Community-Based Health Workers

On reading a draft of an article on the utilisation and effectiveness of community-based health workers in Africa[1].

Effie Schultz November 2005, edited December 2010

The community-based health worker (CHW) concept is situated within Primary Health Care (PHC) as defined by the WHO in the Alma Ata Declaration. PHC is predicated on a reformist ethos. It developed as an alternative to conventional medical practice in an attempt to avert and then to contain what was considered to be a crisis in medical care provision. Concern about the escalating costs of the current system and its failure to meet the needs of developing countries spear-headed the development of the PHC concept. The CHW concept and PHC are both focussed on medically underserved and socio-economically deprived areas.

While PHC has not really worked, there have been some successful CHW projects. Times have however changed. More of the same or similar will not do. A new paradigm of intervention in health and disease … directed at all sections of society is needed. These comments are premised on replacing the CHW with a new cadre of personal medical service provider within the new medical service framework. Such a cadre will be a registered and remunerated member of a medical team and will function as a patient educator, interpreter, motivator, facilitator, and ombudsman, provisionally called a health educator

DEFINITIONS AND INTERPRETATIONS

1 Primary Health Care

Article VI of the Alma-Ata Declaration reads:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

> It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.
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> It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The concept of primary health care was expanded to include action on food, water and sanitation if strictly interpreted and action on all determinants of health and disease if freely interpreted, according to Article VII (3) of the declaration which lists:

- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health, including family planning;
- immunisation against the major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential drugs.

The interaction between health and economics was explicitly recorded. Article III of the declaration states that:

> Economic and social development ... is of basic importance to the fullest attainment of health for all and for the reduction of the gap between the health status of the developed and developing countries. The promotion and protection of the health … is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

This awareness could not be translated into practice in industrialised countries. Reasons for this are noted in a report by the World Health Organisation on a symposium on primary health care in industrialised countries in 1982[2] as:

> (T)he implementation of the Alma Ata recommendation(s) has been a slow process in industrialised countries. One of the main reasons is the concept of primary health care itself, its poor definition and a lack of analysis of its implications for industrialised countries. More often than not the concept is understood too narrowly. It is either considered to be relevant for developing countries only or it is identified with the primary medical services (eg general practice) of the industrialised countries.

> Rigid attitudes based on self-interest were ... the most frequent quoted obstacle to PHC. In some cases financial interest (eg in fee-paying systems) has been to blame, in others the cause is related to the dominance in health care and medical education of the purely medical approach.
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> (T)he diversity of opinion arose in part from the vague ways primary health care is defined: in terms of a philosophy; a strategy; a level of health care; and for a set of activities.

The difficulties in implementing PHC are not confined to industrialised countries because they are structural in nature. The determinants of health and disease are inherent in the organisation of society and cannot be meaningfully changed by attitudes and action within a single sector, whether health-related or other. Tinkering with these issues as promoted by PHC supporters is ineffectual and results in frustration before reversion to a straightforward minimalist medical practice model.

PHC can be interpreted as an attempt to ameliorate social and economic deprivation and as a strategy for preventing social and economic change, as Breil[3] wrote:

> Community medicine (or PHC) is one of the few solutions that capitalism can propose for the problems of public health. It provides a means to attend to minimum levels of social demand as well as basic conditions for the protection of previously neglected populations without changing the social relations or significantly diminishing productive investments. On the contrary, it seems that primary care coverage extension projects are efficiently interwoven with other forms of consumer market expansion.

Community health workers are subject to the same critique.

2 Community

In discussions on CHW community is seldom defined. The implication seems to be that a community is a grouping of poor, socially and economically deprived, un- or under-employed and often illiterate people who are or were marginalised, excluded or vulnerable with little if any income, minimal if any food security, inadequate sanitation and water access, living in a predominantly rural area in a developing country or a part there-of. It resembles the community as envisaged in the concept of PHC as defined by the WHO.

Such an understanding of community restricts the scope of practice of CHWs.

The Concise Oxford Dictionary 1982 7th ed. defines community, inter alia as an "organized political, municipal or social body; (a) body of people living in (the) same locality; (a) body of people having religion, profession etc in common; …" My definition of a community for the purposes of providing a framework within which a CHW could function is people who stay in a defined geographic area and who share broadly similar socio-economic and cultural attributes such as a small village, town, or urban suburb, a religious or ethnic group staying near each other excluding others not of the same religion or group, or possibly also workers in a factory or housed in employer hostels as a group defined by the social networks that constitute it[4]. Therefore for example in any up-market suburb in South Africa there could possibly be at least 2 communities: those staying in the main house or apartment and those who stay in back-yard or roof-top rooms.

3 Health, social medicine, medical service, and health care

Conceptual and practical problems are also encountered with the use of the words, health and health care. The World Health Organisation in 1948 defined health as a state of complete physical, mental and social well-being. It cannot therefore logically be coupled with care. The term, health care, is not only illogical but also misleading referring usually to the care of sick people (medical care), but it may also include aspects of disease prevention and health promotion. When health care is equated with medical care the medical paradigm is reinforced and the role of ordinary people is diminished. The misuse of the word, health, may also contribute to the social, economic and political factors affecting health and disease not being fully recognised and intervention from non-medical sectors being neglected.

The term, health care, should be replaced by the terms recommended by Victor Sidel.[5] According to him social medicine, an umbrella term, encompasses:

1 social well-being

the attainment and maintenance of the socio-economic and political conditions necessary for health and social well-being;

2 public health

the advocacy and implementation of appropriate public health measures to protect and promote health, and to prevent disease in communities and in the nation as a whole;

3 personal preventive medicine

the protection and promotion of health, and the prevention of disease in individuals and families/households;

4 personal medical care

> the provision of (efficient, effective, safe, affordable, and accessible) services to all in need for the diagnosis and treatment of individuals and families/households so as to cure and/or control disease, for assistance in rehabilitation after illness or injury and for care and comfort.

I will use the above terms as well as the term, personal medical service, to refer to preventive medicine and medical care jointly. These terms would more effectively and less ambiguously reflect the many distinct but inter-related interventions in health and disease. As Morris Schaefer[6] wrote:

> [Opinions that] limit the playing field to what the health sector ... might be able to do, ... [lead] to a concentration on disease control and the preventive and curative medical means to accomplish this. [The conceptual framework of social medicine] comes closest to breaching this boundary by giving a place ... to the amelioration of poverty and its sequelae.

4 Community Health Workers

A CHW is usually defined as:

- a person who lives among the people among whom s/he works
- selected by the people among whom s/he lives
- answerable to the people among whom s/ he lives
- supported by the health system but not necessarily a part of its organization
- shorter training than a professional worker
- generalist or specialist
- carry out one or more functions related to health care delivery
- trained in the context of the intervention
- usually no formal professional or paraprofessional certificated qualification
- advocate for (the people among whom she lives)
- agent of social change

If “community” is interpreted as a body of people living in the same locality as it should be, it strengthens my argument that CHWs have very limited career options with high attrition rates. Their work could/would be constrained and restricted by the perceived needs of this body of people with its politics and bureaucracy, etc.

Irrespective of the constraints implicit in the definition of community the above characterisation of a CHW is perversely vaguely inclusive, extending from personal medical service to so-called community development and social activism.

There is however no discussion of the now widely recognised need for education and support personnel in the management of chronic non-communicable diseases (NCDs), or adult nutrition although there is specific reference to such interventions for people living with AIDS and those suffering from TB. NCDs like coronary heart disease, hypertension, diabetes, and asthma are no longer the preserve of highly industrialised societies and urgent attention in all societies to this gap in service provision is needed.

SELECTION OF ARTICLES FOR REVIEW

There is a wealth of experience that has not been reported in accredited medical journals and much that has probably been written up but not published. Some have been reported in magazines, books, radio and TV programmes as well as at conferences and workshops. Do these constitute "grey literature" and have they all as such been excluded from so-called evidence-based review together with material on traditional, faith and complementary healers?

Few people working as and with CHWs (however defined) have the time, the capacity or the money to perform formal controlled studies, and to prepare the findings for publication in peer-reviewed journals. Most CHW or similar programmes probably just become part of lived experience or history – remembered or forgotten by individuals or organisations.

Confining a review to published reports limits its usefulness. There is a real danger that the limitation imposed by such a remit could be ignored and the findings considered comprehensive and definitive.

COMMENTS

role and scope of practice of CHWs

- CHWs should not function as mini-doctors, as nurses or as any other medical service provider but should complement them. They should all work together as members of a team performing functions appropriate to their competencies
- CHWs are not a cheap alternative form of primary medical care providers
- diagnostic and disease management skills enhance CHWs' credibility.

specialist CHWs

Generalist CHW tend to address a range of environmental, developmental and medical conditions. Specialists on the other hand are involved in a single issue or in a few specific issues. They do not have a general training, and their training is usually exclusive and limited. This approach is in contrast to what applies in other disciplines where specialist training expands basic general competencies into usually a single speciality as in medicine or into several specialities as in nursing.

I prefer the latter system. It increases the scope of practice of service providers, and as a consequence their usefulness and credibility. The associated opportunities for occupational mobility and career advancement are important for personal worker satisfaction as well as the sustainability of the discipline.

community health committees

There is no need for community health committees. There are enough committees and boards of residents or rate-payers, wards or other civic institutions, or of public and private bodies such as schools, hospitals, churches, charitable, financial, industrial and commercial organisations, etc that have an interest in health and medical services and that if they do not employ or contract their own medical teams, often advise, subsidise, fund, or support such services.

supervision

Supervision smacks too much of inspection and control. Monitoring and evaluation based on good records in a team setting and as part of an integrated programme coupled with continuing in-service and other training within a framework of a professional body such as the Health Professions Council of South Africa (HPCSA) is less intrusive and top-down and facilitates responsive and responsible functioning.

selection of trainees

A “body of people”[7] can only undertake a formal activity such as selecting trainees to be funded if it is authorised to do so and can impose whatever conditions it deems appropriate on the person so selected when the person is admitted for training. The same applies to existing “organised political, municipal or social bodies” and to private groups and individuals. These bodies cannot however select a candidate for training. The training institution alone exercises this prerogative.

payment of CHWs

Employers and other organisations including “bodies of people” acting as employers should financially remunerate their CHW employees unless payment in kind or volunteer work is mutually preferred.

accountability

CHWs should be accountable to their employers, patients, a professional body and, as members of society to society. There need be no specific exclusive accountability to the “body of people” that selected them or to funders who are not employers.

attitudinal change, democracy and a paradigm shift

Problems with implementing PHC are inherent in the concept. Any resistance to it is legitimate and understandable. There is however no entrenched attitudinal resistance by medical service personnel to primary medical care, defined as first contact care by a medical service provider to a patient. Delegating tasks by doctors, nurses and other so-called “health professionals” to CHWs is not painful if they work as a team and their roles are defined and mutually respected. Hierarchies are not determined by length of training but by qualifications and competencies.

There is no role for democracy, whatever this means in an occupational setting, nor can any “democratic approach to health care”, whatever its meaning, improve health status. A paradigm shift, however, in the training of medical personnel, service structure and care delivery towards a needs-based integrated team approach would promote the smooth functioning of comprehensive personal medical service.

local needs and wants

While it is important to know what people want, it is much more important from a health perspective to know what people need. It is not necessary however to perform expensive, time-consuming methodologically precise research-oriented studies. Most communities and medical facilities are usually able to identify their current needs promptly and accurately.

medical service information system

A fairly accurate assessment of specific disease-based needs derives from an analysis of the local pattern of morbidity and mortality. Therefore an effective and functioning information system including standardised formal record keeping is essential. Data on service encounters must be collected, collated, analysed and reported routinely and regularly and supplemented with data and reports from other medical service and public health structures as well as from non-medical sectors.

The collection etc of data on physical and human resources provides a useful management tool. Data not indicators should be used for routine audit, monitoring and evaluation. Indicators are a luxury and add little operationally.

community health programmes

Community health programmes are not dependent on CHWs and CHWs are not dependent on community health programmes. I envisage CHWs operating in many different places, situations, establishments, projects and programmes, including hospitals, clinics and other personal medical care facilities. Community health programmes on the other hand belong in Victor Sidel's rubric of social well-being and public health and in the Healthy Cities and Villages vision modified by me to incorporate neighbourhoods.

Locally-based organisations can set-up community health programmes and employ CHWs and/or other persons as deemed necessary. The objectives of the programme and available resources will determine personnel requirements.

The characteristics and supportive structures of community health programmes should be customised locally preferably but not necessarily on a formal basis.

There is no need for an bureaucratic super-structure with its paraphernalia to supervise and support CHWs and community health programmes. Committees, committees, committees, and more committees as well as financial and physical resources such as buildings and computers, are often accompanied with corruption, nepotism, bureaucracy, wastage, delays, and all things bad!

It is useful but not essential to have an adequately functioning state apparatus, a vibrant civic society and a not very greedy private sector - which would subsume all the above - so that not only can community health programmes can be effective but all society can thrive.

References

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5 Victor Seidel. Public Health versus Health Care. The Nation's Health. 1993; 23: 2, 2
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7 The phrase ” body of people” is used instead of “community”