

Community health workers and the need for training in communication skills

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Over the past decade governments, international agencies, and private organizations have given increasing emphasis to the development of primary health care (PHC). But, despite their commitment, there seems to be little improvement in overall health standards. For example, one in four of the many children who die in tropical countries suffer the ravages of chronic diarrhoea. It is not a question of not knowing what to do. We very often do know what to do. In most cases the mother can minimize the effect of the disease by doing two things. First, she must recognize diarrhoea in time. Second, she must give a simple mixture of sugar and salt in water equal to the amount her child passes.

Why then are the figures not dropping? There may be many reasons for this. But perhaps the main reason is that we fail to communicate our ideas effectively to the community and the mother in particular.

The most important link in the communication chain in a PHC programme is likely to be the Community Health Worker (CHW).

"A villager's decision to consult with someone outside the family about a health problem is a critical and intimate one. This person should be an informed friend whose range of activity reaches as close as possible to the home so that services are readily available to the most vulnerable groups, especially mothers and children." (Taylor 1978)

The role of the CHW combines not only curative but also *preventive* and promotional aspects of health care. The CHW needs to be equally effective in all three if he is to have a lasting impact on the health of the community.

There is a lot of evidence that we can train CHWs to diagnose and administer treatment effectively for a limited range of illnesses and ailments. This requires little skill in communication. The patient comes to him or he goes to the patient. He questions the patient and, from the answers, makes a diagnosis

on which he bases his treatment. The CHW needs very little training to learn to ask the most appropriate questions for his diagnosis. This is the basis of the Tanzanian programme developed by Essex (1977).

If the CHW wishes to extend his role to prevention and promotion he will need to possess considerable skills in communicating effectively. In fact, his effectiveness as a CHW will largely depend on whether or not he possesses them.

In most countries governments tend to encourage local communities to select CHWs from among their members. He is then more likely to have the confidence of the people in his neighbourhood and he should also know how to communicate with his neighbours. However, he may well be a prisoner of the situation. The confidence of his neighbourhood in him may only extend to his role as a curer of ills. It may not cover the more sensitive political and social issues which are at the heart of promotional and preventive health care. Only a foolish CHW would interfere with issues which in his neighbour's eyes have nothing to do with a CHW.

The alternative is to appoint someone from outside, either from a nearby community or from further afield. This is likely to lead to more difficulties because the CHW is an outsider. The community is, therefore, more likely to restrict his role to cure and to prevent the CHW playing any part outside this role.

There may be other difficulties. The CHW may be too young or too old to give advice to others. As a man he may find it impossible to talk about "women's matters" and vice versa. Such considerations will tend to restrict him to treating sick people.

But if PHC is to succeed the CHW must be able to break out of these bonds. First, he must demonstrate his skills in diagnosing and treating sick people. His success will determine the degree of trust and confidence the community will have in him. Once he has proved himself he is in a position to extend his role. If he attempts this too soon he may well strike opposition or, worse, indifference.

How is he to extend his role to prevention and promotion? He is likely to have had the same opinions and values as the rest of his community. These are often in conflict with many of the concepts fundamental to PHC. If the CHW is to change the ideas of his neighbours he will have had to change his own ideas first. So the first step is the training of the CHW, and many PHC programmes have been successful in converting the CHW to new

ideas and approaches. But this is not enough. The CHW needs not only conviction in PHC methods but also training in communicating these ideas. An examination of a wide range of materials for the training of CHWs is not encouraging. The stress seems to lie almost entirely on the provision of material to teach the CHW about PHC methods. There is little or nothing about how to communicate these ideas to other people.

He is most likely to try to teach his neighbours in exactly the same way as he was taught. This may mean regurgitating passages of his training manual which he has learned by heart. This is particularly likely in those situations where rote learning is a major factor in the training programme.

What are the characteristics of this training material likely to be? Again from an examination of a number of training manuals the most noticeable characteristic is what I call "distancing". In this kind of writing the writer deliberately pushes the reader away from him in order to establish what is often called "scientific objectivity". At best, this style of writing enables a group of people with common interests, training, and experience to communicate with one another. At worst it is a method to exclude non-members of a "club".

The marks of this style of language are: 1. a specialized and often difficult vocabulary; 2. a deliberate use of non-personal forms, such as the passive, and impersonal forms; 3. considerable use of negatives and quasi-negatives; 4. long and complex sentences consisting of three and more ideas. A useful discussion of these issues, entitled *Simple English is Better English* by Dr Felicity Savage (1978) is available from TALC.

Research clearly indicates that language with these characteristics is difficult for most people to understand. In my opinion very few CHWs have had the opportunity of reaching the almost impossibly high standards which their training manuals demand, and the most difficult sections of the manuals deal with promotional and preventive aspects of PHC. The easiest to understand are those sections which deal with the curative aspects. Again the pressure seems to be on the CHW to concentrate on his role as curer.

Perhaps if the language of the training material were simpler the CHWs would find it easier to communicate with their neighbours. Simpler language would in any case also help those CHWs with poor educational backgrounds. Writers of these training manuals could improve them considerably by using simpler language.

Some manual writers have attempted to simplify in a variety of different ways. Some authors have introduced tables and diagrams in the hope that these will improve communication; but without appropriate training in the understanding of these symbols, a reader may have the same problems in interpretation as research has shown with pictures. They have used complex reference systems which require a high degree of training on the part of the reader in the use of the system. Sometimes, however, they have forgotten to include an index to the manual, so that the reader has no means of making references. The most popular form of simplification has been the slogan. But slogans, like posters, may oversimplify or distort a message, particularly if it is concerned with delicate social issues. *Kill flies because they carry disease* may be an admirable slogan, but without a clear understanding of the many implications of this message, effective action by the whole community may not be great.

In addition, the tone of the training manuals is often rather dictatorial. This may be appropriate for instructions such as how to make a diagnosis or what treatment to give, but an audience of villagers, experienced in the ways of the world and perhaps even cynical, may not appreciate the hectoring tone.

The majority of the local community in which CHWs work will probably be illiterate. They will be unfamiliar with the style of written language even if someone reads it aloud to them, apart from, possibly, a few religious works. The CHW may need to be able to transpose his training manual into colloquial spoken language without losing any meaning.

The very terms he has learned may cause immense difficulties. For example, the concept of diarrhoea is a biochemical one which scientists can measure and define, but this concept is one that many people, not only in the tropics but in Europe, have great difficulty in accepting. I have examined dictionaries of 45 different languages in the library of the School of Oriental and African Studies and in none of them is there a word for diarrhoea. There are words for stool and dysentery but not for diarrhoea. I have asked a number of people who speak some of these 45 languages to tell me what the term is for diarrhoea. In general, the term is a qualification of the word for stool. It is a stool that is watery or has a certain colour or has a peculiar smell. The definition depends on the comparison between normal texture, colour, or smell of a stool and something different. But how different? The comparisons can be extremely loose. This may

account for mothers failing to identify diarrhoea in time. The CHW may shout about the dangers of diarrhoea but the mothers of children suffering from diarrhoea may never know what he is talking about.

PHC is essentially a Western concept of health care and at its heart lies the relationship of scientific cause and effect. The well-trained CHW may understand and appreciate this relationship but many of his neighbours may not. They may not be able or willing to accept the relationship between diarrhoea and death or between poor standards of hygiene and nutrition and diarrhoea. Their view of life may run counter to those of the CHW. Unless the CHW knows what to do, his efforts may well reinforce his neighbours' prejudices and practices. He needs special training in overcoming local suspicions and converting people to better health care practices.

We have seen that most training programmes seem to lack any provision to develop the communication skills of CHWs. What would communication skills teaching material comprise? Because of costs involved in training, manuals are probably going to remain the most important form of material, but they will be books with a difference. They may be books written in the style of local colloquial speech and take the form of conversations or stories or songs. The CHW should be able to introduce these while he talks with his neighbours rather than at them. The material needs to be extensive and entertaining.

Does such material exist and is it effective? Two examples of effective communication along these lines have come to my notice. The first is from Nepal (World Council of Churches 1977). The majority of the inhabitants of Nepal are poor and illiterate farmers. One of the main aims of the authorities has been to improve farming practice. One of the most effective means has been a series of radio programmes called *The Junior Technical Assistant (JAT) and the Old Lady* (Dikshits 1979). Programmes last between 12 and 15 minutes and go out once a week. They consist of a series of conversations between an old lady and a young JAT and cover a wide range of issues related to improved

agriculture. These programmes are the most important source of information for farmers about better farming methods whether they own a radio set or not. The scripts are in simple colloquial language judging from their English translations. They are entertaining and humorous and they present the issues in a great variety of ways. From the research reports these programmes have been a major instrument in introducing new and improved farming methods in Nepal. There is no information about the use of these programmes as part of the training for JATs. But if the JATs had training in using the radio programmes or in using the contents of the radio programmes, their own effectiveness could be enhanced.

The second example is from Gazenlulu State, Northern Nigeria. Here the CHWs receive training in PHC methods through story telling, drama, mime, and dance. They return to their villages and use the same methods in communicating PHC to their neighbours.

The radio programmes from Nepal and the songs and stories from Nigeria could be the beginnings of collections of successful material. These and other similar materials could help developers in other places to produce effective local materials.

Until CHWs receive training in better communication, their impact on the prevention of disease and promotion of better health care may continue to be unsatisfactory. They need both training in how to communicate and also aids to help them communicate. This is the next step.

NOTE

I have written this article in Simple English, apart from the quotation. I hope that its style will not offend my readers.

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