Paradox and Policy:
Some Lessons from CHW Projects

Francie Lund

People argue for the merits of community health workers (CHWs) on different grounds. Some would say that the most important reasons for their work are cost and appropriateness. The majority of health problems in rural areas are either readily preventable, or can be dealt with by people with far less costly training than doctors or nurses.

There is a different way in which the term 'appropriateness' is used. Some argue that CHWs, coming from the community, understanding local health practices and causes of ill-health, and 'speaking the language' (in more than just a literal sense), are best placed to understand the barriers between the people and the formal health system, and to do health education.

Then there are those who see the organisation of CHWs as a platform for working towards other, non-health related goals. They see community health as an entry point for integrated rural development, and especially for the organisation of women.

In 1982, I undertook a comparative study of three projects using community health workers. I became familiar with the work of a number of others as well. They were carefully chosen to reflect different ways of working. No matter where they were located geographically (KwaZulu, Transkei, Gazankulu), or where they placed themselves in terms of the health system (inside or outside), or whether the CHWs were paid or not, or did curative or preventive care, all the projects faced important paradoxes. These were of prevention, of professionalisation, and of participation - which hindered their ability to do what they set out to do.

Community health care was a popular idea in South Africa for a brief time in the 1930s and 1940s. When I started the study, the CHW concept was being revisisted, following the Alma Ata Conference. People in the projects were therefore trying out 'new' ideas in hostile surroundings. These were exceptional people, who were learning how to go about the business of introducing more democratic, more participatory, less authoritarian forms of health care delivery. There was very little funding available for rural health. They were struggling with very few resources.

Health and development: who elects, who teaches, and how?
Photo: unkown

Much has been learned, since then, about the implementation of primary health care programmes. Some of the lessons have been learned from these particular schemes. Now, ten years later, when there is an attempt to look at how to integrate community health workers into a national policy for primary health care, it may be useful to look again at some of the chief lessons learned from the schemes. I would argue that the three paradoxes remain. They have not been resolved, because the context of unequal development still exists. We still do not have democratic structures at local government level. And now a fourth paradox has been added - the paradox of policy.

How the three paradoxes operate

The paradox of prevention: When the idea of CHWs is being introduced to other professional health personnel, the rationale is often given that the CHWs will be able to assist the nursing sister, and lighten her load. But CHWs are introduced into a context of scarce health resources and a poor health system. To

the extent that the CHWs does her work well, she creates more work for the health personnel. Her efforts at early detection of health problems means that she brings more patients to the clinic for the nursing sister to deal with.

The paradox of professionalisation: It is a popular idea that the CHWs are ideal as they are from the community, accountable to the community, and therefore they can get people to take more responsibility for their own health. In the very act of choosing some people to go for training as health workers, however, the CHWs are professionalised in the eyes of local people - who therefore are likely to say that health care is something that other people - CHWs - do. In this way a broad band of local people may become less likely to participate in health education, or health campaigns.

The paradox of participation: Another popular idea is that 'the community' should participate in the election of the CHWs, as they themselves know who the most appropriate people would be for the task. However, in a society such as ours, with little tradition of democracy, local elections get rigged and controlled by those in positions of power, and there is little real participation in a free and fair way.

How are the trainers trained?

The three projects were all trying to implement a model of experience-based, participatory learning. In this process, people are encouraged to be responsible for their own learning - to become active learners rather than passive recipients of information, building on what they already know.

All project staff acknowledged how far they were from reaching the ideal. A problem shared by directors and trainers was that they had had to learn about the experience-based approach as they went along. As health professionals, they had gone through a training that was hierarchical and authoritarian. They spoke frankly of how they had not been equipped to deal with, let alone teach others, the process of becoming an active learner, learning how to guide rather than instruct, to nurture group discussion rather than lecture, and to handle the sense of loss of control that comes when the conventional one way teaching method is overturned.

So in all projects, the trainers were learning while they were training other health workers, who were in turn being trained to educate others. If the trainers are themselves inappropriate role models, this gets transferred to the health workers. In one project, a staff member said that most CHWs considered themselves 'instructors' or 'teachers'. They felt that the early training might have contributed to this:

How are health professionals, trained in hierarchical, urban-based curative care to train others in a totally different context? *Photo: Laura Santamaria*

"I think they were trained very much in the way that health people were trained, which is a way of telling people what to do. You have the advice, and people must take your advice, rather than getting involved with people, and getting people to work together."

An important lesson for two of the projects was that, if they were to start a project again, they would introduce a more systematic and thorough course for trainers before recruiting grassroots health workers. However, given the scale on which people are being trained and will need to be trained, we should perhaps consider a far greater contribution from people with the skills and approach of adult education, lodged inside formal training institutions and in projects themselves.

An important question is thus: is it perhaps easier for well-trained adult educators to learn health content, than it is for health professionals to learn progressive educational process?

Professional attitudes towards chws: 'pathological professionalism' in progressive phc?

> "...there are some nurses who are aware of the dignity of their profession to a pathological degree."

> "Many of the sisters don't support the health workers at all. On the contrary, they think it is an intrusion into the realm of their closed profession of sisters."

The project staff who were trying to get other health professionals to accept the new role of CHW had a difficult job to do. They found themselves isolated from other health professionals in their environments.

In rural hospitals, which typically have a shortage of medical staff, the project doctors found the slow business of training and organising health workers was in direct competition with the urgency of their curative role in the hospital or at clinics. Where doctors and nurses were employed full-time on the projects, and did not have to do the 'normal' clinical work, they often faced hostility: the hospital-based staff believed that all this community work was a waste of time, a soft job, compared to their own 'real' work in the wards and theatres.

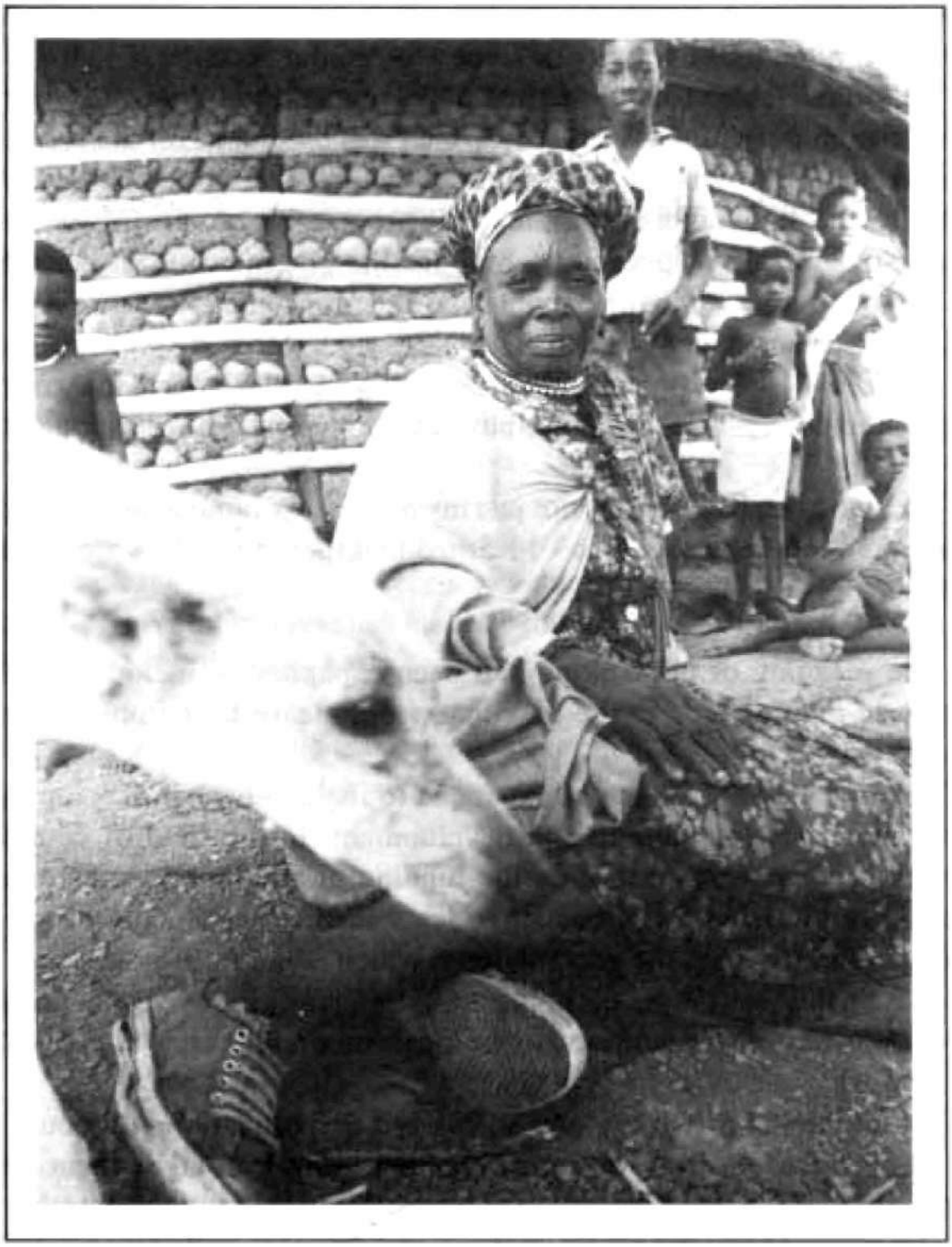
The CHWs themselves expressed a great deal of anger at the attitudes of professionals towards them - not their own project staff, but others in their environment. They singled this out - along with obstructive tribal authorities and alcoholism in the community - as one of the most serious problems in their work.

A typical story from one CHW told how, in line with her duties, she took a person to a clinic with a letter of referral. The clinic sister, overworked, isolated, and with few resources, had run out of the medication required, and took her frustration out on the CHW in full view of everyone else in the clinic. This is abusive and undermining, rather than empowering.

In this sort of situation, it was perhaps not surprising to observe a clinic sister scolding the health workers for not taking notes fast enough, expressing irritation with their slowness in understanding a point, and finishing the session with an instruction to the CHWs to go out and work with love. When she had left, a health worker said:

> "She says we must love the community, but she has no love for us in her heart, and we are the community."

Would a different training for health personnel make much of a difference under present circumstances? How effective is it to devote time to planning details of a core curriculum for community health workers independently of radical curriculum changes for the other health personnel as well? And then the material circumstances under which the professionals work in rural areas will have to be improved if the paradox of prevention is to be resolved.



New policies for South Africa are about making things equitable, empowering and democratic. *Photo: Market Theatre Photo Workshop*

Is networking something only professionals do?

Networking is the process in which people working for social change reach out to each other, share ideas, inform each other about problems, available resources, changing trends in the environment, new information about their field. Networking is very important. It is very much in vogue, not least within progressive primary health care in South Africa. However, networking has been, and still largely is, limited to the activity of some few 'senior' people.

Important lessons were learned about networking from this study, in particular from the national workshop which was organised for the community health workers. A number of key factors guided the workshop design and process: the health workers determined the programme; no professionals were allowed (save for two who acted as group facilitators, and were chosen for their skills in listening and drawing people out); and proceedings were held in Zulu, Xhosa and Shangaan, not English.

The CHWs spoke potently about how meeting each other at the workshop, with they themselves in control, was strengthening. In the words of one person:

"I came to realise that it is not just my nurses, my induna, or our husbands who are the problem in my area - I learned that these problems are across the country."

The meaning of networking had been expanded to include the CHWs themselves, giving force to the idea that people learn best from others with similar experiences.

Networking should also be expanded to include further development of existing materials for training and development. In the field of community health, there should be a brake on the funding of any more resource centres (unless in rural areas). The challenge is to share what already exists more broadly, and to translate the good material which is in English only, into more languages. In this way the people doing the training can give over what they know to the people they are training, and to the local communities in which the CHWs live and work.

An additional role for a networking and dissemination unit could be to write the stories of projects, documenting the lessons learned by them. People in the field in rural development are overwhelmed by day-to-day tasks. They know they should be writing their work up, and many know that they never will. They sit on a wealth of experience and knowledge, which is not widely shared. We cannot afford to let the lessons of our recent history slip by.

The fourth paradox: policy

The national initiative to forge a policy surrounding community health workers, in order to ensure that they have a place in the health system of the future, is surely a good thing, and very necessary in order to get the role of CHWs firmly on the agenda. But even though it comes from the progressive health sector, it will turn out to be top-down, disempowering, and regressive unless the paradox of policy is taken into account.

New policies for South Africa are about trying to make things more equitable, empowering, and democratic. But policies can tend to be prescriptive. They can make universal prescriptions - such as all CHWs must be paid, must have accredited training courses, must be chosen by communities. The intention is honourable - to stop CHWs from being exploited, and giving this category of worker a proper place.

However, the need on the ground may be for a recognition of diversity, of different needs, various conditions. And the need may be not for a forced choice - either government provision or provision through non-governmental organisations - but for an informed choice of either or both, depending on what the reality is in a particular area.

The best policies may be those which create the enabling environment within which the best informed choices between alternatives can be made. By and large, CHWs themselves can make an important contribution to defining the choices they would like to have.

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Note: The full report of the study on which this article is based is Lund, F J, *The community based approach to development: a description and analysis of three rural community health projects.* Durban: Centre for Social and Development Studies, University of Natal, 1987.