The Village Health Worker: Lackey or Liberator?

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Thailand

The policies, objectives and targets of the present national health development plan were already in harmony with Health for All by the Year 2000.

The National Economic and Social Development Board is responsible for formulating national goals, objectives and strategies for social development for the next 20 years.

Country health programming has emphasized wider coverage of the rural population and provided for increased resource allocation for primary health care. A secretariat office of the Primary Health Care Committee, which undertakes programme planning, coordination, and evaluation, has been established in the Ministry of Public Health. The Ministry of the Interior has formed intersectoral committees at central, provincial, district, *tambon* and village levels. The village development committee is seen as the key to community participation.

The basic manpower for primary health care comprises village health volunteers and village health communicators, supplemented by local healers, traditional birth attendants, and traditional practitioners.

By the end of 1981 the primary health care programme is expected to cover 22 400 villages and 18 462 000 people, or 50% of the rural population. By 1986 all rural villages will be covered. There will be 50 000 village health volunteers and 500 000 village health communicators working in 50 000 villages, and 12 000 local health supervisors will be trained for the programme.

The health authorities are aiming to provide an infrastructure of one health centre in every *tambon*, one 30-bed hospital in every district, and one hospital with 240–360 beds in every province. Already this target has been half reached through past health development plans. However, an unequal distribution of health resources needs to be corrected.

Health services research is being undertaken by the Ministry of Public Health, universities, and private agencies and is being strengthened by formal training, seminars and workshops. The Ministry has set up a research committee to formulate research policy and strategy, to advise on research projects, and to support and coordinate research by health institutions.

Besides a national health development network which the Ministry is establishing, key health-related sectors are included on multi-foci planning and coordinating bodies.

The first demonstration intersectoral mechanism, between the Ministry of Public Health and Mahidol University, is concerned with health services and manpower development and health services research. Another, with the Ministry of the Interior, is aimed at integrated local development planning and implementation. Among other intersectoral activities are national food and nutrition planning, rural water supply, and health education.

Intersectoral bodies have been established at provincial, district, subdistrict and village levels.

The village development committee functions as an advisory body to the village headman. It appoints the village health volunteers and the village health communicators, who are then supervised by the *tambon* health staff.

At central level the medical schools, the Medical Association and the training institutions for medical auxiliaries have cooperated in reorienting curricula to include primary health care concepts and approaches.

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Round Table

David Werner[1]

The village health worker: lackey or liberator?

As anyone who has lived among villagers or slum-dwellers knows only too well, says David Werner, the health of the people is far more influenced by politics and power groups and by the distribution of land and wealth than it is by the treatment and prevention of disease. Does this mean that, to be successful, primary health workers should act also as agents of political reform? This highly controversial issue is the starting point for a round table presenting the views of nine experienced health workers from various parts of the world and with different political and social backgrounds.

Throughout Latin America, the programmed use of health auxiliaries has, in recent years, become an important part of the new international push of "community oriented" health care. But in Latin America, village health workers are far from new. Various religious groups and non-government agencies have been training *promotores de salud*, or health promoters, for decades. And to a large (but diminishing) extent, villagers still rely, as they always have, on their local *curanderos*, herb doctors, bone-setters, traditional midwives and spiritual healers. More recently, the *médico practicante* or empirical doctor has assumed in the villages the same role of self-made practitioner and prescriber of drugs that the neighbourhood pharmacist has assumed in larger towns and cities.

Until recently, however, the health departments of Latin America have either ignored or tried to stamp out this motley work-force of non-professional healers. Yet the health departments have had trouble coming up with viable alternatives. Their Western-style, city-bred and city-trained MDs not only proved uneconomic in terms of cost-effectiveness; they flatly refused to serve in the rural areas.

The first official attempt at a solution was, of course, to produce more doctors. In Mexico the National University began to recruit 5000 new medical students per year (and still does). The result was a surplus of poorly trained doctors who stayed in the cities.

The next attempt was through compulsory social service. Graduating medical students were required (unless they bought their way out) to spend a year in a rural health centre before receiving their licences. The young doctors were unprepared either by training or disposition to cope with the health needs in the rural areas. With discouraging frequency they became resentful, irresponsible, or blatantly corrupt. Next came the era of the mobile clinics. They, too, failed miserably. They created dependency and expectation without providing continuity of service. The net result was to undermine the people's capacity for self-care. It was becoming increasingly clear that provision of health care in the rural area could never be accomplished by professionals alone. But the medical Establishment was, and still is, reluctant to yield its legal monopoly.

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At long last, and with considerable financial cajoling from foreign and international health and development agencies, the various health departments have begun to train and utilize auxiliaries. Today, in countries where they have been given half a chance, auxiliaries play an important role in the health care of rural and periurban communities. And if given a whole chance, their impact could be far greater. But, to a large extent, politics and the medical Establishment still stand in the way.

Rural Health Projects

My own experience in rural health care has been mostly in a remote mountainous sector of western Mexico, where, for the past 12 years, I have been involved in training local village health workers and in helping foster a primary health care network run by the villagers themselves. As the villagers have taken over full responsibility for the management and planning of their programme, I have been phasing out my own participation to the point where I am now only an intermittent adviser. This has given me time to look more closely at what is happening in rural health care in other parts of Latin America.

Last year, a group of my co-workers and I visited nearly 40 rural health projects, both government and non-government, in nine Latin American countries (Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Hoduras, Mexico, Nicaragua, and Venezuela). Our objective has been to encourage a dialogue among the various groups, as well as to try to draw together many respective approaches, methods, insights and problems into a sort of field guide for health planners and educators, so that we can all learn from each other's experience. We specifically chose to visit projects or programmes that were making significant use of local, modestly trained health workers or that were reportedly trying to involve people more effectively in their own health care.

We were inspired by some of the things we saw and profoundly disturbed by others. While in some of the projects we visited people were in fact regarded as a resource to control disease, in others we had the sickening impression that disease was being used as a resource to control people. We began to look at different programmes and functions in terms of where they lay along a continuum between two poles: community-supportive and community-oppressive.

Community-Supportive Programmes—or Community-Oppressive

Community-supportive programmes or functions are those that favourably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision-making and self-reliance at the community level, that build upon human dignity.

Community-oppressive programmes or functions are those which, while invariably giving lip-service to the above aspects of community input, are fundamentally authoritarian, paternalistic or are structured and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions, and in the long run cripple the dynamics of the community.

It is disturbing to note that, with certain exceptions, the programmes that we found to be more community-supportive were small non-government efforts, usually operating on a shoestring and with a more or less *sub rosa* status.

As for the large regional or national programmes — for all their international funding, top-ranking foreign consultants and glossy bilingual brochures portraying community participation — we found that when it came down to the nitty-gritty of what was going on in the field, there was usually a minimum of effective community involvement and a maximum of dependency-creating hand-outs, paternalism and superimposed, initiative-destroying norms.

Primary Health Workers

In our visits to the many rural health programmes in Latin America we found that primary health workers came in a confusing array of types and titles. Generally speaking, however, they fall into two major groups:

Auxiliary nurses or health technicians
at least primary education plus 1–2 years training;
usually from outside the community;
usually employed full time;
salary usually paid by the programme (not by the community).

Health promoters or village health workers
average of third-grade education plus 1–6 months training;
usually from the community and selected by it;
often a part-time health worker supported in part by farm labour or with help from the community;
may be someone who has already been a traditional healer.

Many Latin American countries have programmes for the supervision of empirical midwives, known as *control de parteras empiricas* — a terminology that too often reflects an attitude. Thus, to mosquito control and leprosy control has been added midwife control; small wonder so many midwives are reluctant to participate! Once again, we found the most promising work with village midwives took place in small non-governmental programmes. In one such programme, the midwives had formed their own club and organized trips to hospital maternity wards to increase their knowledge.

Key Questions

What functions can the village health worker perform? How well does he perform them? What are the limiting factors that determine what he can do? These were some of our key questions when we visited different rural health programmes.

We found that the functions that village health workers actually performed varied enormously from programme to programme. In some, local health workers with minimum formal education were able to perform with remarkable competence a wide variety of functions embracing both curative and preventive medicine as well as agricultural extension, village cooperatives and other aspects of community education and mobilization. In other programmes—often those sponsored by health departments—village workers were permitted to do discouragingly little. Safeguarding the medical profession's monopoly of curative medicine by using the standard argument that prevention is more important than cure (which it may be to us, but clearly is not to a mother when her child is sick) instructors often taught these health workers fewer medical skills than many villagers had already mastered for themselves. This sometimes so reduced the people's respect for their health workers that they became less effective, even in preventive measures.

In the majority of cases, we found that external factors, far more than intrinsic factors, proved to be the determinants of what the primary health worker could do. We concluded that the great variation in range and type of functions performed by village health workers in different programmes has less to do with personal potential, local conditions, or available funding than with the preconceived attitudes and biases of health programme planners, consultants and instructors. In spite of the often repeated eulogies about "primary decision-making by the communities themselves", the villagers seldom have much say in what their health worker is taught and told to do.

The Political Context

The limitations and potentials of the village health worker—what he is permitted to do and, conversely, what he could do if permitted—can best be understood if we look at his role in its social and political context. In Latin America, as in many other parts of the world, poor nutrition, poor hygiene, low literacy and high fertility help to account for the high morbidity and mortality of the impoverished masses. But as we all know, the underlying cause—or more exactly, the primary disease—is inequity: inequity of wealth, of land, of educational opportunity, of political representation and of basic human rights. Such inequities undermine the capacity of the peasantry for self-care. As a result, the political/economic powers-that-be assume an increasingly paternalistic stand, under which the rural poor become the politically voiceless recipients of both aid and exploitation. In spite of national, foreign and international gestures at aid and development, in Latin America the rich continue to grow richer and the poor poorer. As anyone who has broken bread with villagers or slum-dwellers knows only too well: the health of the people is far more influenced by politics and power groups and by the distribution of land and wealth than it is by the treatment or prevention of disease.

Political factors unquestionably constitute one of the major obstacles to a community-supportive programme. This can be as true for village politics as for national politics. However, the politico-economic structure of the country must necessarily influence the extent to which its rural health programme is community supportive or not.

Let us consider the implications in the training and function of a primary health worker. 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.

However, in countries where social and land reforms are sorely needed, where oppression of the poor and gross disparity of wealth is taken for granted, and where the medical and political establishments jealously cherish their power, it is possible that the health worker I have just described knows and does and thinks too much. Such men are dangerous! They are the germ of social change.

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 standardized cement-block health post, and who is subject to restrictive supervision and rigidly predefined limitations. Such a health worker has a limited impact on the health and even less on the growth of the community. He, or more usually she, spends a great deal of time filling out forms.

In a conference in Washington in December 1976 on appropriate technology in health in developing countries,[2] it was suggested that "Technology can only be considered appropriate if it helps to lead to a change in the distribution of wealth and power". If our goal is truly to get at the root of human ills, must we not recognize that health projects and health workers are likewise appropriate only if they help bring about a healthier distribution of wealth and power?

[2] BLOEM, K. ET AL., ED. *Appropriate technology in health in developing countries, Washington, DC, December 1976.* Washington, DC, National Council for International Health, 1976.

Prevention

We say prevention is more important than cure. But how far are we willing to go? Consider diarrhoea. Each year millions of peasant children die of diarrhoea. We tend to agree that most of these deaths could be prevented. Yet diarrhoea remains the number one killer of infants in Latin America and much of the developing world. Does this mean our so-called "preventive" measures are merely palliative? At what point in the chain of causes which makes death from diarrhoea a global problem are we coming to grips with the real underlying cause? Do we do it:

— by preventing some deaths through treatment of diarrhoea?
— by trying to interrupt the infectious cycle through construction of latrines and water systems?
— by reducing high risk from diarrhoea through better nutrition?
— by curbing land tenure inequities through land reform?

Land reform comes closest to the real problem. But the peasantry are oppressed by far more inequities than those of land tenure. Both causing and perpetuating these crushing inequities looms the existing power structure: local, national, foreign and multinational. It includes political, commercial and religious power groups as well as the legal profession and the medical Establishment. In short it includes . . . ourselves. As the ultimate link in the causal chain which leads from the hungry child with diarrhoea to the legalized inequities of those in power, we come face to face with the tragic flaw in our otherwise human nature—namely, greed.

Where, then, should prevention begin? Beyond doubt, anything we can do to minimize the inequities perpetuated by the existing power structure will do far more to reduce high infant mortality than all our conventional preventive measures put together. We should, perhaps, carry on with our latrine-building rituals, nutrition centres and agricultural extension projects. But let's stop calling it prevention. We are still only treating symptoms. And unless we are very careful, we may even be making the underlying problem worse . . . through increasing dependency on outside aid, technology and control.

But this need not be the case. If the building of latrines brings people together and helps them look ahead, if a nutrition centre is built and run by the community and fosters self-reliance, and if agricultural extension, rather than imposing outside technology, encourages internal growth of the people towards more effective understanding and use of their land, their potential and their rights . . . then, and only then, do latrines, nutrition centres and so-called extension work begin to deal with the real causes of preventable sickness and death.

The Village Health Worker

This is where the village health worker comes in. It doesn't matter much if he spends more time treating diarrhoea than building latrines. Both are merely palliative in view of the larger problem. What matters is that he gets his people working together.

Yes, the most important role of the village health worker is preventive. But preventive in the fullest sense, in the sense that he helps put an end to oppressive inequities, in the sense that he helps his people, as individuals and as a community, liberate themselves, not only from outside exploitation and oppression, but from their own short-sightedness, futility and greed.

The chief role of the village health worker, at his best, is that of liberator. This does not mean he is a revolutionary (although he may be pushed into that position). His interest is the welfare of his people. And, as Latin America's blood-streaked history bears witness, revolution without evolution too often means trading one oppressive power group for another. Clearly, any viable answer to the abuses of man by man can only come through evolution, in all of us, towards human relations which are no longer founded on short-sighted self-interest, but rather on tolerance, sharing and compassion.

I know it sounds like I am dreaming. But the exciting thing in Latin America is that there already exist a few programmes that are actually working towards making these things happen — where health care for, and by, the people is important, but where the main role of the primary health worker is to assist in the humanization or, to use Paolo Freire's term, *conscientizacion* of his people.

Misconceptions

I shall try to clear up some common misconceptions. Many persons still tend to think of the primary health worker as a temporary second-best substitute for the doctor, that if it were financially feasible the peasantry would be better off with more doctors and fewer primary health workers. I disagree. After 12 years' working and learning from village health workers, and dealing with doctors, I have come to realize that the role of the village health worker is not only very distinct from that of the doctor, but, in terms of health and well-being of a given community, far more important (see Appendix).

You may notice I have shied away from calling the primary health worker an "auxiliary". Rather, I think of him as the primary member of the health team. Not only is he willing to work in the front line of health care, where the needs are greatest, but his job is more difficult than that of the average doctor. And his skills are more varied. Whereas the doctor can limit himself to diagnosis and treatment of individual "cases", the health worker's concern is not only for individuals, as people, but with the whole community. He must not only answer to his people's immediate needs, but he must also help them look ahead, and work together to overcome oppression and to stop sickness before it starts. His responsibility is to share, rather than hoard, his knowledge, not only because informed self-care is more health-conducing than ignorance and dependence but because the principle of sharing is basic to the well-being of man.

Perhaps the most important difference between the village health worker and the doctor is that the health worker's background and training, as well as his membership in, and selection by, the community, help reinforce his will to serve rather than bleed his people. This is not to say that the village health worker cannot become money-hungry and corrupt. After all, he is as human as the rest of us. It is simply to say that for the village health worker the privilege to grow fat off the illness and misfortune of his fellow man has still not become socially acceptable.

I may seem a little bitter, but when one has lived and shared the lot of Mexican villagers for 12 years, one cannot help but feel a little uncomfortable about the exploits of the medical profession. For example, Martin, the chief village medic and co-ordinator of the village-run health programme I helped to start, recently had to transport his brother to the big city for emergency surgery. His brother had been shot in the stomach. Now Martin, as a village health worker supported through the community, earns 1600 pesos ($80) a month, which is in line with what the other villagers earn. But the surgeon charged 20 000 pesos ($1000) for two hours of surgery. Martin is stuck with the bill. That means he has to forsake his position in the health programme and work for two months as a "wet-back" in the USA — in order to pay for two hours of the surgeon's time. Now, is that fair?

No, the village health worker, at his best, is neither chore-boy nor auxiliary, nor doctor's substitute. His commitment is not to assist the doctor but to help his people.

The day must come when we look at the primary health worker as the key member of the health team, and at the doctor as the auxiliary. The doctor, as a specialist in advanced curative technology, would be on call as needed by the primary health worker for referrals and advice. He would attend those 2–3% of illnesses that lie beyond the capacity of an informed people and their health worker, and he might even, under supportive supervision, help in the training of the primary health worker in that narrow area of health care called medicine.

Health care will only become equitable when the skills pyramid has been tipped on its side, so that the primary health worker takes the lead, and so that the doctor is on tap and not on top.

APPENDIX

COMPARISON OF THE MEDICAL DOCTOR AND THE PRIMARY HEALTH WORKER

The medical doctor described here is the typical Western-style MD, as produced by medical schools in Latin America. Clearly, there are exceptions. Most Latin American medical schools are beginning to modify their curricula to place greater emphasis on community health. However, not modifications but radical changes, both in selection and training, are needed if doctors are ever to become an integrated and fully positive part of a health team that serves all the people.

CONVENTIONAL DOCTOR	Village Health Worker (at his or her best)
Class background	
Usually upper middle class.	From the peasantry.
How chosen	
By medical school on basis of grade point average and socioeconomic status.	By community on basis of interest, compassion, knowledge of community.
Preparation	
Mainly institutional, 12–16 years' general schooling, 4–6 years' medical training. Training concentrates on physical and technological aspects of medicine and gives low priority to human, social and political aspects (now changing in some medical schools).	Mainly experiential; limited, key training appropriate to serve all people in a given community; diagnosis and treatment of important diseases; preventive medicine; community health; teaching skills; health care in terms of economic and social realities and of needs (felt and long-term) of both individuals and the community; humanization (*conscientización*) and group dynamics.
Qualifications	
Highly qualified to diagnose and treat individual cases. Especially qualified to manage uncommon and difficult diseases. Less qualified to deal effectively with most important diseases of most people in a given community. Poorly qualified to supervise and teach the village health worker (well qualified in clinical medicine but not in other more important aspects of health care, he tends to favour imbalance and to have the wrong priorities).	More qualified than doctor to deal effectively with the important sicknesses of most of the people. Non-academic qualifications are: intimate knowledge of the community and its language, customs, and attitudes to sickness and healing. Willing to work and earn at the level of the community, where the needs are greatest. Not qualified to diagnose and treat certain difficult and unusual problems; must refer.
Orientation	
Towards disease, treatment, and individual patient.	Towards health and the community. Seeks a balance between curative and preventive medicine (curative to meet felt needs, preventive to meet real needs).

Primary job interest	
The challenging and interesting cases (often bored by day-to-day problems).	Helping people resolve their biggest problems because he is their friend and neighbour.
Attitude towards the sick	
Superior; treats people as patients; turns people into "cases". Underestimates people's capacity for self-care.	On their level; treats patients as people. Mutual concern and interest because health worker is village-selected.
Attitude of the sick towards him	
Hold him in awe; blind trust (or sometimes distrust).	See him as a friend; trust him as a person, but feel free to question him.
How he uses his medical knowledge	
Hoards it. Delivers "services", discourages self-care, keeps patients helpless and dependent.	Shares it. Encourages informed self-care, helps the sick and their families to understand and manage problems.
Accessibility	
Often inaccessible, especially to poor. Preferential treatment of haves over have-nots. Does some charity work.	Very accessible. Lives right in village. Low charges for services. Treats everyone equally and as his equal.
Consideration of economic factors	
Overcharges. Expects disproportionately high earnings. Feels it is God-given right to live in luxury while others starve. Often prescribes unnecessary costly drugs. Overprescribes.	Reasonable charges. Takes the patient's economic position into account. Content (or resigned) to live at economic level of his people. Prescribes only useful drugs, considers cost, encourages effective home remedies.
Relative permanence	
At most spends 1–2 years in a rural area and then moves to the city.	A permanent member of the community.
Continuity of care	
Cannot follow up cases because he does not live in the isolated areas.	Visits his neighbours in their homes to ensure they get better and learn how not to get sick again.
Cost-effectiveness	
Too expensive ever to meet medical needs of the poor unless used as an auxiliary resource for problems not readily managed by village health worker.	Low cost of both training and practice. Higher effectiveness than doctor in coping with primary problems.
Resource requirements	
Hospital or health centre. Depends on expensive, hard-to-get equipment and a large subservient staff to work at full potential.	Works from home or simple structure. People are the main resource.

Present role	
On the top. Directs the health team. Manages all kinds of medical problems, easy or complex. Often overburdened with easily treated or preventable illness.	On the bottom. Often given minimal responsibility, especially in medicine. Regarded as an auxiliary (lackey) to the physician.
Impact on the community	
Relatively low (in part negative). Sustains class differences, mystification of medicine, dependency on expensive outside resources. Drains resources of poor.	Potentially high. Awakening of people to cope more effectively with health needs, human needs and ultimately human rights. Helps community to use resources more effectively.
Appropriate future role	
On tap (not on top). Would function as an auxiliary to the village health worker, helping to teach him more medical skills and attending referrals at his request (the 2–3% of cases that are beyond the village health worker's limits). He would be an equal member of the health team.	Would be recognized as the key member of the health team. Would assume leadership of health care activities in his village but rely on advice, support and referral assistance from the doctor when he needs it. He would be the doctor's equal (although his earnings would remain in line with those of his fellow villagers).

- END -