other fields, such as Agriculture, Administration, Social Welfare, etc. also be invited to participate in the training project..

Very often, people knowledgeable in technical disciplines included in the CHW curriculum are invited as guest speakers during the training programme. This approach is generally found to be non-productive, especially when the speakers have an inadequate understanding of the trainees' abilities and of the job expected of them. Very often, they try to cover too many topics during a brief presentation, thus confusing rather than teaching the CHW trainees. It was felt that the assistance of such people should be minimized and that they should be prepared to limit their talks to what the CHW trainees really need.

Duration of Training:

The duration of the training which CHWs receive in the countries ranges from five days to one year.(1) On average, part-time CHWs receive less training than full-time CHWs (6 weeks compared to 10 weeks, excluding the Sudan which has a much longer training period) - but the duration of the programme varies considerably from country to country. It was noted that the decision on training duration rarely derives from an estimation of the time required to train CHWs adequately to perform their job; rather, it is made on the basis of financial or personnel availability, or (perhaps most commonly) in a somewhat random manner. Participants thought it would be useful to conduct operational research on this topic, to compare the skills learned by CHWs who have experienced different durations of initial training.

Another aspect of the duration of pre-service training which was discussed was whether the total period is to be structured as a single training programme, or divided into a series of courses spread over a longer period of time. The latter form of training would

(1) PNG is excluded: see footnote Table 1 for explanation.

TABLE 6. CHW TRAINING

	BENIN	BOTSWANA	COLOMBIA	INDIA	JAMAICA	LIBERIA	PNG	PHILIPPINES	SUDAN	THAILAND	YEMEN
Pre-service training	4 weeks	11 weeks	urban, rural 13-14 wks., indigenous 8 weeks	200 hours in 3 months	8 weeks	6 weeks	2 years	a) 1 month b) 2 weeks c) once per week for 15 months	1 year	a) 5 days (VHC) b) 15 days (VHV)	3 months
In-service training duration and frequency	1 week every 6 months	usually 1 week per year	irregular carried out through supervision	supposed to be 1 day per month - but has not succeeded	duration- 1 day monthly and as needed	monthly 1/2 - 1 day	every 6 months for 1 week	once a week for 4 hours	10 days, 6 months after pre-service training, then periodically thereafter	a) 1 day (VHC) b) 2 days (VHV) Also self-teaching modules motivated/ supervised by HC staff	with supervision visits - usually monthly (by Training Supervision Teams)
Pre-service Trainers: Health Centre Staff (HC), Training Institution Staff (TI), others	HC + district health staff	TI	-district health staff -nursing school -heads of programme	HC	district health staff	TI	TI	- some HC; - some HC+ project staff + people from health, other sectors	TI	HC	separate supervision training team
Do trainers also supervise CHWs?	Yes	No	occasionally	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes

TABLE 5. DRUGS PERSCRIBED BY CHWs (continued)

PNG	PHILIPPINES	SUDAN	THAILAND	YEMEN
Acriflavine Emulsion Antibiotic Compound powder Application for Treatment of Scabies Benzoin Compound Tincture (Friars Salson) Crystal Violet 1%, solution (Gentian violet) "Tincture of Iodine" Salicylic Acid Paid 10% (Grille Lotion) Ammoniated Mercury ointment (H.D.A.) Cod Liver Oil Ointment Oral Drugs Amodiaquine tablets 100mg Aspirin tablets, 300mg Chloroquine tablets, 150mg Cod Liver Oil Ointment Cough Mixture Cough Mixture for Infants Pyrantel tablets 125mg "Kaolin Sedative Mixture" Sulphadimidine tablets 0.5mg Oral Rehydration Local Anaesthetics Procaine Hydrochloride Injection (Plain) 1%, 2ml Injection Drugs Penicillin Aqueous Procain Injection (Plain) 1%, 2ml Quinine Injection 600mg ml amp Ergometrine Maleate Injection Antiseptic Drugs Chlorhexidine, Comp.Antiseptic Iodine solution 2.5% Ointments Sulphadetamide Eye Ointment, 10% 5mg tube Liniment of Turpentine Water for injection 10ml	No standard list, but usually cough mixtures, anti-pyretics, vitamins anti-parasitics and 1 NH	Standard list of drugs but not specified in report	1. Household Medicines 1.1 Stomachic mixture 1.2 Compound Magnesium Trisilicate tablets 1.3 Alumina and magnesia tablets 1.4 Alumina and magnesia oral suspension 1.5 Sodamint tablets 1.6 Peppermint spirit 1.7 Tincture Asafetida 1.8 Compound Cardamum 1.9 Sodium Bicarbonate 1.10 Salol and Menthol Mixture 1.11 Sulfaguanidine tablets 1.12 Phythalylsulfathiazole 1.13 Camphorated Opium 1.14 Kaolin Mixture 1.15 Kaolin Mixture with Pectin 1.16 Kaolin and Camphorated Opium Mixture 1.17 Castor Oil 1.18 Aromatic Castor oil 1.19 Liquid Paraffin 1.20 Milk of Magnesia 1.21 Magnesium Sulfate 1.22 Piperazine Citrate 1.23 Aspirin tablets 1.24 Paracetamol tablets 1.25 A.P.C. Tablets 1.26 Paracetamol Syrup, 1.27 Cough Syrup 1.28 Brown mixture 1.29 Compound Ammonium 1.30 Eucalyptus oil 1.31 Cold Inhalant 1.32 Aromatic Ammonia Spirit 1.33 Sulfadiazine tablets 1.34 Trisulfapyrimidine 1.35 Trisulfa Suspension 1.36 Sulfadoxine and Pyrimethamine tablets 1.37 Quinine Sulfate tablets 1.38 Sulfadxone tablets 1.39 Vitamin B1 tablets 1.40 Vitamin B Complex tabs 1.41 Multivitamin tablets 1.42 Multivitamin capsules 1.43 Vitamin C tablets 1.44 Cod Liver Oil Capsules 1.45 Compound Ferrous Sulfate Tabs 1.46 Sulfacelamide eye drops 1.47 Tetracycline eye ointment 1.48 Nitrofurazone ear drops 1.49 Ephedrine nasal drops 1.50 Mandl's Paint 1.51 Sulphur ointment 1.52 Salicylic acid & sulphur 1.53 Salicylic acid & sulphur 1.54 Analgesic balm 1.55 Compound Methyl Salicylate Liniment 1.56 Methyl Salicylate Ointment 1.57 Coal Tar Ointment 1.58 Whitfield Ointment 1.59 Calamine Lotion 1.60 Scabicide Emulsion 1.61 Burns and scalds Mixture 1.62 Thimerosal Tincture 1.63 Iodine Tincture 1.64 Thimersal Solution 1.65 Merbromin Solution 1.66 Gentian Violet Solution 1.67 Acriflavine Solution 1.68 Tooth-ache drops 2. Drugs announced by the Ministry of Public Health 2.1 Chlorpheniramine 2.2 Baralgin 2.3 Di-iodoquinoline group 2.4 Ethyl alcohol 2.5 Ma-kleao and ma-had 2.6 O.R. S. Groups of drugs which can be used by VHV: Gr. 1 Antibiotic Gr. 2 Analgesic Gr. 3 Antacid Gr. 4 Antitussis Gr. 5 Antihistamine Gr. 6 Antispasmodic Gr. 7 Antidiarrhoea Gr. 8 Antirheumatic Gr. 9 Vitamin Gr. 10 Anthelminthian Gr. 11 Miscellaneous - First Aid - ENT - Skin	Sulpha ORS Aspirin MV & FS capsules Tetracycline eye ointment Chloroquine Penicillin V tabs Diperazine tab Tetracycline (Caps symp)