The Forgotten Community Health Workers

Medical doctors, as we recognise today, have not been always the health care providers for most of the people in this world. Health care providers, other than doctors have been instrumental in providing first level of care in the world from time immemorial. Military health services are a good example where ordinary assistants were trained in lifesaving skills to treat wounded soldiers in battles and later in peace time military hospitals. Anaesthesia is a good example. In seventies, when I started as a young doctor, we had a medical assistant anaesthetist who provided excellent general anaesthesia to all patients and functioned well alongside doctor anaesthetists. Bone setters in India provide treatment by setting the fracture and immobilising the affected joints in exactly the same way as trained orthopaedic surgeons do, except that they use different (local) materials than plaster of Paris. Examples of non-doctors performing vasectomies and post-partum tubal ligation (Papua New Guinea, Thailand and Bangladesh) are well documented.

After all what is medical education? One learns to use art of medicine passed on by one's peers, through structured and formalised *apprenticeship,* so called the medical education. This method has developed from ancient times where *guru's* or teachers taught their pupils, generally one to one, with great devotion on both sides.

In rural and remote areas, *where there is no doctor,* someone has to come forward and provide help during illness and other times of health need. David Werner, recognising the need in remote and rural neglected areas; and ability of a common man (*person*) to provide basic health care, used this principle to provide excellent help to millions in more than fifty countries around the world. His classic manual, *Where There Is No Doctor,* is perhaps the most widely-used health care manual with us today.

In traditional societies, especially in resource-limited settings, *traditional birth attenders* and *village health workers* are among the most frequent first-line health workers to be encountered. Commonly referred to, in different parts of the world, as barefoot doctors (China), community health workers and now ASHA (India), Aid Post orderlies (PNG) are some examples. In addition to the large-scale implementation by countries such as China, India, Bangladesh, Tanzania, Liberia, Brazil, and Iran, many countries have implemented CHW programs in small-scale for a variety of health issues. Reliable figures for the numbers of these workers is estimated to be over two million.

Traditional Birth Attenders

Necessity is the mother of invention. Almost every women requires some support and assistance during child birth. Deaths are common during childbirth of both the mother and the newborn, especially in countries with limited resources, cautions family members to seek help during childbirth. Traditionally, it was the grandmother who helped the women in labour because of her own experience of bearing many children. She passed her skills to her daughters and thus came the more experienced and known TBAs in the village communities. So much so that the famed ones were called by neighbouring villages to conduct the difficult deliveries.

In early seventies, when the concept of CHWs was becoming popular in India; I had an opportunity to visit the CHWs training programme in Jamkhed Health Project. Impressed by the success of the project and seeing the potential of this approach, I started a VHWs training programme in Mussorie, then Uttar Pradesh in India. Our training programme started with a dialogue with TBAs, asking them to describe their most difficult experience in assisting a childbirth. I can never forget the story told by one of the TBAs. One night, this TBA was called to assist a women, where progress of labour was

hampered by prolapsed hand and the women was in agony. She told us that she thought for a while and then asked for some warm oil. She smeared the hand with oil and gently pushed the hand back into the uterus, turned the head and delivered baby alive. In older text books of obstetrics, one would find this procedure described not different from what this TBA had done. She was an intelligent and smart lady and had learnt to read and write Hindi on her own by sitting with the returning school children and asking them to teach her to read and write. We effectively used her to read the text aloud from manuals and translate and explain in the local dialect to other TBAs.

Most of the TBAs need to be taught watchful expectancy during child birth, as over 85% of the births are spontaneous, requiring no intervention. If they can recognise the complications of pregnancy early enough and refer, many lives can be saved. The important thing is to impress upon them that washing hands before delivery is more important than washing after. TBAs as CHWs are probably the most effective village health workers, if trained and adequately supported to provide primary health care.

China's Barefoot Doctors

World has learnt a great deal from China's experience of CHWs. The name barefoot doctor became popular in late 1960s after an editorial in the *People's Daily* by Chairman Mao in 1968, saying that the name 'barefoot doctor' originated in Shanghai because farmers in the south were often barefoot working in the paddy fields. But China's village doctors had been there long before. In 1951, the central government declared basic health care should be provided by health workers and epidemic prevention staff in villages. In 1957, there were already more than 200 000 VHWs across the nation, enabling farmers to receive basic health care at home and work every day. The barefoot doctor scheme was simply the reform of medical education in the 1960s. In areas lacking medicine or doctors, village doctors could go through short-term training – three months, six months, a year – before returning to their villages to farm and practise medicine.

India's Community Health Workers and ASHA

The most populous country in the world also started CHWs programme in early 1970s which has survived to date as ASHA. According to Rajani R Ved (June 3, 2015), ASHA is India's CHWs. With nearly one million women volunteers across the country, the programme is here to stay. ASHA was a part of health system reform initiative, the National Rural Health Mission (NRHM) launched in 2005. There is some evidence to show that the role of the ASHA in encouraging communities particularly mothers and children to health facilities for institutional deliveries and immunisation is significant.

Aid Post Orderlies of Papua New Guinea

Those who are familiar with Papua New Guinea (PNG) and akin countries, and there are many in this world, will agree with me that providing hospitals and more doctors will not help improve the health of people and their illnesses and causes of premature death. As far back as 1930s it was recognised that village level workers were needed to address the health problems of the country. There are over 5000 CHWs in PNG who are trained for two years after grade 10 schooling as Aid Post Orderlies (APOs). APOs provide bulk of primary health care in rural Papua New Guinea. The main role of APOs as CHWs is to prevent and protect the community through identifying health needs, delivering health education and applying preventive measures such as conducting immunisation programs right where people live, especially in the rural and remote areas. APOs have an opportunity to further their careers and have been working in many district and provincial hospitals in pivotal positions. Under the UNFPA/WHO's Strengthening Reproductive Health Services in PNG in 1996, we trained APOs to conduct no scalpel vasectomies in PNG in four provinces, first time vasectomies were accepted by men among rural populations in PNG.

Sub-Saharan Africa

The mission of the One Million CHWs campaign is to accelerate the attainment of universal health coverage in rural sub-Saharan Africa by supporting governments and other stakeholders and partners in health. The published CHW country profiles, available on the **One Community Health Workers website** and on **CCM Central form** a high-level program status guide intended to fill information gaps that exist within countries and between country stakeholders and global partners who are working conjointly to rapidly scale and strengthen CHW programs.

What can we learn from this experience?

So what have we achieved through CHWs, the village level health workers, since Alma Ata in 1978. Each time a new initiative is identified and advertised, all previous work is dumped and new work starts from a clean slate. When are we going to learn to build on what we already have?

There is a huge manpower waiting to be utilised. CHWs are a sure solution in improving health of the people in the world *where there is no doctor*. Where we have failed is to continue to believe that doctors and hospitals are the answer to poor health. Yes, doctors and institutions from which they operate, are essential for illness care but not for health and better quality of life. The Alma Ata Declaration of 1978 failed because Primary Health Care initiative did not realise that millions of CHWs who were already there, could be incorporated into the promotion and implementation of PHC. CHWs should have been actively involved as change agents and appropriately trained and supervised for the implementation of PHC. With proper assistance and support, CHWs could organise the villagers for comprehensive maternal and child health and for other common health problems to ensure that all children were immunised, all pregnant women could get antenatal and post natal care, family planning needs were met and health education provided. Needs for monitoring treatment and care of chronic diseases could also be catered through CHWs. At village level, the population is small and the work load for these preventive and promotive services is manageable. If each health center outreach team makes a monthly visits to each one of the village under the jurisdiction of the center, where the CHW and village health committee organises the clinic, effective Primary Health Care can be delivered to all.

It is never too late and perhaps even now we can engage this precious resource, the CHWs, in an effective manner to implement **Primary Health Care** to attain the goals of **Health for All** and the **Universal Health Coverage**.