CHAPTER 2

Selecting Health Workers, Instructors, and Advisers

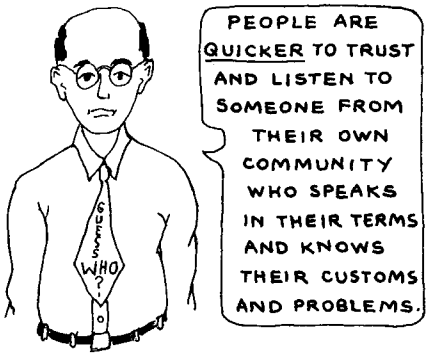
WHO MAKE THE BEST HEALTH WORKERS?

SHOULD HEALTH WORKERS BE FROM THE VILLAGE OR COMMUNITY WHERE THEY WORK?

Many health programs, large and small, agree that it is important for health workers to be selected from the communities where they will work. But their reasons differ:

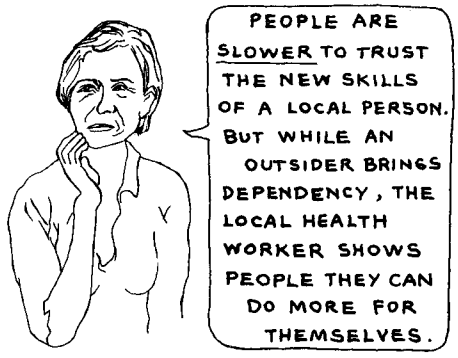
TWO EXPLANATIONS FOR WHY IT IS BETTER THAT HEALTH WORKERS BE FROM THE COMMUNITIES WHERE THEY WORK

The 'expert' with little community experience:



Theory has it that community health work is *easier* for the local person than for an outsider, because people know and trust him. And he knows the community.

Persons living and working in the community:



Experience shows that at first it is often *harder* for the local person. But in time, health workers from the community can do more to help build people's self-confidence and self-reliance.

There is an old saying: ***No one is a prophet in his own land.*** A villager complains, "What does Mary, the health worker, know? I remember her as a skinny little girl!"

Such distrust in their own health worker reflects people's lack of confidence in themselves: "How could one of **us** understand new ideas or master new skills?" This lack of self-confidence is especially great when it comes to health care. Most people believe that modern medicine requires mysterious knowledge that only "strangers better than ourselves" can master.

Some American Indian health workers in Arizona found it so hard to win the trust of people in their own villages that they traded jobs with health workers in distant villages. They found that as 'outsiders' they could command more immediate authority. People were quicker to follow their advice without question.

Similar 'swaps' have been made by health workers in several countries. And some of the larger health programs make it a point **not** to send health workers to work in their own communities.

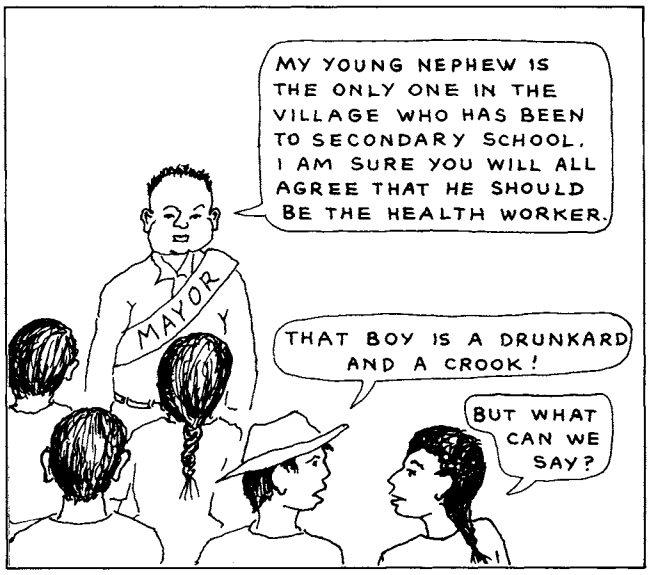
We feel this is a mistake. A stranger to a community, no matter how well he works, perpetuates dependency on outside help. **Only when a health worker is from the community can his example show "what we people in this village can do for ourselves."**

WHO SELECTS HEALTH WORKERS AND HOW?

Many programs feel that health workers should not only be **from the community** where they work, but that they should also be **selected by the community.** These are the reasons:

- If everyone takes part in the selection, chances are greater that the health worker will be well accepted.
- Participation in the selection process is a step toward greater responsibility and control by people over factors that affect their health.
- A health worker chosen by the community is more likely to feel that his or her first responsibility is to the community.

Problems with selection by the community



Problem: In many villages, the local headman, mayor, or a powerful landowner insists that one of his children or family members be chosen as health worker. Even if a public vote is taken, the poorer people may be afraid to suggest or vote for someone else. As a result, the health workers selected may represent the interests of those with land and power rather than those with greatest need. This is a problem reported from many countries.

Another problem: Sometimes villagers select a person who is very young, inexperienced, or irresponsible. This may be because people feel that "study is for the young." Also, older persons frequently have too many other responsibilities.

Part of the reason for poor choice of health workers, however, is that often the selection is made in a hurry, without enough critical discussion. Somebody suggests a friend, or someone he likes. Someone else suggests another friend, and a vote is taken. More often than not, the winner is the person for whom the first show of hands is called.

Still another problem: Many programs find that health workers with more than a primary school education are likely to leave their villages for better-paying jobs in the cities.

To avoid these and other problems, some community-based programs in the Philippines do not accept the following persons for health worker training:

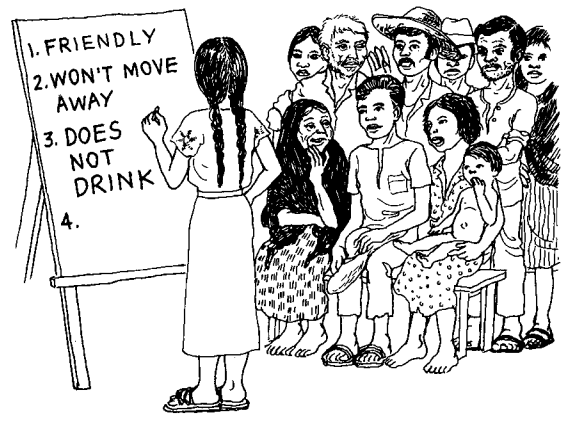
- close relatives of village leaders or officials
- young people and those likely to marry soon
- those with more than a primary school education
- those with many other responsibilities or official positions

In a similar way, a health program in Iran decided to exclude from health worker selection, family members of any village authority or large landholder. After this decision was made, villagers chose health workers who were more representative of the poor and more concerned with their needs.

Ways to help communities select wisely

Rather than deciding for the community what kinds of persons it should or should not select, it is often better to help the community decide wisely for itself. But this takes time and care.

For example, instructors from the villager-run health program in Ajoya, Mexico ride on muleback to mountain villages, spending a few days in each. Often they will make several visits, getting to know the people better. Then an all-village meeting is held. Women and children are encouraged to attend (instead of only men, as is customary). The instructors try to get an active discussion going: ***What are our health needs? Do we need our own health worker? What qualities should this person have?*** As the people make suggestions, these are written on large sheets of paper or a blackboard, and discussed further.



The people's list might include any combination of the following.

THIS LIST CONTAINS SUGGESTIONS FROM SEVERAL PROGRAMS.

We want a health worker who:

- is kind
- is responsible
- is honest and shows good judgement
- has a mature personality
- is interested in health and community work
- is humble; feels equal to and not superior to others
- will probably stay in the village (not move away)
- is accepted and respected by all the people, or at least by the poor
- has the full agreement and cooperation of his or her family
- can read and write (preferably)
- does not have more than a primary school education
- is eager to learn; open to new ideas
- is a good leader and organizer
- has healthy habits (does not smoke, does not drink too much)
- can draw, or is a good storyteller
- works well with mothers, children, and working people
- has a good record of taking part in or leading community activities
- has some experience in health care or healing (preferably)
- understands and respects people's beliefs and traditional practices
- identifies with and defends the interests of those in greatest need

The team in Ajoya feels it is important for the villagers to develop the list of qualities themselves, rather than to have a list handed to them. If, however, the people forget certain important qualities, the instructors may ask questions that help the people consider those points.

Only after the list of qualities has been developed and thoroughly discussed, are the people asked to suggest names of persons who might make good health workers. **If certain persons are known to dominate discussions or decisions, they are asked, politely, to remain silent** so that those who seldom speak can make their suggestions first. When necessary, the vote is taken by secret ballot.

In this way, selection of a health worker is the beginning of a process in which the poor find a voice and fairer representation. But all this takes time. In the Makapawa program in the Philippines, a team works in the village for at least 3 months, helping the poor organize and consider their needs before a health worker is selected.

A village health committee is often chosen at the same time. (See page **10**-3).

Other programs take different approaches to the selection of health workers. Some have requirements for age, sex, schooling, physical health, etc. Some give simple tests to check for such things as skill with one's hands. Generally, the more distant the headquarters, the more requirements are set in advance.

Joint selection by the community and program leaders

Some programs feel the best selection of health workers results from combining **the community's knowledge** of its people with **the program leaders' experience.** The village is asked to pick 3 or 4 'candidates'. From these, the instructors choose the one they think most suited—perhaps after testing their skills and attitudes.

PEOPLE WITH DISABILITIES AS HEALTH WORKERS

Some programs require that health workers be in "excellent physical health." Clearly, health workers should be free of contagious diseases such as untreated tuberculosis, and healthy enough to handle their responsibilities.

We have found, however, that **some of the best health workers are persons with serious physical disabilities;** polio, for instance, or an amputated arm or leg. Unable to do hard physical labor, they may find more time for health work and greater satisfaction in doing it. Because of their own problems, they also have more understanding for others who are ill or disabled. In some ways, their weakness becomes their strength. As health workers serving their community, they set an example for others who are disabled.

People with disabilities often make excellent health workers. Here a young man, himself disabled by juvenile arthritis, repairs braces for a child with polio. (Mexico-Project Piaxtla)

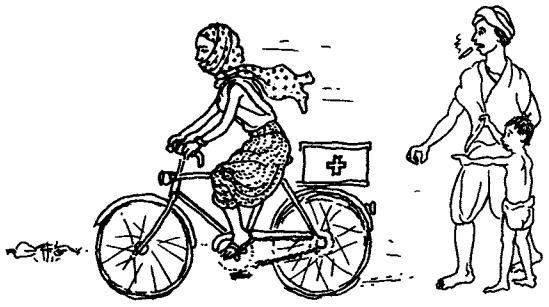
WHO MAKE BETTER HEALTH WORKERS—MEN OR WOMEN?

Some programs train only men as health workers. Others only women. Others train both.

Reasons often given for selecting <u>women</u> as health workers:

- Women and children make up ¾ of the population. Their health needs are especially great. And women usually prefer health workers who are women.
- Women have more experience in caring for children, and may be more tender.

- Women usually stay closer to the village, and so are more available when needed.
- Women often are more exploited and abused than men. Therefore their sympathies are more likely to lie with those who have less power and greater need. A health program in India states: "Women and children are the more vulnerable groups in the rural area, therefore a woman is best able to motivate and bring about change."*



Women health workers in Bangladesh ride bicycles, which only the men used to do. This is helping women gain more equal rights.

- "With women there is less fear of misuse or malpractice," states the same program from India. In many areas, women tend to be more responsible, and they drink less. They may also be more willing to work for the people, not the money.

Reasons often given for selecting men as health workers:

- Men often can move about more safely and freely than women. They can go alone or at night to a distant house or village to attend an emergency.
- Much of the work to improve health involves farming, water systems, latrine building, and other activities for which the help of men is needed. Men can perhaps be better led by a male leader.
- Where part of the health worker's job is to work toward social change, men are more likely to take action and to organize the people than are women. (This is not necessarily true. It is interesting to note, however, that in some countries where human rights are often violated, government-run health programs train mostly women health workers. In those same countries, community-based programs working for land rights and social change often train mostly men health workers.)

Some programs happen to train mostly men, others mostly women. Usually this is **not** because they feel one sex makes better health workers. In some places there are difficulties in recruiting either men or women. Men (especially young men) may be too 'proud' to consider training for 'nursing' work—especially if on a volunteer basis. In some areas, unmarried women may not be permitted to leave home to attend a training program. And married women may be unable to leave their children and their work, or their husbands may not let them.

Experience shows that **both women and men can make good health workers.** Often men are able to relate better to the health needs of men, and women to the needs of women and children. Some health programs resolve this difference by training both a man and a woman (sometimes a married couple) from each village.

*From ***Moving Closer to the Rural Poor,*** by the Mobile Orientation and Training Team, Indian Social Institute, New Delhi.

YOUNGER OR OLDER HEALTH WORKERS– WHICH WORK OUT BEST?

Although most health programs train health workers who are quite young, many find that **somewhat older or middle-aged persons often work out better.** Young people sometimes have more open minds (and may be easier to recruit), but they have more difficulty in winning people's confidence and cooperation. Also, younger persons may be less likely to stay in the village. Some programs find that unmarried girls are likely to get married and move away. Other programs find that young men often move to the cities or to migrant farm-working camps.

Older persons are usually more likely to remain in their communities, and to work with great dedication and responsibility. Also, people are more likely to respect and listen to them. But they may be more fixed, or even rigid, in their ideas. This can be both a strength and a problem.

In the experience of many programs, the most reliable age group is from about 25 to 40. When health workers are younger or older than that, more difficulties seem to arise. There are, of course, many exceptions. In Ajoya, Mexico, the present leaders of the program began as 'junior health workers' when they were 13 to 16 years old.

EDUCATIONAL LEVEL

Capable health workers have been trained from every educational level, from persons who cannot read to those with university or medical degrees. Each level presents special strengths and special problems.

Persons who cannot read and write often have unusually well-developed memories–sometimes far better than those of us who depend on writing things down. But to train health workers who cannot read and write calls for somewhat different educational methods. Few instructors have been taught these methods, but they can learn them with the help of the students.

In most programs, the average education level of community health workers is from 3 to 6 years of primary school. Yet some programs make 6 years of primary school a minimum requirement. Others require completion of secondary school.

Education requirements sometimes give rise to problems. For example, in Guatemala, a government training program for 'health technicians' in the highland Indian communities started with two requirements: 1) Applicants must speak a native Indian language as well as Spanish. 2) They must have completed secondary school. However, it turned out that very few native language speakers had finished secondary school. One of the two requirements had to be dropped.

Unfortunately, the language requirement was dropped and the education requirement kept. This meant that almost all the health technicians trained were of Spanish *(Ladino)* origin. They neither spoke the local languages nor represented the people where they were to work. As a result, the program has had many difficulties.

As we have already mentioned, persons who have completed secondary school often do not make as good health workers as those with less schooling. Their education seems to separate them from the majority of their people. Many are more interested in getting 'higher education' or 'better jobs' in the city. They are more likely to abandon their people.

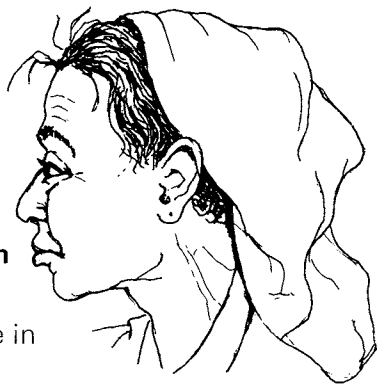
Also, as we discussed in Chapter 1, persons with much formal education may have an extra burden of unhealthy values. They need to unlearn and relearn a great deal in order to become effective community health workers.

By contrast, persons with less formal education tend to feel themselves more in harmony with, and equal to, the poor majority. They may be more ready to commit themselves to community health work.

Persons with only a few years of schooling often make more reliable, more community-strengthening health workers than those who have had more formal education.

Once again, of course, there are exceptions.

TRADITIONAL HEALERS AND MIDWIVES AS HEALTH WORKERS



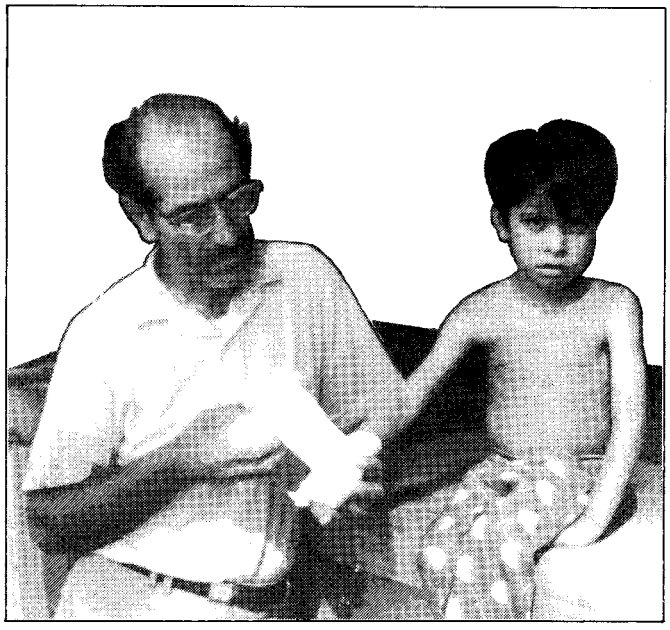
Many programs have trained traditional healers, herbalists, bone setters, and traditional midwives as village health workers—often with good results.

Advantages to training traditional healers as health workers:

- They already have the confidence of the people in their own special area of health care.
- They have a strong grounding in traditional and spiritual forms of care and healing. To these they can add concepts of modern health care and medicine. Often the combination of the old and the new, unique to the area, is better than either way by itself.
- They are usually persons with great experience and strong beliefs. So they may be more able to defend their people's culture and resist the use of foreign ideas and technologies not suited to local needs.
- They are often persons firmly rooted in their communities and deeply committed to serving people in need. (But be careful. Some traditional healers use their special knowledge to exploit or gain power over others.)

Difficulties in training traditional healers as health workers:

Traditional healers often are **very set in their ways.** Like modern medicine, traditional medicine includes many practices that are helpful, others that are useless, and some that are harmful. Traditional healers, like many modern doctors, may be reluctant to examine critically the practices they have always followed. They may be unwilling to omit or change harmful but profitable practices. (These may include the misuse or overuse of certain modern medicines, sometimes combined with herbal medicines.)



This 'herb doctor' was chosen by his village to train as a health worker. His art of healing adds much to the science of health care. Today, he combines aspects of modern and folk medicine. (Mexico)

A common difficulty with traditional healers relates to their approach to problem solving. **Most traditional healers rely, to a large extent, on the psychological 'power of suggestion'.** This is a very important part of the healing process as they know it. The traditional healer convinces the sick person and his family that he or she knows immediately just what the illness is, what caused it, and how to treat it. This immediate and absolute certainty is a key to traditional healing.

But the science of modern medicine calls for just the opposite approach. **The scientific healer begins with doubt, not certainty.** He starts by asking questions, collecting related information, and systematically considering and testing possibilities (see Ch. 17).

It is often difficult for persons used to traditional healing to learn the more scientific approach. As established healers, they may find it especially difficult to ask for advice or suggestions, or to admit when they have trouble diagnosing an illness.

An instructor who is unaware of all this, may treat these persons as if they were ignorant or dishonest. This makes it more difficult for both to admit their doubts or mistakes. In our own experience, however, we have found that when an instructor understands and appreciates the local forms of healing, most misunderstandings with traditional healers can be avoided. When this is so . . .

Traditional healers can become some of the most capable and dedicated primary care workers.

PERSONAL QUALITIES, ATTITUDES, AND CONCERNS

Of far more importance than age, sex, experience, education, and even place of origin, are a health worker's personal qualities—his or her understanding of people and their needs. It is essential that the health worker identify with the poor and have a strong sense of fairness and social justice. To some extent, these attitudes can grow and develop during training. But the seeds need to be there already. People's attitudes are far more easily strengthened than changed.

Perhaps the most important quality to look for when selecting a community health worker is the person's concern for social justice.

Does he treat other people as his equals?

Is his first concern for those in greatest need?

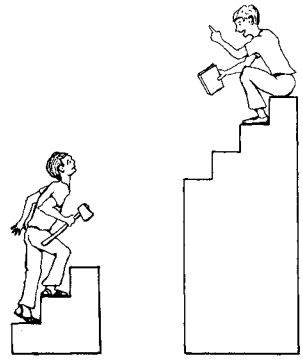
This is a scene from a 'Farmworkers' Theater' production in Ajoya, Mexico. It was presented to help villagers recognize the differences between a good health worker and the typical doctor.

WHO MAKE THE BEST TEACHERS OF VILLAGE HEALTH WORKERS?

Selection of appropriate instructors is just as important as selection of the health workers themselves. **Instructors provide the example or 'role model' for teaching and learning** that health workers follow when they return to their communities.

If the instructor bosses and 'talks down' to students, the students, in turn, will be more likely to 'talk down' and act superior to others when they become village health workers. But if the instructor relates to the students as his equals, building on strengths and knowledge that they already have, then the health workers will be more likely to work with their people in a similar way.

THE EDUCATION GAP



A common problem: Instructors often have a very different social and educational background from that of the health workers they teach. They may be doctors, nurses, social workers, or health officers who have grown up in cities and have had far more formal education. They can easily lose touch—if they ever were in touch—with the wisdom, hardships, strengths, and weaknesses of people who still live close to the land, the seasons, and physical work.

The knowledge of highly educated persons is not necessarily ***better*** than that of most of us, but it is ***different.*** It is as difficult for the doctor to speak in the basic, clear, colorful language of the villager, as it is for the villager to understand the long Latin words of the doctor.

This wide separation between instructor and students is called an 'education gap'. When the 'gap' is too wide, it is often difficult to bridge. So teacher and students never really come to know, appreciate, or learn very much from each other.

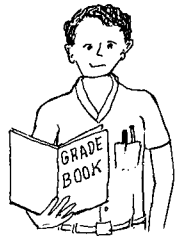
Many kinds of professionals have served as trainers of health workers:

- doctors
- senior medical students
- nurses
- paramedics
- intermediate-level health workers
- public health graduates (often foreigners)
- social workers
- school teachers
- teaching teams made up of doctors, nurses, anthropologists, social workers, agricultural extension officers, and foreign experts

Little study has been done to compare the strengths and weaknesses of these different professionals as health worker trainers. But here are some common impressions:

Doctors. As a general rule, doctors make poor instructors of health workers. Their curative, hospital-based training does not prepare them to look at the needs of a whole community. Attitudes are also a problem. Doctors have a tendency to take charge, to regard themselves as decision-makers even in areas they know little about. Feeling that even simple diagnosis and treatment are 'risky' without years of medical school, they often limit teaching of curative medicine to a few minor chores. This severely weakens the role of health workers in the community. Yet the courses doctors teach usually include a deadly overdose of anatomy, with countless Latin names. This gives the health worker a magic vocabulary with which to confuse and impress the people in his community.

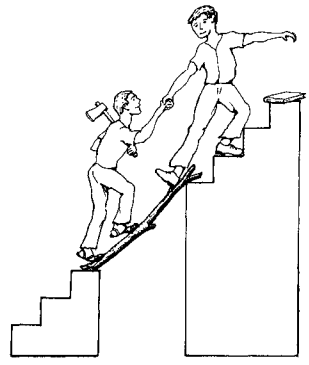
Nurses. Some nurses make excellent instructors of health workers. But such nurses are exceptional. The nurses' job has traditionally been to take orders without question, and to clean up after the doctors. They are given little decision-making responsibility. So it is not surprising that, when nurses instruct village health workers, they place strong emphasis on unquestioning obedience, filling out forms, and functioning as errand boys or girls. As they have been dominated and undervalued, they tend to do the same with health workers. For a nurse to effectively prepare health workers as leaders of social change, she must be a true rebel. Fortunately, many such nurses exist! Unfortunately, they are rarely chosen as instructors.



School teachers. In Honduras, some young school teachers have proved to be surprisingly good instructors of village health workers. These teachers are given 2 or 3 months of special training in community development and primary care activities. Then they are sent to teach and work with village health workers. The young teachers are far more willing to go to remote villages than are nurses or doctors. They also are able to relate well to the health workers and local people. Having a limited background in health, they do not set themselves up as 'authorities'. Rather, they explore and learn with others about approaches to solving different health problems. This puts them on a more equal footing with students and villagers. It seems that, in some circumstances at least, **teaching skills may be more important than an extensive background in medicine and health care.**

Bridging the education gap

If, as an instructor, you find you are separated from your students by a wide social and educational gap, there are things you may be able to do to help bridge it:



1. **Admit openly to your students that the gap exists**—and that the shortcoming is yours as much as theirs. Invite your students to discuss and look for ways of bridging the gap together.

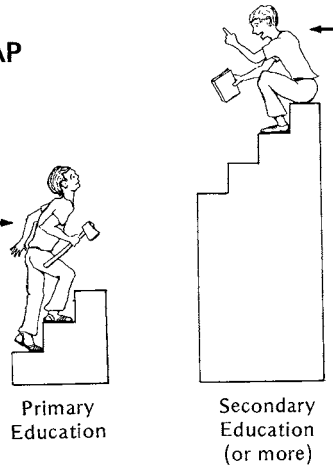
2. Do whatever you can to **understand in a personal way the life, language, customs, and needs of your students and their communities.** Live, if you can, with one of the poorer families in the community (paying your way). Eat their food. Drink their water. Help each day with some of the physical or farm work. Accept no more income than an average member of the community earns. (This is only a suggestion—but a good one.)

3. If you are from out of the area, or are specialized in a narrow field of health care (like medicine), **try not to be the main teacher,** but rather a teaching assistant or auxiliary. (The main teacher will need a wide range of skills and knowledge, including, above all, teaching skills and inside knowledge of the local people. He or she needs personal understanding of what it is like to approach learning new things without much formal education.)

4. When teaching, make every effort to **always begin with the knowledge and skills the health workers already have, and help them build on these.** You are the stranger, so try to adapt your language to theirs; don't make them adapt to yours. If they are used to learning from stories or from actually doing things, rather than from lectures and books, try to adapt to their way of learning—even if this means exploring forms of teaching and learning that are new to you.

5. Most important! **Make yourself as unnecessary as possible, as soon as possible.** Look for local persons who are socially more qualified (less schooled, more in harmony with the people) to take over the training. Work toward having more experienced village health workers become the teachers of new village health workers as soon as possible. Every chance you get, move one step further into the background. Become the teacher of teachers. Then, just an adviser or 'person with ideas'. Then leave.

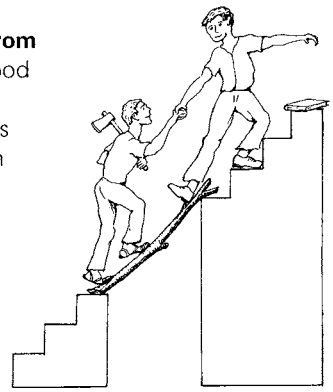
BRIDGING THE EDUCATION GAP



and you try to teach him from this level,

you will be talking over his head. You will bore him and, in time, lose him. You will make him feel stupid and he may hate you for it—because he is not stupid. There are probably many things he can do much better than you can, and many important things he knows that you do not.

If you try to **learn from him,** and to make good use of the language, knowledge, and skills he already has, often you can help him bridge the gap to learning new skills.



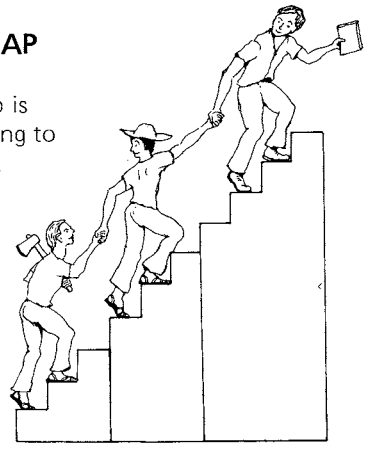
There are many shortcuts to increasing the student's skill and understanding: teaching aids, problem solving, role playing, learning by doing, etc. But it is important to begin with the skills and understanding the person already has.

Go more than halfway to meet him.

Start with the knowledge and skills a person already has—and help him build on these.

CLOSING THE GAP

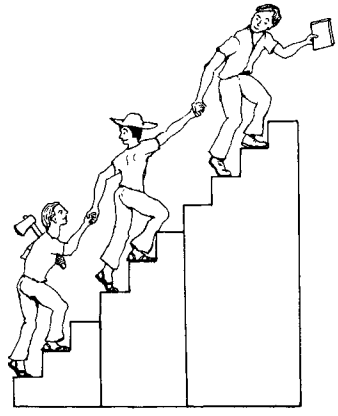
If the educational gap is wide, better than trying to bridge it is to close it. Work toward training community persons who are closer to the educational level of the students, so they can take over most or all of the teaching.



The sooner a local health worker can be trained to take over the teaching of new health workers, the better. Then training is more likely to be appropriate and helpful.

If you are an outsider, **work toward making yourself as unnecessary as possible, as soon as possible.**

Closing the education gap: community persons as instructors



When there is a wide 'education gap' between instructor and students, try, instead of bridging it, to close it or avoid it. This means trying to find or prepare instructors who:

- are from the same immediate area as the health workers-in-training
- speak the local language
- have the same cultural and social background (a farmer, worker, father, mother, etc.)
- have had more or less the same amount of formal education as those they teach (although they may have had far more experience or training in health care at the community level)
- dress, act, speak, and feel as equals to the students and villagers

It is important that instructors be culturally close to the students. But they also need enough basic knowledge and skills (in health care, in problem solving, and in teaching) to help students learn effectively. At first it may be difficult to find local persons with this combination of culture and skills. During the first few years, 'outside' instructors may be needed. But their first responsibility should be to **prepare local people to take over most or all of the instruction.** The more outstanding and experienced health workers are often the best ones for the job.

CAN LOCAL PERSONS BECOME EFFECTIVE INSTRUCTORS OF HEALTH WORKERS?

Health professionals may be skeptical (doubtful) about whether villagers can make effective instructors. But community-based programs in many countries have found that:

Experienced village health workers—with appropriate preparation, back-up, and friendly criticism from the learning group—can make excellent instructors.

Just as with doctors and nurses, villagers who make good instructors are exceptional. The challenge is to find persons with the right combination of attitudes, interests, and talents, and then to create the situation that permits and helps them to grow.

STRENGTHS AND WEAKNESSES OF VILLAGE-LEVEL INSTRUCTORS

A story:

When a training program is taught and run by village-level instructors, certain problems and obstacles are avoided. But others commonly arise. Once, when we were observing a training course taught by villagers, a visiting nurse was present. Herself a trainer of health auxiliaries in a neighboring program, she was highly critical of the way the village-level instructors conducted the course:

TOO INFORMAL.
CLASSES DO NOT BEGIN ON TIME.
INSTRUCTORS SLOPPILY DRESSED.
THEY USE VULGAR EXPRESSIONS.
MISSPELLED WORDS.

INCOMPLETE COVERAGE OF MATERIAL.
FREQUENT STRAYING FROM THE TOPIC BEING TAUGHT.
TOO MUCH NOISE AND LAUGHTER.
INACCURATE INFORMATION.

After listening to her many complaints, the village instructors invited the nurse to give a class to show them how to do it better. They suggested a class on "The Human Body and How It Works."

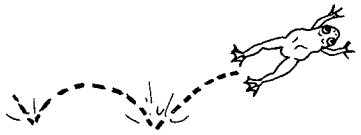
So the visiting nurse presented a class on "Anatomy and Physiology." It was carefully timed: 40 minutes of lecture with 10 minutes for questions at the end. She briefly and expertly covered each of the body systems, naming the major organs and stating their functions. When she finished, she asked one of the health workers if he had understood. He slowly shook his head. "I didn't understand beans!" She called on student after student to see what they had learned. But with the exception of two who had studied in secondary school, her lecture had gone completely over their heads. One of the village instructors had made a list of over 60 words she had used, which no one understood. He asked her to explain some of the words. But each time she tried, she used 2 or 3 more words that nobody understood.

The students then asked if the nurse would be willing to give the class over again, but more simply. The nurse admitted she didn't think she could. She asked one of the village instructors to do it for her.

The next day, one of the local instructors led a discussion about "The Body and How it Works" (not "Anatomy and Physiology"). Rather than lecturing, he started by holding up a box. He challenged the students to ask as many questions as they could in order to find out whether the box contained something living or not. They asked questions like:

DOES IT GROW?
DOES IT BREATHE?
DOES IT MOVE BY ITSELF?
DOES IT NEED WATER AND FOOD?
DOES IT PEE AND SHIT?
CAN IT MAKE BABIES OR SEEDS?

The instructor wrote the questions on the blackboard and then opened the box. Out jumped a frog!



Next, the instructor asked how we, as people, also do each of the things listed on the blackboard. He started with what the class knew about the body, and built on that, asking questions like:

WHAT BECOMES OF THE FOOD WE EAT?
WHAT HAPPENS TO US WHEN WE DON'T GET ENOUGH FOOD?

At one point, he asked two of the students to run fast around the building, and had the group observe them and take their pulse. Then he asked:

WHY DO WE SWEAT, BREATHE HARD, AND HAVE A FAST PULSE WHEN WE RUN OR DO HARD WORK?

WHAT IS THE PURPOSE OF THE HEART AND LUNGS?

After the group had given their ideas (which were mostly correct), he asked:

WHY DO PEOPLE WHO ARE VERY PALE GET TIRED MORE QUICKLY?

WHAT IS THE PURPOSE OF BLOOD?

He spoke in the people's language, using the village names for different parts of the body: 'guts' for intestines and 'belly' for abdomen.

In this way, the students themselves were able to piece together many of the different systems of the body and their functions. It was like solving a mystery or putting together a puzzle. The students loved it. And everyone understood. The class was noisy and went overtime, but no one objected—this time not even the nurse!

Of course, some of the body systems were forgotten, and others were barely mentioned.

"There is a lot more to the body than we have talked about today," explained the group leader at the close of the class. "But we will talk about other parts of the body and how they work when we need to, to understand about particular health problems as they come up." (See p. **5**-11.)

By the time the visiting nurse left, she had changed her mind—and said so. She had seen that, in spite of certain inaccuracies and shortcomings of the teaching, the students had learned more and taken a more active part in the classes taught by their fellow villagers!

Not all the credit is due, of course, to the fact that the instructors were villagers themselves. Much of the difference was in the teaching methods they used. But **the technique of building on the students' own knowledge and experience is often easier for a local person who shares a common background.**

In Project Piaxtla in Mexico, we (the authors) and other outsiders used to do most of the teaching for the health worker training courses. Then, several years ago, the local health team (made up entirely of experienced village health workers) took charge of the training. The first year that the course was taught by the village team only, 3 students were present who had taken previous courses taught by outsiders. When asked which course they thought better and more appropriate, all 3 agreed, "This one, taught by the village health workers." Their reasons:

EASIER TO UNDERSTAND.

THE INSTRUCTORS SEEM TO KNOW JUST HOW SLOW OR FAST TO GO TO BE SURE WE UNDERSTAND BUT DON'T GET BORED.

WE FEEL MORE COMFORTABLE WITH THE TEACHERS WHO ARE OUR OWN PEOPLE. IT MAKES LEARNING EASIER. IF THEY CAN UNDERSTAND SOMETHING, WE KNOW WE CAN, TOO!

'TRAINING ORGANIZERS' OR 'BACK-UP PERSONS'

Supportive back-up (supervision) can be as important for instructors as for health workers. This is true for instructors who are doctors and nurses, as well as for village-level instructors. **We all can benefit when someone with more experience, or a different perspective, observes our teaching and makes helpful suggestions.**

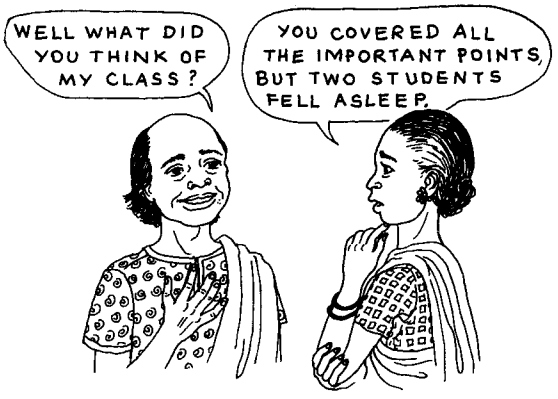
The person who provides this sort of support and suggestions can be called a 'back-up person', 'advisor', or 'training organizer'. Since her main goal is to help people meet their needs, the training adviser should not only be an experienced health worker, but should also sympathize and identify with the poor.

The role of the training organizer in a health worker training program in Bangladesh has been described as follows:*

"The 'Training Organizer' will sit in the class, quietly and discreetly at the back, and then review the class with the teacher afterwards, with emphasis on points like:

- Did the message get across clearly?
- Did the trainees have an active or passive role in the class?
- Were visual aids used effectively?
- How many of the trainees fell asleep before the end of the class?

"The 'Training Organizer' will review some of the above points with the trainees as well as the teacher."



Village health workers can make excellent instructors. But at first they often lack basic teaching skills and experience in course planning. It is here that the training organizer can help. But it is essential that he or she be willing to stay in the background and let the community-based instructors assume full responsibility. Once again:

Advise, don't boss!

To emphasize the secondary role of this advisor, 'training assistant' might be a better term than 'training organizer'. To move into this back-up role is a natural step for the outside professional or foreigner who has been active as an instructor early in the program. It allows the outside person to begin phasing herself out, to pass teaching and organizing responsibilities to local workers. In time, outstanding local instructors (who started off as community health workers) may likewise be able to take over the role of 'training assistant'. In this way, the outsider moves one more step into the background. The sooner she is not needed, the more successful she has been.

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* From a personal communication with Martin Schweiger, Medical Adviser/Administrator, Rangput Dinajpur Rehabilitation Service Program, Lalmanirhat-Rangpur, Bangladesh.