

**SECOND CARNEGIE INQUIRY INTO POVERTY
AND DEVELOPMENT IN SOUTHERN AFRICA**

Community health workers in Mhala,
Gazankulu: Perversion of a
progressive concept?

by

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PREFACE

Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated island midway between Nelspruit and Tzaneen. It is typical bushveld with limited water and poor agricultural potential. 152,000 people live in Mhala's 87 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 200-bed hospital (Tintswalo), one health centre, ten clinics and a mobile clinic.

Why did Wits Medical School become involved here? It was by both design and fate. At Wits we had people interested in rural health and a benefactor (Anglo American Chairman's Fund) prepared to sponsor rural health work. The government has encouraged the various medical schools to become involved in rural health care and has designated schools to particular "homelands".

So we became involved in Gazankulu and the Health Services Development Unit (HSDU), a project of the Wits Department of Community Health, was established. The objectives of the Unit are the training of appropriate health service staff, the expansion and development of clinic services and the creation of a health service which is community supportive and responsive to local needs. To succeed we need the goodwill, support and respect of the community and the wholehearted backing of the existing health service.

This paper and the others of the HSDU are reflections, analyses, recommendations and ideas and are the product of our first two years' experience. Opinions expressed are based on the critical analysis of hard data on the one hand and on personal impressions on the other. Whatever the opinion, it has been acquired by first hand and sustained personal experience.

The papers cover three aspects of our experience:

1. The State of Health and Health Care in Mhala

- a. Health and Health Care in Mhala : an overview.
- b. The Nutritional Status of Children 1 - 5 years.

2. A Critique of Some Health Service Interventions in Mhala

- a. Community Health Workers in Mhala : Perversion of a Progressive Concept?
- b. How well do our Rural Clinics Function?
- c. Reviewing the Health Centre Policy.
- d. Mobile Clinics : What can and do they Achieve?

3. Health Service Interventions by the Wits HSDU

- a. Do Primary Health Care Nurses in Gazankulu provide Second Class Cheap Care to the Poor?
- b. Can good Tuberculosis Services be provided in the Face of Poverty?
- c. School Health Services : Problems and Prospects.
- d. Mass Immunisation Campaigns - The Tintswalo Experience.

The message is that:

- Health care in Mhala is inadequate.
- This care can be improved without preceding changes in the present economic and political systems.
- Such improvement is limited by social, economic and political constraints which are the root cause of much illness.
- It is worth working in "homeland" health services because of what can be achieved.

In acknowledging all who have worked in or with HSDU it must be remembered that health service development is a team effort. Many of the people of Mhala, the hospital staff, primarily Dave Stephenson as superintendent and the community health nurses, Dr Erica Sutter and the superintendents and staff of Gazankulu's other hospitals, the health department led by Dr Roos and, more recently, Dr Robert, and the Chief Minister of Gazankulu have all contributed to the establishment and development of the Unit. The Chairman's Fund of Anglo American and the University of the Witwatersrand have provided the infrastructure.

The action has come from Anita and Bob Backentoss, Eric Buch, Rob Collins, Cedric de Beer, Clive Evian, Vic Gordeuk, Meryll Hammond, Thoko Maluleka, Shirley Maswanganyi, Saniliso Mtetwa, Dipuo Mosoua, Robert Maugh and Norrick Zwarenstein.

COMMUNITY HEALTH WORKERS IN MHALA, GAZANKULU:
PERVERSION OF A PROGRESSIVE CONCEPT?

Merryl Hammond and Eric Buch

INTRODUCTION

We recently had to make a decision about our involvement with Community Health Workers (CHWs) in the Mhala district of Gazankulu. CHW training had begun before we started working in Mhala and nine were working in the villages. However, training had been stopped because of problems in the course and the lack of adequate trainers. We were asked to help get things going again.

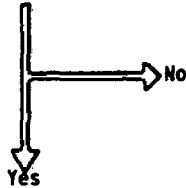
We knew that we had to think through this request very carefully, because we had learned that our best intentions could produce very harmful results. We refer to this process as "perversion of a progressive concept": you enter a situation with a theoretically "good" idea and all the energy and determination to make it work; but much later when the outcome is examined, you discover that reality has so badly transformed your idea that it is actually perverted into the opposite of what you had intended. So what starts as a plan to help a community develop becomes a process which uncontrollably but predictably underdevelops it.

We have therefore learned to examine situations very critically before getting caught up in the momentum of them. In this case we felt especially wary because the CHWs would work in such close contact with vulnerable villagers.

We start this paper by outlining the questions we asked ourselves in a flow diagram. We follow with the answers and conclude with our thoughts on how the issue of village-based health workers can be tackled in the South African situation.

THE QUESTIONS WE ASKED OURSELVES

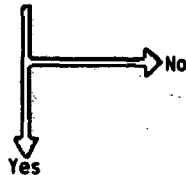
1. Can CHWs be good health workers?



2. Can CHWs be good in our local situation?

In other words can we guarantee at least:

- 2.1 A good selection procedure.
- 2.2 A good training:
 - 2.2.1 relevant course content.
 - 2.2.2 appropriate trainers and nature of training.
 - 2.2.3 appropriate location and duration of training.
- 2.3 A good support system when CHWs are working.
- 2.4 A positive effect on the delivery of health care.
- 2.5 A positive effect on community development.



3. Can we start a training programme:

Is it within our resources and is it the most productive way of using our time, money, skills etc?

Let us consider each of these in turn.

1. CAN CHWs BE GOOD HEALTH WORKERS?

Auxiliary health workers going by various names and roles have been part of health services from before this century. One group of these is village-based and may be called a village or community health worker (CHW). Newell's general statement summarises the extensive reporting of CHWs in the literature: "There is no longer any doubt that a primary health care

worker of this type can work effectively and in an acceptable manner." (1) This is not to deny, however, that such workers can also at times work ineffectively and in an unacceptable manner.

But what would lead to a worker functioning so negatively? Werner (2) captures the contrasting outcomes of community health worker programmes when he distinguishes between a "community supportive" worker at the positive end of a continuum and a "community oppressive" one at the negative end. A community supportive worker is described by Werner in this way: "If the village health worker is taught a respectable range of skills, if he is encouraged to think, to take initiative, and to keep learning on his own, if his judgement is respected, if his limits are determined by what he knows and can do, if his supervision is supportive and educational, the chances are that he will work with energy and dedication, will make a major contribution to his community and will win his people's confidence and love. His example will serve as a role model to his neighbours, that they, too, can learn new skills and assume new responsibilities, that self improvement is possible. Thus the village health worker becomes an integral agent of change, not only for health care but for the awakening of his people to their human potential and ultimately to their human rights." (our emphasis) (2)

Such a progressive worker is clearly "effective" and "acceptable". Contrast that image with this description by Werner of a "community oppressive" health worker. "So we find, in certain programmes, a different breed of village health worker is being moulded - one who is taught a pathetically limited range of skills, who is trained not to think but to follow a list of very specific instructions or 'norms', who has a neat uniform and a handsome diploma, who works in a standardised cement-block health post, and who is subject to restrictive supervision and rigidly pre-defined limitations. Such a health worker has a limited impact on the health and even less on the growth of the community." (our emphasis) (2)

Returning to Newell's statement above, we agree that CHWs can work effectively and in an acceptable manner. But we agree that the opposite could also apply in some situations. So we respond with a qualified "Yes" to the question of whether CHWs can be good health workers, but we need to think very carefully about whether this is possible in our local situation.

2. CAN CHWs BE GOOD IN OUR LOCAL SITUATION?

Our local situation is a typical South African homeland area with all the associated problems: politically powerless people accustomed to living in an unjust society; severe poverty and its associated diseases; families disorganised by migrant labour, oppressive laws and resettlements; minimal community organisation at village level; and poorly developed primary health care services. There is clearly a need for a "community supportive" CHW to meet both health care and community development needs. But what are our chances of having such workers within an official homeland health service?

A study by the UNICEF/WHO joint committee on health policy gives a pessimistic view. They discussed the problems of initiating village-based health programmes in "politically unfavourable" circumstances. "The state, although essentially supporting the existing situation by its economic policies, and possibly even by its control or oppression of trade union or political activities of the masses, may wish to mitigate the potentially explosive effects of great inequality.... If communities are being involved by official organisations in such circumstances, it is unlikely that attention will be drawn to the main causes of their ill health, their poverty and underdevelopment. Moreover, through their contribution in time and resources, the rural poor are effectively taxed to pay for a second class service, whereas sophisticated facilities, available largely to the better-off, continue to be expanded in the urban areas." (3)

The fear that CHWs would be used in our area to pacify people who were making demands and to provide the facade of an accessible health service was a major one, and will be discussed in more detail later. Clearly it was not our aim to have CHWs practising second class care, aiding the state to keep order, and saving it the expense of providing adequate primary care for everyone. On the contrary, we want to see CHWs who are competent health care providers and effective community developers. We think that the health care provision and community development roles are inseparable if a village-based health worker is going to avoid practising in the "oppressive" manner described by Werner (2)

But how can we avoid the trap of producing workers that provide second class care? How can we ensure "supportive" health workers for our villages? We felt that if our CHW programme was to have even a chance of

success in Werner's terms, the following requirements were essential:

- a good selection procedure.
- a good training system.
- a good support system.
- a positive effect on the delivery of health care.
- a positive effect on community development.

Let us examine each of these issues in turn, and see what we found amongst the CHWs already working in Mhala.

2.1 IS THERE A GOOD SELECTION PROCEDURE?

Many authors have commented on the difficulty of getting students who have been democratically chosen by their communities. (4,5) Democratic selection is essential because a CHW's work is very intimately involved with changing the daily practices and way of life of villagers. So people must have confidence in and really respect and like their CHW. This relationship is much more important for a CHW who works together with villagers in their homes than for a clinic nurse who only sees people at her clinic.

The problem of powerful and often unpopular local authority figures sending a relative or friend for training is universal. Many communities do not have an organisational base that facilitates democratic processes - the chief is either powerful enough or assumes himself competent enough to make decisions on "the people's behalf." And, as Wood points out "even if a public vote is taken (at a village meeting), the poorer people may be afraid to suggest or vote for someone else." (5) Yet, as we shall see, if the selection process is inadequate, inappropriate candidates will end up in training and the chances of success in a CHW programme will be very slim.

The most important qualities in a CHW candidate are dependability, motivation, and a concern for the community. (4,6) They should respect others and be respected by fellow villagers. This "respect by others" is essential, and must not be confused with fear or feelings of intimidation or inferiority. In many communities a poor, illiterate, older woman may be highly respected and well liked and is therefore the right person to become a CHW. In contrast, a young well-educated, wealthy relative of the chief may be despised, have

little respect, and therefore be the wrong person. The CHW should also be from the community and should plan to remain there. Many programmes have found that upwardly mobile youngsters see CHW training as a "stepping stone" to get out of the village and into a higher status, better paid career elsewhere. High educational skills should not be a requirement because they exclude the illiterate and hence poorer people from becoming CHWs.

The CHWs in Mhala offer examples of the kind of problems one can expect to encounter in South Africa. In many areas the tribal authorities no longer have the legitimacy they once had, but are paid civil servants appointed to keep control in homeland areas. Many chiefs and headmen abuse their authority. In Mhala many simply sent one of their young relatives for training without opening selection to the community. In one village, while the popularly chosen candidate was waiting to go for training an unelected relative of the chief arrived back at the village as their qualified CHW. The chief had sent her without telling anyone...

In addition to their links with the often repressive village authorities, CHWs in Mhala have other severe drawbacks. They are all young women, many still teenagers. Most are unmarried and childless in a society which respects age and motherhood. They are considerably better-off than the average villager and are therefore less able to identify with them and understand their problems. Because their course required a minimum of a Standard 6 education they are also better educated than average village women, and often display the superiority and elitism which their education has fostered. Finally, because of their privileged upbringing, their youth, their education, their marital status and their lack of commitment to community work, most CHWs desire to leave their villages to work at the hospital as "real nurses".

It is clear, that many of the problems with selection mentioned by other authors are found in the Mhala area, and we shall soon examine the consequences of their inappropriate selection. We believe that the thorny issue of selection of CHWs in a community dominated by non-representative authority figures, and lacking strong democratically based organisations will be difficult to resolve. If we were to get involved in CHW training, however, we would make some changes. The

first step would be to remove the choice from the chief, and to insist that the trainers make the final choice from three or four possible candidates. Another possibility would be for each village to have two or three part-time CHWs. The chances of all sectors of the community being happy to co-operate with one of them is greater than under the present system. Finally, if the literacy requirement were dropped, we could also overcome some of the problems.

2.2 IS THERE A GOOD TRAINING SYSTEM?

There are many different elements that contribute towards a good training programme. We will consider three of these:

- the relevance of the course content.
- the appropriateness of trainers and the nature of training.
- the location and duration of training.

2.2.1 Relevance of course content.

Abbatt (7) among others has emphasised the need for trainers to examine what tasks their students will be expected to perform in their jobs. They should then focus their teaching on ensuring that their graduates are competent to perform these tasks.

Gazankulu decided to run an adapted nursing assistant's course for CHWs. This meant that the initial part of their training was spent in a hospital setting learning the skills of nursing assistants. Not only were these skills not directly relevant to work in a village setting, but it brought the CHWs into contact with the role-models they now aspired to become - clinical nursing sisters. Their training was completed in similar vein at a health centre.

The decision to exclude curative skills from their training was also inappropriate. This major criticism will be detailed when we consider the impact of CHWs on the delivery of health care in the villages.

The third major problem with relevance was that although the need for community development was mentioned in the training

plan, only twelve periods in their six months course were devoted to it. It was stated that CHWs should learn about "homecraft essential for community development (cooking, gardening, mud-stoves etc.)". This unnecessarily restricted view of community development focuses on technical accomplishments as ends in themselves, rather than community development as a process of building people's confidence and awareness. We feel that a genuine community development approach should use technical skills as aids to help people learn to work together, to test their abilities, to experience pride and confidence, to gain some control over their lives, and to feel freer to start exploring other abilities and potentials within themselves as individuals and as groups.

These are some of the shortcomings we would alter if we started training CHWs. The first step would be to create a CHW category separate from a nursing assistant so that there is relevant training for community based workers. A task analysis would reveal the need for a much greater emphasis on relevant community work, community development and curative skills, and the course would need to ensure that it developed the appropriate insight and approaches to go with these skills. We examine this issue next as it is closely linked to the nature of training.

2.2.2 Appropriateness of trainers and the nature of training

For training to be good, you need good trainers using an appropriate adult educational approach.

A CHW trainer should have had experience in community work, primary health care and adult education. The adult education approach starts from the premise that adults learn differently from schoolchildren, and so teaching should be adapted accordingly. Instead of authoritarian teachers and passive students as we find in most schools, adult education changes the roles of both teacher and student. The teacher is a facilitator and an active learner together with the class. Students learn to be more active learners, to take responsibility for their own learning and to question,

criticise and solve problems. In this process, not only do students learn new skills and knowledge, but they acquire new confidence in their own abilities. Even more important they learn that the old barriers between teachers and students can be broken, and that people can work together as equals.

This insight into their abilities and into new ways of relating is essential for CHWs to acquire. It helps them to cope with the many problems they will face as isolated village workers and to ensure that they will approach villagers in a "community supportive" way. A CHW who has discovered her own potentials during training is surely much more likely to help villagers discover their abilities once she starts work.

Unfortunately the Mhala CHWs were trained by nursing sisters with little experience of village work, no primary health care skills and no adult educational skills. The serious consequences of the poor trainers and their approach to education will become evident when we discuss the effects of CHWs on health care provision and on community development. Readers will then appreciate why we would feel a great responsibility to approach training from an adult education base. Our experience in training primary health care nurses (see the paper by Buch et al: Do Primary Health Care Nurses in Gazankulu provide second class care to the poor?) reinforces our commitment to this approach.

2.2.3 Location and duration of training

Trainers often find it easier to centralise training in one location and to run their course on a full-time basis. This may be appropriate for many categories of health worker but is not so for CHWs, because it will lead to barriers forming between the CHWs and the villagers. A village member who is "removed", "trained" in a distant place for a long time and then "returned" becomes remote, even awesome in the eyes of fellow villagers. Villagers also have no idea what the CHW has learned to do, and so have inappropriate expectations. A useful way of preventing intellectual barriers from developing

is to localise training so that students can remain active members of their community and villagers can participate in classes.

The Khala CHWs unfortunately had to travel to a different, distant part of Gazankulu for their six month, full-time, hospital or health centre based training. This had the adverse effects on the CHWs themselves of irrelevant training, social disruption, and growth of elitism. Villagers were likewise at a disadvantage: someone was sent without their approval for training; they had no idea what was taught or what they could expect from their CHW; then, several months later a "qualified" CHW was presented to them at a village meeting; and they were told to obey her because she was "a gift from Gazankulu" to them. We will argue later that as far as most villagers were concerned, the CHW was probably just another privileged and authoritarian figure in the already extensive network of village control.

If we started a training programme we would want it to be locally run, part-time and open to other villagers, who could then see exactly what was involved. This would help to balance the considerable power that a single person with a monopoly of knowledge wields in any group.

2.3 **IS THERE A GOOD SUPPORT SYSTEM?**

Of all rural health workers, a lone village-based worker is potentially the most geographically, socially and intellectually isolated. To prevent loss of motivation and feelings of being "dumped and forgotten" the CHW needs a good support system after training. Such a system would normally include regular advisory and educational visits from supervisors, formal in-service education, a communication link with the hospital, and adequate transport services to refer emergencies. Given the nature of CHWs work and their community base, we would add that the community itself is a vital part of the support system.

The Khala CHWs have had severe problems in all these spheres. Visits from supervisors are not only very brief and infrequent, (once a year

on average) but when they do occur they are used to "check-up on" or "police" the CHWs, rather than to provide assistance and support. There is no on-going system of in-service education - not even a time for CHWs to get together informally to share ideas and discuss their problems. There is also no communication or transport link to reduce isolation.

In addition to these problems, Mhala CHWs receive little support from their villagers. We shall discuss later that some CHWs have formed "care groups", and find some acceptance and support from them. But many villagers are described as "uncooperative" and appear to be antagonistic towards the CHWs. These problems may relate back to the poor systems of selection and training, or to the way the CHWs approach their work. This latter point will be discussed in the next two sections.

We believe that for a successful CHW programme both "external" supervisory support and "internal" grassroots support (from the villagers themselves) is essential. The former would require an improved infrastructure of transport and communication and extensive supportive supervision. Future supervisors will need to be involved in the training programme to build their responsibility to and concern for their CHWs. The grassroots support could be facilitated by selection of popular candidates and the kind of open and relevant local system of training discussed earlier.

2.4 **DO CHWS HAVE A POSITIVE EFFECT ON THE PROVISION OF HEALTH CARE?**

A CHW should have a positive effect on the provision of health care in her village. Such care includes both curative and preventive/promotive aspects. Let us examine each in turn.

2.4.1 Curative health care

In a rural area where the majority of illnesses stem from poverty and deprivation a CHW can diagnose and treat most common ailments. This curative role is essential because other primary health care services are inaccessible and the felt needs of most villagers are for curative services. If a CHW responds to these felt needs her credibility will grow and she

can then use the trust and confidence developed to successfully introduce preventive and promotive concepts. Morner points out that in spite of the obvious need for CHWs to learn curative skills, many are "taught a pathetically limited range of skills" (2) and that curative work is often considered "too complex". The effect of this conservatism is that CHWs are instrumental in creating a facade of accessible primary health care services. Because of the curative restraints such services provide "primitive" rather than primary health care. And the CHWs delivering them are much more likely to be "community oppressive" than "supportive".

Mhala CHWs were only trained to treat diarrhoea. Their lack of adequate curative skills has led to all the problems of loss of credibility and "primitive" services mentioned above. All the CHWs say that villagers expect them to be able to treat diseases like the clinic nurses do. Some people have offered to pay the CHW the R2.00 clinic fee if only she would save them the time, effort and extra expense of travelling to the distant clinic. One CHW clearly saw how her lack of curative skills affected her ability to influence preventive and promotive aspects. "If a person comes to me when they are sick and I just refer them to the clinic, how will they feel next week when I do a home visit to tell them about hygiene or toilets?" She answered her own question: "They think I know nothing because I couldn't help them when they were sick."

The pressure for curative care has led some CHWs to keep a "medicine box". They proudly show off the tools of their "curative" trade. A few pain killers, some disinfectant and some cotton wool. These clearly don't help much, and look rather meagre when compared with the well stocked shelves of the village shop - laxatives, cough mixtures, pain tablets, "blood purifiers", "liver pills", antacids and a myriad of other products. These remedies may be of dubious value, but villagers believe that they can get better health care from the shopkeeper than from their CHW.

We consider the neglect of the curative aspect to be a major criticism of the CHWs job description and a major factor in her low community esteem.

2.4.2 Preventive and promotive health care

In addition to being competent to diagnose and treat common ailments a CHW should be able to provide preventive health care and to motivate people about promoting better health.

The training course for Mhala CHWs focused on these aspects. However, our impressions have been that even in these limited spheres the CHWs are providing inadequate care. For example, their factual knowledge about when to plant seeds, or how to build toilets, is very limited. They only know how to "tell" people to do these things. Other skills, like building mud-stoves, are well-mastered by some CHWs, but as we will see in the next section, CHWs seem satisfied with the mere existence of such structures rather than the effective use of them.

The CHW's approach to health education tends to be very dictatorial and their response to failure in this field somewhat petulant. "These people refuse to listen to me!" or "I've told them so many times but they don't do what I say." A brief descriptive study of one clinic which serves two villages with CHWs and two without revealed no evidence that the CHWs were being effective at motivating mothers to take their children to under 5 clinics - a major part of the CHWs-job description.

We decided to study two aspects of their preventive work more formally. These were whether villages with a CHW have more pit latrines, and if they have less street litter, than other villages. These seemed fair aspects to focus on because they are both taken seriously by CHWs and were included in their training.

a) Do villages with a CHW have more households with pit latrines?

Pit latrines can be seen on aerial photographs, but the latest ones in

Khala were taken before the CHWs were trained. We therefore counted pit latrines seen from the road in four villages with a CHW and four adjacent ones without. The findings are presented in Table I below.

TABLE I
PIT LATRINES IN CHW AND NON-CHW VILLAGES IN KHALA

Village	No. pit latrines counted	Total homesteads counted	% with latrines
<u>No CHW in village:</u>			
Rolle	10	28	36%
Lilleydale	13	28	46%
Huntington	17	37	46%
Somerset	11	35	31%
Total for non-CHW villages	51	128	40%
<u>CHW in village:</u>			
Newington	23	64	36%
Croquet Lawn	7	18	39%
Justicia	17	25	68%
Belfast	22	35	63%
Total for CHW villages	69	142	49%

Table I shows that in this small sample we found villages with a CHW have a slightly higher average rate of households with latrines (49%) than other villages (40%), but this difference is not statistically significant ($p > 0.5$). In fact, the mean for villages with CHWs is only higher because of the very high rates in Justicia and Belfast. An immediate interpretation might be that the CHWs in these two villages are effective health educators, but this is not necessarily the case. In many villages, chiefs are fining people (R20) who do not have toilets, and in both Justicia and Belfast, the CHWs have been acting as fine collectors for the chiefs. So what we may be seeing is the result of very invasive "law enforcement" rather than effective health education.

b) Do villages with a CHW have less street litter than other villages?

CHWs spend a lot of energy trying to eliminate litter. In response to a question about the major problem in her village one CHW replied: "We have no problems any more. Before I came here the place was filthy. People just used to throw their rubbish anywhere. But now I have stopped that... we have no other problems now."

To measure the impact of CHWs on street litter, panoramic photographs were taken of the street immediately outside the village shop. This was done in the same eight villages as the pit latrine study. Without knowing which villages had CHWs, observers were asked to rate each village on a scale of one (exceptionally clean) to five (exceptionally littered). Table II shows these results.

TABLE II
MEAN RATINGS GIVEN BY 11 OBSERVERS TO LITTER IN CHW AND
NON CHW VILLAGES

(Rating scale 1 = "exceptionally clean" to 5 "exceptionally littered")

Village	Mean rating	Mode (1)	Range (2)	Standard deviation
Rolle	2,09	2	1 - 4	
Lilleydale	2,82	2	1 - 5	
Huntington	4,18	4	3 - 5	
Somerset	1,55	1	1 - 3	
Total				
non CHW village	2,66	2	1 - 5	
Total				
Newington	3,82	4	2 - 5	
Croquet Lawn	1,91	1,2	1 - 3	
Justicia	4,27	5	3 - 5	
Belfast	3,82	4	3 - 5	
Total				
CHW village	3,46	4	1 - 5	
Total CHW and				
non CHW villages	3,06			2,92

Table II shows that in this small sample, villages with CHWs are not judged by "blind" observers to be less littered than other villages. In fact, the observed differences show that villages with a CHW have a worse mean rating (3,46) than other villages (2,66). These differences are not, however, statistically significant. These preliminary results seem to show that CHWs are not having a very positive effect on street litter.

- (1) Mode is the rating which was given by most observers.
 (2) Range gives the lowest and highest ratings given, but tells nothing of the spread of ratings.

2.5 DO CHWs HAVE A POSITIVE EFFECT ON COMMUNITY DEVELOPMENT?

This section is based on numerous visits by both of us and our Tsonga-speaking primary health care nursing students to the villages where CHWs are working. We have grouped our major observations under three headings:

- the imposition of ideas by CHWs
- the initiation of "care groups"
- the "police theme"

2.5.1 The imposition of ideas by CHWs

A fundamental principle of community development is that the external agent, in this case the CHW, should help to recognize and isolate issues that are important to them (felt needs). People would then be very clear about what they want to work on: they would discuss what kinds of solutions they could try; they could organise to work together to solve the problem; and in so doing, they would learn about their own and each others strengths, weaknesses and potentials.

Armed with new confidence and determination, they could then move on to tackle other problems. And gradually, people who are so accustomed to being overlooked and oppressed, will gain some small measure of control over their own lives.

Precisely the opposite process has been happening in Mhala. The CHWs returned from their course with a predetermined "agenda" of what was to be "done" in the villages. They started "doing it" without any discussion or exploration of alternatives, and simply expected villagers to comply.

The CHWs seem obsessed with the building of certain structures which were emphasised in their course (mud stoves, refuse pits, toilets, and vegetable gardens) and ignore other problems in the effort to get as many of these built as possible. The CHWs do not focus on the process of working together, the importance of people learning to discuss their problems and work out solutions, or the positive effects of acquiring new skills. The structures are viewed as ends in themselves and people are

then judged as worthy or unworthy, depending on the presence or absence of these structures in their homesteads.

Ironically, the CHWs are more concerned about the existence of these structures than their use. Many unused mud stoves were proudly shown off to us. When we asked why people were still using the old open-fire method for cooking, replies varied from "They say the stove doesn't keep tea warm", to "They say the stove uses extra wood," to "The kitchen gets too smokey", to "I don't know". But the issue had not been explored further and no attempt had been made to solve the problem. As long as the stove existed, the owner was in the CHW's "good books".

Vegetable gardens revealed a similar contradiction. We would peer over a little fence and see a patch of ground with a few wilting weeds. The CHW would say: "This is her vegetable garden" and everyone would smile "Swi sasekile" (It's beautiful) and then move on to the next place.

Finally, the same pattern emerged with toilets. We saw bolted toilets, small buildings without the hole underneath, and large holes without a superstructure - all useless, but the facade was there.

One of the saddest examples of the imposition of ideas concerned trachoma. The CHWs were trained near Giyani where trachoma is endemic. As a result, CHWs were taught to keep separate face cloths for each child to prevent its spread. In Mhala, however, trachoma is not a problem, yet mothers are still made to buy separate cloths - the CHWs had only been taught to impose their ideas and not to adapt their practice to suit local needs.

Imposition of ideas from outside was also expressed in the formation of "care groups". These groups have such a major potential role in community development that we shall discuss them separately.

From the examples given in this section it is clear that the neglect of community development principles in the selection,

training and support of CHWs has had major negative consequences in the villages. People have been encouraged or co-erced into "doing" certain things without any understanding of why it should be done, any chance of offering alternative suggestions for action, or any spin-off benefits of the growing awareness and human dignity which can result when a skilled "community developer" helps villagers work together to solve problems.

2.5.2 Initiation of "care-groups" by CHWs.

In the district of Gazankulu where the CHWs were trained there is an extensive network of "care-groups." These are voluntary groups of women doing unpaid health work. In that area there is also an extensive support system: full-time "care-group motivators", vehicles, funds, and supervisory staff. There is some debate as to how effective even these well-supported care-groups have been in community development but we will not concern ourselves with this and will only look at what has happened in Mhala.

The Mhala CHWs spent some time during their training visiting care-groups, and were encouraged to start a similar programme in their own villages. And so it has happened. The CHWs themselves have had no formal preparation for this, they have no insight into group dynamics, and no understanding of the potential evils of exclusive, elite groups on social life in the village, and no conception of how to build trust, confidence and awareness in a group situation. Add to this poor start the total lack of infrastructure for care-groups in the Mhala area - no motivators, no vehicles, and no skilled community developers - and it is not surprising that the "care-groups" as they exist in Mhala are very different from the now well-known ones in the Elim area.

The members of Mhala's care-groups tend to be young, fairly well-off and friendly with the CHW. Large sections of the village are not represented in the groups at all - particularly older and poorer women. It is possible that non-Christian

women are also excluded because religious singing and praying forms a major part of care-group meetings.

Members of these "in groups" emulate the CHW in many ways. They wear a distinctive uniform, just as the CHW wears a nurses uniform. These uniforms perform three functions. First, they provide a visible "bond" which reinforces care-group members' feelings of unity. Second, they clearly separate members of the "in-group" from other villagers, and in so doing perhaps increase disunity in the village as a whole. And third, they reinforce a fairly rigid "class system" within the groups. Very poor people who cannot afford to buy the correct coloured clothes are excluded altogether. Women who can afford, say, velvet skirts and chiffon blouses are privileged to enter the meeting place first and sit in the front on the few available chairs, while more modestly dressed women enter later and sit further back on the floor....

Care-group members also imitate their CHW's way of relating to others. They appoint "officials" whose specific task is to "check-up" on other care-group members. They impose their ideas about what problems should be tackled and so prevent villagers from discovering their own problems. They select a chairlady who assumes an authoritarian role in the group. This selection is not done democratically.

Thus we see that even within the exclusive groups any possibility of building the kind of relationships that lead to genuine community development is removed. The role-model of the CHW is inappropriate (perhaps because of the nature of her own selection, training and support) and the way the groups have been moulded precludes such development. When we look at how these groups relate to villagers and effect village development as a whole, the picture looks even bleaker.

People who have not joined the care-group are looked down upon and scorned. The group refers to them as "dirty", "unhelpful" and "ignorant". Their homes are pointed out to visitors as filthy examples. When the CHW enters their yards people often hide away, close the doors or walk out the back. This is the

cause of much mirth - "They are scared of us because they know they are dirty!"

In short, one gets the sense of a great division in the villages between the "clean" and the "dirty", the "enlightened" and the "ignorant", the "accepted" and the "shunned", often the "well-off" and the "poor". The effect of this disunity in the villages is impossible to assess. We do not know whether "care-groups" have replaced or reinforced existing divisions, or whether they are responsible for creating previously unknown tensions. Either way, a CHW should be trying to break this disunity down as part of the process of community development. We felt ashamed that our "care-groups" under the guidance of an official health care provider could be responsible for such uncaring behaviour. If this is the only community development that will emerge within an official "homeland" health service, then it is surely better for us to direct our energies elsewhere.

2.5.3 The "Police Theme"

Given the principles of community development discussed earlier, especially the focus on motivating people to work together to solve their own problems, the CHW should not be a local inspector of health. And, as we have said, the CHW supervisors should support not "check up" on the CHWs.

The theme of "checking-up", "inspecting" and "policing" arose often and in many different contexts. The three major areas concerned the supervisors "policing" CHWs, the CHW "policing" care-group members and other villagers, and care-group members "policing" each other and others.

The first problem, that of supervisors "checking-up" rather than supporting and educating, has been dealt with when we discussed the need for a good support system after training.

The second issue of CHWs "policing" villagers was encountered often. For example, one CHW threatens mothers that if they don't attend the under 5's clinic and have a "Road to Health

chart" to prove it, they won't be helped if their baby gets sick. When doing home visits in the village she always checks whether the mothers have these charts, because she says "mothers often lie and just say they do."

As visitors, we often found that we were used to reinforce the CHWs power as an inspector. For example, one CHW proudly pointed out how clean all the homes were one day. "I told them you were coming from the hospital to inspect the village...." Another day, a teacher walked past us in the road and said "Good afternoon! Have you come to check us today?"

Finally, this pattern "policing" is repeated in the functioning of the care-groups as well. The care-groups select several "police-women" (their words) whose duty it is to check-up on other members "like the police do" to ensure that their homes and children are clean. And when we asked what job the "treasurer" of a care-group does, we were told that she "collects the fines": 20c if your house is not clean, and 10c for arriving late at a meeting...

And so, time and again, we saw how negative aspects of the larger social system find reflection in the work of that system's subjects. The authoritarian selection, training and supervision of CHWs reinforced the already present aspects of control that people have learned. So CHWs have become a kind of "health police" - and the villagers perceive both the CHW and anyone associated with her, including care-group members and visitors like ourselves, in this oppressive way. The more we saw, the more it seemed that CHWs in Mhala had become yet another link in the already effective chain of control that homeland authorities have over people's lives.

CONCLUSION

This paper has been a detailed analysis of most of the points of the flow diagram in the introduction. We have analysed and criticised the selection, training, and support of CHWs in Mhala, and have pointed out that they have minimal effect on health care provision and a negative effect on community

development. Throughout the paper we have made suggestions about ways we would try to overcome these difficulties.

The third question in the flow diagram queries whether we would have the time, money, and skills to devote to a training programme which would overcome the many problems we have identified. Frankly, we do not. But even if we were free to make such a decision, our experiences with the current CHWs have left us very disenchanted.

For the point is this: the concept of introducing village-based CHWs in Gazankulu was a very progressive one. And the people involved in the original planning had the very best interests of the villagers at heart. And they tried very hard to get things done in the best possible way. Yet look at the perversions that have occurred in Mhala! Who could have predicted just how wrong things could go? And which of us could guarantee that a new course with the changes we have suggested here will definitely not prove to do more harm than good in the villages?

We are frankly sceptical about our chances of success. Although we have no firm evidence, we feel that a CHW who originates in an official health service programme may never succeed in a South African "homeland". Perhaps such a low-status, poorly paid health worker at the bottom of the rung of the official career ladder, in an underdeveloped health service, in an underdeveloped "homeland" in a politically, economically and socially oppressive country is doomed to offer "second class care" in a community oppressive way. Perhaps it is inevitable that most such workers will represent yet another strand in the extensive web of control that officials already have over poor villagers.

But what can progressive health workers who are concerned about the unavailability of health care and the lack of grass roots community development in their villages do? We see three options.

First, such health workers could say that the potential for perversion of a progressive idea like CHWs is too great in the current political - economic situation, and that they could best use their energies working within the existing hospital, clinic and mobile clinic system to really improve these services.

Second, health workers who believe that they fully understand the potential hazards and have the skills, time and resources to prevent the problems described in this paper, may decide that the need for village based health care and community development is so urgent that they want to start a programme.

Third, health workers may believe that the best chance of success in a CHW programme will only come when villagers are organised in progressive groups and are working together on solving their problems. If at some stage members of the group express the need for health skills, then responsive people within the official health service could offer training. In this case, the whole relationship will have changed, and we would be consulted only when villagers felt the need, on their terms, in their villages. The new health workers would be responsible to the other members of their group, who would be skilled in other spheres like education or agriculture.

Of course, the problem in all this is: what sparks the formation of these progressive groups? The chances of trained health professionals having the skills to help people form groups which are not exclusive or elitist are very slim. And there are precious few progressive community developers around to act as "external agents". So for many health workers, subscription to this third option will in practice mean that they act with people who choose the first option.....

We do not feel the need to apologise for considered inactivity. After our experiences with the Mhala CHWs we are certain that a village-based worker is much too potentially powerful and influential to be a mere representative of an official health service, responsible only to her distant "employer" rather than to the community she supposedly serves. We believe that if villagers are going to have to live in such close proximity and in such intimacy with a worker who is concerned with their health and their development, then we have no right to impose anything on them.

We have chosen option three above. We will support any community efforts at forming broad-based, "community supportive" groups, although we do not feel in any way competent to act as initiators in this process. And we will respond to any requests for health training originating from such groups. Until that happens, we will concentrate on working for change and improvement within the health services as already exist. As rural workers will appreciate, there is work enough there for many years to come!

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