Health Educators and Community Health Workers

Edited correspondence with:
Irwin Friedman. The SEED Trust, South Africa

Effie Schultz edited December 201

Simon Lewin (Health Systems Trust South Africa) sent me on request a copy of the Cochrane Review on Lay Health Workers which he had co-authored[1]. I replied to him as follows and asked for the contact details of Irwin Friedman.

19 October 2005

Dear Simon,

I read your review with interest. It worried me. I started to comment in detail but stopped because we are talking about different things. I am looking at a new cadre of professionals operating within a new inclusive medical-health intervention paradigm while you reviewed the performance of an ill-defined category of lay heath workers[2] working within the existing health service framework. These were similar to or subsumed within the rubric of community-based service providers as defined in the South African National Primary Health Care Facilities Survey, 2003[3].

I am not comfortable with stand-alone, vertical programmes or cadres, nor with quantitative evaluations - especially in the RCT format - even of narrow specific health systems interventions. There are too many methodological and interpretative problems.

I recommended the establishment of a new cadre of medical-health workers which for want of a better name I called health educators (HEs) because their prime objective would be empowering patients/people with knowledge, skills, methods, competence and self-confidence etc (all the goodies) to be able to promote and protect their own personal and public health, and prevent and manage disease, disability, distress and even death. They do not address disease states as is done by doctors, dentists, nurses, pharmacists and the other such cadres, which I lump together as medical workers. They help, support, complement patients/people and medical workers. They do not substitute medical workers. They do not have to be non-professional or so-called lay. I outlined their scope of practice in an attached file, a later version of which was presented as a poster at a Rural Doctors Association of Southern Africa (RUDASA) conference

A critical element in their training is to develop the ability to interact positively with people, communicate empathetically and provide correct information. I believe that their curriculum/s must be formalised and regulated, that they must be registered with a professional body and that their status must be accredited.

Now then, if some of the HEs are to be used to motivate breast cancer screening, or immunisation or breast-feeding (as discussed in the review) or whatever, training modules in these programmes could be introduced as supplementary to their basic training as and when needed. The HEs would still be able to discuss authoritatively for example the role of nutrition in breast cancer prevention and weaning foods and their timing, as the case may be. The HEs could also if they prefer leave this specific field of work and pursue another interest in health education (HE) or study further etc as outlined in the presentation with credit for past experience and training in HE.

The training and intervention modules should be evidence-based. If sufficient published material is not available on which to base a module, non-published or amnestied (as the Cochrane Collaboration did some years back) material could be reviewed or existing programmes could be evaluated - even informally.

PS I attached a file in which I addressed primarily the training of doctors and also commented on a new paradigm in which doctors and other clinicians would work together with HEs. The poaching of “developing world” doctors by the “developed world” could be partially undermined by my recommendations. Later versions were presented at a Wits Community Health Department seminar and at a RUDASA conference.

The rest of the letters were addressed to Irwin Friedman

---

20 October 2005.

I have just read your chapter on Community Health Workers (CHWs) in the 2005 South African Health Review (SAHR)[4].

I agree with you on the need to rationalise this very important sector and especially the need for SAQA (Standards and Quality Assurance) recognised standard basic training, and accreditation. I am pleased to hear that the Department of Health is now more sympathetic to the role of CHWs but it is worrying that they still do not want to accord them a formal paid role in the provision of medical services and in health programme participation.

I belong to a very old school - somewhat to the left of the Kalks' Community Oriented Primary Care model (COPC)[5] - and have worked very successfully with all sorts of non-medical personnel in primary care and especially in chronic disease care. I found them indispensable to effective service. I conducted no random controlled trials and the reports that I wrote have not been published in peer-reviewed journals. Like you (as you stated in your SAHR chapter) I base much of my enthusiasm and ideas on personal experience and on journal readings.

I have a problem with your recommendations on the deployment and accountability of CHWs. I think they should be accountable to the public that they serve via their employers and a professional ethics body like the Health Professionals Council of South Africa. Rather than commenting more I am sending you two files prepared several years ago (later versions were presented at a RUDASA conference and at seminars in the department of Community Health at Wits). In earlier versions they were extensively peddled and presented to senior functionaries at the Department of National Health (DNH) and other regulatory bodies and to academics - without much feed-back and no uptake. I called what you call CHWs, health educators (HEs). The file on medical care providers is included because it outlines a different service paradigm, one in which HEs would play an important role.

I heard from Simon Lewin that you are advising the DNH on policy in this area. Good Luck. I am interested and willing to be involved in any groundwork and investigations leading to policy formulation and curriculum development especially in adult nutrition, medical informatics, and chronic non-communicable disease care.

23 October 2005.

I am ad libbing in response to some of the issues you raised in your letter dated 20 October. After this I outline briefly what happened at the different chronic disease care clinics that I set up and ran. My experience in health education (HE) in the community was in a sense indirect. Patients and nurses developed their own programmes in their communities. They told me about this and I occasionally met with their groups.

Yes, we threw out the baby with the bath water in respect of health educators. I had the privilege of working at Entokosweni Centre in Alex (Alexandra township in Johannesburg) with one of the people who had trained at Polela with the Karks. She had also worked with Helen Navid at the centre before Helen had to flee the country.

The concept of health education should not have been condemned because the message was wrong (eg feed infants vegetables as their main food) as it often was. Because the health educators were talking rubbish, they lost the confidence and trust of the community/people and their own self-respect forcing them in a sense to become authoritarian and insensitive. Describing their behaviour as based on the medical model is also partially correct but this implies a bad medical model with doctors and their acolytes playing god. Often again the message was wrong. We (doctors) have hopefully at least in precept moved towards a more participatory approach. The process of educating people should never be only didactic and seldom top-down. It should be a shared experience.

It is unrealistic to expect knowledge per se to change behaviour, even if the knowledge is accurate and accords with people's customs, traditions and current reality, etc. particularly as subverted by adverts, consumerism, biased, bought media, ... Knowledge should empower people to question and think, and then to act with insight and in personal and local contexts.

All the goodies that some people now ascribe to health promotion (HP) apply to what I call health education, with health promotion only one aspect of HE (not a perfect word but more inclusive than others). Besides HP as promoted by Susan Goldstein et al in their book is much like the old moral rearmament movement[6]. HPs or HEs or lay health workers, or CHWs or … operate in a socio-economic and political context which they must understand. They should not have as their brief the need to compromise with the local set-up nor to teach, advocate, encourage accommodation with it, nor as you put it should they focus “on advocacy for policy and social infrastructure transformation”. Strong skills in mediation and facilitation are therefore not needed except possibly in helping patients to resolve inter-personal conflicts.

I do not think that it is our role as professionals to guide and assist any community, but we should share our expertise and work with the community as private individuals in a political capacity if we so desire. As “health workers” our political and revolutionary, transformational role is to empower people with an understanding of the political, economic and social determinants of health and disease, not to ameliorate conditions to make life bearable.

What Erika Sutter and her health care team did in Elim in respect of trachoma (face clothes, chloromycetin eye ointment, toilets, vegetable gardens) was very successful but unrelated job creation which they also tried (making bricks, candles) had little impact on health. Cooperation with Operation Hunger was more meaningful in this regard. Of course structural political, economic and social changes would have contributed more to health. David Sanders et al described the environmental constraints well in their recent BMJ article[7]. The Charter for Action on and for Health adopted years ago by London University laid out the same in general terms[1]. I have not read our South African charter yet. I should.

I also did not like the emphasis in the health promotion book placed on bio-statistics and epidemiological methodology. Again I preferred Erika Sutter’s approach as in her excellent little book, Hanyane – A village struggles for eye health[8].

Accountability towards a general community is perhaps appropriate in your concept of HEs/CHWs but not in mine. HEs must be accountable to their employer and the specific community they serve. The employer and the community can be patients in a specific ward or OPD (out-patient department) or clinic or NGO, or a commercial or industrial enterprise, a street, village, suburb, local authority, … and what you call the community.

Sure, it is preferable that CHWs come from the community among whom they work. This applies to all health workers including doctors, as encouraged and/or practiced in Cuba. But it is not essential. If strictly applied this could restrict the scope of practice of this cadre of workers as well as narrow their options for advancement.

In my thinking HEs should work not only in poor communities and in isolation from doctors and other medical personnel. They should work everywhere, preferably as members of teams - not necessarily medical - and also independently. It is of interest to read about the new roles given to nurses in the UK, roles that could be more appropriately filled by HEs (my definition) while not depleting the nursing cadre.

---

1 My adaptation of the charter is printed at end of the document

A note on (so-called) lifestyle.

I am pleased you did not write about “lifestyle modification”. This I think equates to victim-bashing. People should not be encouraged or educated to change their habits and diets. They should be helped to understand the role of market forces in determining what they eat, smoke, drink and do, and they should be able to choose a healthy way of living because they know, because they have financial, physical and intellectual access to appropriate choices and because society does not inhibit good healthy choices.

My experience:

HTDMC (Hypertension and Diabetic clinic) at
NEH (Johannesburg Non-European Hospital) and Hillbrow Hospital
Nongoma Hospital CDC (Chronic Disease Care) clinic

At the HTDMC clinic I recruited (as volunteer lay health workers) - some deliberately and others fortuitously - members of Grow, Black Sash, TM and Yoga groups, World Vision, women’s organisations, activist NGOs, hospital physiotherapists and members of the hospital podiatry department, social workers, typists, administrative clerks, a lay dietician, pharmacists, pharmaceutical representatives, friends and relations, and others to join the clinic to share with the patients and the staff their specialised knowledge and to provide a service. Several of them worked as clinical clerks entering detailed histories onto structured questionnaires, monitoring patients and advising on compliance, diet, exercise, tobacco use and alcohol abuse as well as on the management of common acute ailments.

I employed an in-service trained informatics clerk and research assistant. This IT clerk doubled-up as a very good HE and clinical clerk. The clinic was linked via a crude modem with the main-frame at the computer centre at Wits (University of the Wiwatersrand, Johannesburg). Clinic data were daily entered into a functioning data base which was used to schedule appointments, trace and recall defaulters, monitor encounters, evaluate clinic process and outcome, and used for reports and papers.

The matrons at the hospital were very supportive of the clinic and seconded nurses, assistant nurses and ward helpers with good communication and social skills – one of whom acted only as a HE – to the clinic. The clinic received research funding from the Wits Foundation and some funds from the SAn Diabetic Association.

All volunteer and employed staff except the doctors were initially and later continuously in-service trained by myself in hypertension and diabetes and in the prevention and non-drug management of common conditions (GBP/OA, URTI, UTI). They received no training in advocacy, communication, community development, or mediation, etc skills. Most of us were politically aware and within prudent limits

during the apartheid years conveyed our commitment to the patients. We constituted a team but I was in charge (first among equals!).

I am attaching two articles I wrote about the clinic. You might get an impression of the work we did from them. The article on non-drug treatment was published in a non-peer reviewed magazine and the other was rejected by the SAMJ, the WHO Bulletin and the BMJ (and then shelved).

At Nongoma in KZN an assistant nurse and a matron worked as HEs in the hospital-based chronic disease care clinic (HT, DM, asthma, epilepsy and CCF) that I ran.

---

10 November 2005

I used your draft article on the utilisation and effectiveness of community-based health workers in Africa[9] to review my ideas on CHWs and what I called health educators. I wrote my thoughts out as comments which I attach.

I am reminded that I had prepared and presented a series of lectures for Huib Cornielje at the Institute of Urban Primary Health Care at AHCUC (Alexandra Health Centre and University Clinic) for students in community-based rehabilitation and geriatric care. I think he collated the course material in a booklet for the students. The students responded very positively to the course and when I met some of them several years later in Alex, they were still enthusiastically following what they had learned. I was associated with only 1 course. Huib left and Drs Paulo Ferrinho and Tim Wilson who were powerful operators at Alex were no fans of mine. I was not even allowed to participate in a post-mortem of the course.

Several years earlier on a brief from the Witwatersrand Hypertension Group, Felicity Gerber of the Heart Foundation and I organised and ran a work-shop for lay people in an attempt to decentralise hypertension care into the community – or at least that was our aim. It very early on petered out.

Thanks for the opportunity to think and to look again at the material to which I refer.

---

12 November 2005.

Some comments on your letter. What you wrote is in italics

On the whole my view would be that we should not polarise the debate to infer that in encouraging support for CHWs one is against Health Educators.

It will be unfortunate if any debate is hamstrung by problems with definitions or designations. We see this in the use of words and phrases like health care, PHC, CHW, health education/educators and health promotion. At one stage in the drafting of my comments I called HEs WYCTs (whatever you call them) in an attempt to avoid a semantic hang-up. There is a need to concentrate on the role and scope of practice of a category of workers and to define these unambiguously.

[H]ealth education should be a skill in which all health professionals should be fully competent.

You obviously expect them to use this skill in routine patient care. This is not possible. Even in a less demanding clinical practice environment than usually encountered in under-served areas, there is no time for individual personal health education, never mind interactive participatory group education – very effective.

[A]dvocacy for PHC does not mean that one is opposed to good quality primary medical care.

I do not see CHW and HE nor PHC and primary medical care (PMC) as dichotomised, separate concepts. CHW and HE are not opposed to each other, but rather subsumed within each other. PHC if it can be practiced would include PMC, CHW/HE, health promotion, and much more besides and equates to Victor Sidel's social medicine. I prefer to use the latter term as it is clear and unambiguous.

The work of Sydney and Emily Kark and others around COPC … is … seen as a pre-cursor to much of the work that is currently being proposed on district health systems development.

I do not understand this. Perhaps it is because I do not understand what is meant by district health systems. Even in the draft national health bill – I do not know how it is handled in the subsequent act – it was a vague concept. It seemed to refer to an unnecessary administrative level intermediary between a local authority and a province. I have the same problem with the role of the district itself. To me a district is just a bureaucratic obstruction with jobs and status for old comrades, friends and relations. Is a district health system not the same?

[Erica Sutter's] experience at Elim is one of the best examples of how valuable community health workers … can be in transforming community health.

The Elim Care Group Members (as these CHWs were known) did not transform community health. They were effective in eradicating trachoma and controlling diarrhoeal disease when they operated as HE/WYCTs. They worked with the people and with others to build latrines as part of the intervention but their brick-making and other job-creating projects, which I as a medical practitioner would have had to supervise if I got Erica's job after she left and for which I almost applied, should not have been included in their remit.

On the issue of the importance of democracy and group participation in health, I would, however, disagree strongly with you. Any good health educator would have to work both with groups as well as individuals, …

Yes, HEs have to work with groups as well as individuals. But this has nothing to do with democracy. Hitler and Goebbels worked most effectively with groups. We could learn from their technique.

Medical service providers including HE/WYCTs should work with teachers, PTAs, social workers, the police, and other stake-holders in dealing with problems. They should also bring problems to the notice of the public and its organisations. One of the effects of an effective medical team and specifically of its individual members is the credibility it/they have among the public and in communities and the contacts it/they can establish. HE/WYCTs must not dissipate their efforts on "lateral" projects but must concentrate on their core competencies.

Similarly "*advocacy and structured democratic community involvement, intersectoral collaboration, appropriate technology and improved access"* while of critical importance to a functioning society and to health, have nothing directly to do with "*working with lay workers or with the PHC approach"* nor with democracy.

You should have a look at the Health Cities and Villages initiative. I prefer to call it the Healthy Cities, Villages and Neighbourhoods (HCVN) initiative. It provides an inclusive, established and successfully implemented framework for lay action on health. And it does not apply only to rural deprived areas. In 1990 I looked at how the HCVN initiative could be implemented in Sandton. My concept differed from that of a group under William Pick when he was Professor of Community Health at Wits but resembled what was studied in a work-shop organised I think by the Wits Centre for Policy Studies at the Spier farm, and implemented in Liverpool and Toronto inter alia.

[T]he democratic change of 1994 was a more important step in improving the overall health of the population than all the medical interventions … [in] the past century

I fully support your hope that the new dispensation in SA will result in improved health status by its effect on the social, political and economic environment implicit in the statement. McKeown's opinion on the determinants of health which I often like to quote reinforces this hope:

> "Past improvement [in health] has been due mainly to modification of behaviour and changes in environment and it is to these same influences that we must look particularly for further advance.[10]"

The editorial in the BMJ[11] that I sent you also applies. But we live in a globalised world with the IMF, WTO, SAPs, TNCs, … all very powerful destructive forces. Hopes are often dashed.

It is also questionable if the changes brought about by our new democratically elected government will have a positive impact on medical services. It is sobering to reflect that Rene Venter, Minister of Health in the last apartheid government, was probably a better minister of health than either of the recent ANC incumbents. Perhaps this was because she was a professor of sociology and not a medical doctor.

CHARTER FOR ACTION ON AND FOR HEALTH

The requirements for HEALTH FOR ALL are:

* PEACE -

  not simply the absence of war or social unrest,
  but a climate of stability.

* SOCIAL JUSTICE -

  the right to the protection of the law and to
  equality of access to the necessities of life.

* DECENT HOUSING and SANITATION

* EDUCATION

* SECURE EMPLOYMENT -

  so that everyone has a valued and
  rewarding role in society.

* EQUITY IN HEALTH -

  so that all have the best possible opportunity
  to develop healthily and to obtain required care.

* PUBLIC LIFE POLICIES that make it easier to:

  adopt healthy life-styles,
  participate in health policy-making,
  enhance the role of the family and
  other social groupings.

* MEDICAL CARE AND PREVENTIVE MEDICINE SERVICES

  which are appropriate to people's needs and wishes.

* ACCEPTANCE OF THESE GOALS by the health professions.

The special responsibility of health workers:

All health workers including:

> doctors, nurses, pharmacists, physiotherapists, occupational therapists, speech therapists, community health workers, service managers, clerks and cleaners etc as well as teachers, trainers and scientists in health-related disciplines,

should work together to provide:

* responsible leadership in health matters;
* information on available health services.

They should:

* set an example in healthy living;
* work with other organisations and members of the community to plan ways for people to be healthy.

They should ensure that people:

* know what determines health;
* are able to participate in taking decisions that affect their health;
* have sufficient knowledge, freedom and personal resources to choose a healthy lifestyle.

They should:

* use their knowledge and skills to promote and protect health, and prevent and manage disease;
* not discriminate on the basis of race, gender, creed, social standing, political allegiance and nature of disease;
* foster a good relationship with others based on mutual respect, communication and trust;
* respect the rights of others, including the right to informed consent; respect the confidentiality of information given to them;
* recognise their limitations and consult with, or refer to their colleagues and others when necessary;
* maintain and improve their skills.

This charter has been adapted from a document published by the Faculty of Community Medicine at London University in 1990 and from the Credo of the Medical Association of South Africa published in 1993.

References

[1] Lewin SA, Dick J, Pond P, Zwarenstein M, Aja G, van Wyk B, et al. Lay health workers in primary and community health care. *Cochrane Database of Systematic Reviews.* 2005, Issue 1. Art No: CD004015. DOI:

[2] Lay Health workers were defined as any person carrying out functions related to health care delivery; trained in some way in the context of the intervention; and having no formal professional certificated or degreed tertiary education. Their scope of practice was broad including all aspects of personal care delivery (health promotion and protection, disease prevention, diagnosis and treatment, rehabilitation and patient support).

[3] Community-based service providers were defined as paid or unpaid personnel working in or from the facilities to provide services in communities. These comprise Community Health Workers health promoters, DOTS supporters, HIV/AIDS home-based care providers, lay counsellors, and supporters of people on HIV treatment, peer educators, …

[4] Irwin Friedman**.** CHWs and Community Caregivers: towards a unified model of practise South African Health Review. 2005, Chapter 13.

[5] Sidney and Emily Kark. Promoting Community Health. From Pholela to Jerusalem. Wiwatersrand University Press. 1999. page xiii.

[6] In 2001 the MRA (Moral Rearmament Army) movement changed its name to Iniaitives of Change

[7] D M Sanders, C Todd, M Chopra. Confronting Africa's health crisis: more of the same will not be enough. BMJ 2005;331:755–8

[8] Hanyane – A Village Struggles for Eye Health. Erika Sutter, Allen Foster and Victoria Francis. Macmillan Publishers. 1989

[9] Irwin Friedman, Uta Lehman, David Sanders. Review of the Utilisation and Efectiveness of Community-Based Health Workers in Africa. Draft version - personal communication.

[10] Thomas McKeown. The Role of Medicine (1979) or Introduction to Social Medicine (1977)

[11] D M Sanders, C Todd, M Chopra. Confronting Africa's health crisis: more of the same will not be enough. BMJ 2005;331:755–8