COMMUNITY HEALTH WORKER TRAINING: LINKING PEDAGOGY AND PRACTICE

Workshop Report

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CONTENTS

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The Workshop

There is a significant body of experience and evidence, gathered over 30 years of experimentation, which demonstrates the potential of community-based health workers (CHWs) as one of the most cost-effective strategies to improve a range of primary health and nutrition outcomes.[1] These workers or volunteers, predominantly local women, if sensitively selected, trained and supported can act as agents of health-related information and function as links between resource-constrained primary health systems and the unreached communities that need their services.[2] India has had a long history of innovation in the area of community health workers, with civil society organisations having pioneered the development of successful community health worker models in different parts of the country, which have been proved to be successes in achieving desired impact on health, albeit with limited population and geographical reach. The CHWs in these programmes have largely been conceptualised to improve utilisation of the existing public health care services and also undertake advocacy for equitable access to effective health services, as well as to provide a measure of knowledge on health and nutritional issues, preventive and referral guidance and in the long term organise the community, especially women and weaker sections around health care issues.[3] While civil society groups have shown consistent successes of community health worker programmes in achieving better maternal and child health outcomes, those undertaken by the state at scale have shown mixed results.

The current context represents the innovations undertaken in CHW training in the past thirty years and the current opportunities presented by the National Rural Health Mission (NRHM),[4] 2005-2012, and its core strategy of the Accredited Social Health Activist (ASHA) – a trained community based change agent at a 1000 population level, to catalyse a sustainable community-owned process for behavioural change and to facilitate access to basic health services by the poor.[5] Given this context there is a sectoral interest in consolidating learnings from CHW training experiences and the implications for sustainability and performance in scaled processes. Though a large amount of work has been undertaken by different groups in this area, a need exists to understand in depth the critical aspects important for conceptualising and implementing effective and innovative training for CHWs.

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1 For a review of the effectiveness of different CHW programmes in Africa, see Lehmann, Uta et al, "Review of the Utilisation and Effectiveness of Community Health Workers in Africa" Joint Learning Initiative (2004). In the context of Asia, especially Thailand's experience in improving maternal and child nutrition, see Tontisirin, Kraisid and Gillespie, Stuart, "Linking Community Based Programmes and Service Delivery for Improving Maternal and Child Nutrition" in *Asian Development Review*, vol. 17, nos. 1,2, pp 33-65 (1999).

2 Pratinidhi, A. et al. 1986. "Risk-Approach Strategy in Neonatal Care." *Bulletin of the World Health Organisation* 64 (2): 291- 97; Datta, N.V. et al. 1987. "Application of Case Management to the Control of Acute Respiratory Infections in Low Birth weight Infants: A Feasibility Study." *Bulletin of the World Health Organisation* 65 (1): 77- 82; Daga,S.R. et al. 1992. "Rural Neonatal Care: Dahanu Experience." *Indian Paediatrics* 29 (2): 189- 93; Bang, A.T. et al. 1999. "Effect of Home-Based Neonatal Care and Management of Sepsis on Neonatal Mortality: Field Trial in Rural India." *The Lancet* 354 (9449): 1955-61.

3 Mander, H. 2005. "People's Health in People's Hands?: A Review of Debates and Experiences of Community Health in India" CEDPA: Delhi; Patnaik B. "The Mitanin Programme :A presentation at the Additional Health Worker Workshop", Social Initiatives Group, ICICI Bank, March 2003.

4 Ministry of Health and Family Welfare, Government of India, 2005.

5 Ibid.

An analysis and understanding of the various CHW programmes across the country, initiated by different groups at different levels of scale, have highlighted the role of training of CHWs as a critical factor contributing to the success or failure of the CHW programme and its impact on the health outcomes of a community. Within the paradigms of sustainability and processual quality of CHW initiatives, training acts as the foundation for any programme, irrespective of scale and orientation. Although training is only one element in the implementation of a CHW programme, it is the element that, through its pedagogy and methodology must reflect the underlying philosophies of the programme as a whole. Various CHW initiatives have undertaken the creation of innovative, engaging and contexualised content and methods for training CHWs. It is within the training component that the quality of the CHW's work, her credibility, her interest, her communication skills, and her confidence gets established.[6]

In an attempt to address this issue of training in CHW programmes – learning from innovations in CHW training in various contexts and operationalising these at scale in the context of the NRHM., the Foundation for Research in Community Health (FRCH) and the Social Initiatives Group (SIG) at ICICI Bank had organised a National Workshop on Community Health Worker Training: Linking Pedagogy and Practice during April 10 - 12, 2006 in Pune.[7]

The workshop represented an effort after almost a decade to bring together a diverse group of individuals with an aim to initiate sectoral dialogue and action on community health worker (CHW) training, and sustain it through a network of resource and research organisations. Located within the current context of the NRHM and the ASHA, the workshop aimed to share and consolidate innovations and learnings in community health worker training across programmes over the last three decades; discuss and develop initiatives to mainstream these innovations and learnings to extend coverage and enhance quality of community health worker training; and to initiate a dialogue and create networks between various health worker training programmes, and between civil society groups and the NRHM.

The workshop brought together representatives from the central government and from the states of Jharkhand, Chhattisgarh, Rajasthan and Nagaland; civil society representatives and practitioners from more than fifteen different groups and programmes in various parts of the country; academics from international and national universities; and media persons to share experiences of and perspectives on content and methodology of training community health workers.[8] It represented a vibrant forum for sharing and consolidating innovations and learnings in community health worker training across programmes over the last three decades, discussing and developing initiatives to mainstream these innovations and learnings to extend coverage and enhance quality of community health worker training, and initiating dialogue and creating networks between various health worker training programmes, and between civil society groups and the NRHM.

Community Health Worker Training - An Introduction

Training is an extremely critical component of CHW programmes. It marks the trend for its performance, credibility and eventual sustainability. Whether the programme is at scale or at the level of small programmatic intervention, its quality, character and impact is reflected through training - as the medium through which ideology and objectives of the programme get instilled and transferred to all cadres of personnel, and in determining the role of the CHW by

[6] In the Mitanin Programme, a general trend of enhanced self confidence was observed in the women who had undergone all the rounds of training.

[7] See Annexure 1: Workshop Programme

[8] See Annexure 2: List of Participants

building her knowledge and skills in specific areas. Training of CHWs have been identified as a significant factor contributing to the success or failure of a CHW programme and its impact on the health outcomes of a community. Access to basic training has been found to be a fundamental need of CHWs, and improving access to training is an important element of improving retention. Despite the importance of CHWs and the need and relevance of training, the challenges of providing them with high-quality training opportunities remain. Strong and effective community health worker programmes have drawn their impact centrally from a strong training component[9], conceived and delivered in them. A large body of work exists and has been undertaken, where CHW training has been conceptualised as a form of education for participation, empowerment and action for change[10]. The rich discussions in the workshop contributed to this discourse on CHW training, in its various innovative forms, contexts, and scales.

Locating Community Health Workers in the Larger Context

One of the issues that was highlighted foremost in the workshop was to locate CHW programmes, and the aspect of training within them, in the larger context of globalisation and the macrosystemic environment of debt and structural adjustment policies that exacerbate inequities both within and between countries in all dimensions of development, including health. Globalisation can be described as a process of integration within the world economy through movement of goods and services, capital, technology and labour, which lead to economic decisions being influenced by global conditions.[11] Although globalisation is not a new phenomenon, its present day form is characterised by the debt crisis and consequent deepening of poverty and inequity. The current global health crisis in the world reflects these widening inequalities within and between countries. As income inequities have increased, advances in science and technology are securing better health and longer lives for a small fraction of the world's population, while the poor and the vulnerable continue to die of preventable diseases.

In his presentation, Dr. N.H. Antia highlighted that while there is an abundance of funds and expertise to solve these problems, the predominance of neo-liberal economics and a culture of materialism has led institutions that were established to promote social justice into imposing policies and practices that achieve just the opposite. The discussions indicated the global debt crisis and the medicalisation of health as significant social, economic and political determinants of negative health outcomes, especially for the poor and vulnerable. Dr. Antia reiterated the need for valuing traditional health related knowledge of communities over western systems of medicine, and for empowering communities to assert their rights, challenge policies and present alternatives related to their health and development.

The close interrelationship between health and other vulnerabilities pronounced by poverty was detailed by Dr. Parvez Imam's film "*Grassroots Realties"* that captured the socio-political experiences of CHW programmes in various parts of the country, and analysed the impact of community mobilisation around health on related social, economic and political indicators. Being selected and trained in health – an area which is traditionally mystified and exclusive –

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[9] Small scale successful CHW programmes, such as Gadchiroli have had intensive training undertaken by the programme initiators and staff trained by them. Even from international experiences such as

[10] Werner D., *Communication as if People Mattered: Adapting health promotion and social action to the global imbalances of the 21st Century*. Background Paper #5, for the People's Health Assembly, December, 2002.

[11] Jenkins, R. 2004. Globalisation, production, employment and poverty: debates and evidence. *Journal of International Development,* 16:1-12

have succeeded to instill confidence and a sense of agency and self efficacy in the CHWs from various programmes. This is illustrated by experiences of trained rural CHWs opposing injustice and inequity, initiating action against domestic violence and alcoholism in their communities, and rising against the state for preservation of forests to protect their sources of livelihoods.

Professor David Sanders, in his introductory key note address, traced the international history of CHWs and the emphasis on people's participation in ensuring basic health of communities in the current context of globalisation. Over the past decades the developing countries have seen many improvements in population health indicators such as infant mortality rate, crude birth and death rates and life expectancies, however, certain other indicators such as neonatal mortality, maternal morbidities and mortalities, and undernutrition have seen significant deterioration. Although aggregate data hides intra-national, interregional and inter group inequalities, closer examination shows that urban-rural and gender related health inequalities have increased significantly even in developed economies, indicating differential access to health services. One of the primary factors contributing to these inequalities is the decreasing state budgetary allocations towards health, and resulting increase in private or out-of pocket expenditures. Predictably the quality of public health services is low and deteriorating, predisposing the poor to increased health vulnerabilities. Given these realities, the need for primary health care through strengthened community based and systemic interventions has assumed utmost importance. It is in this context that CHW programmes have been conceptualised as agents for realising the right to health for the poor, and have been positioned within global economic, social and political processes, which in turn determine the characteristics and efficiency of these programmes.

History of CHW Programmes and Experiences

The genealogy of community health in the country can be traced back to the Health Survey and Development Committee Report (1946) by Dr. Joseph Bhore that recognised the need for health outreach to increase coverage of health services and facilities to the rural poor. Given the realities of limited availability and accessibility of health care by the poor, especially in rural areas, the need for a health worker for community outreach activities was realised in the country. A number of civil society groups pioneered the development of successful community health worker models in different parts of the country to introduce CHWs for primary health care provision.

Tracing this long history of innovations and experimentation in the area of community health and CHW programmes, Dr. Ravi Narayan noted the *Tais* of the Comprehensive Rural Health Care Project in Jamkhed, the *Sahyoginis* of the Foundation for Research in Community Health (FRCH) in rural Maharashtra, the health activists of Aarogya Iyakkam in Tamil Nadu, the Health Aides of the Rural Unit for Health and Social Affairs (RUHSA) Project in Vellore, the maternal and child health workers of the Child In Need Institute in West Bengal, the health workers in the Arogya Sathi programme of CEHAT, and the neonatal health workers of SEARCH in Ghadchiroli as having achieved some success in emphasising an empowerment approach to health and in achieving desired impact on health outcomes, albeit with limited population and geographical reach.

While civil society groups have shown successful impact of community health worker programmes in achieving better maternal and child health outcomes, those undertaken by the state at scale have shown mixed results. Noteworthy among these are the Community Health Volunteer Scheme initiated in 1978 by the post-emergency Janata Dal Government, which launched one paid and incentivised CHW per 1000 population for addressing simple medical

aid, preventive and promotive care; and the Jan Swasthya Rakshak programme launched by the Government of Madhya Pradesh in 1995, introducing one CHW per village without a functioning sub–centre to treat minor ailments and implement national health programmes on the charge of user fees from the community.

These programmes, however, did not have the desired impact on health outcomes due to structural gaps in the system, issues in training and lack of supportive human resource. Some of the prime factors related to such experiences with community health worker programmes can be traced to issues of design and implementation of the programmes – the role attributed to the CHW, the lack of community based support structures and linkages with the public health system, degeneration of the CHWs into providers of irrational care, inadequate training of the CHWs, extremely low salaries thus making them the lowest cadre of workers in the health system, selection of a majority of male CHWs thus leading to poor accessibility by women, extremely centralised and decontextualised approach leading to alienation of the civil society and lack of accountability of the CHW towards the community.[12]

In the policy environment, while the National Health Policy, 1983 had completely ignored the component of community health, notably after the failure of the CHV Scheme, the National Health Policy (2002) and the Reproductive and Child Health Programme have revived the concept of community health, and within it the community health worker. Concurrently, the People's Health Charter of the Jan Swathya Abhiyan (2000) reflected on new ways of addressing the issue of "Health for All". The concept of the CHW also evolved in these 50 years from an alternative health care provider or extension worker of the public health system to a health empowerment agent working towards community mobilisation on health. The recent experience of the Swasthya Mitanin Programme (2001) in Chhattisgarh that has trained over 60,000 hamlet level women health volunteers performing the role of health change agents by providing preventive-promotive and basic curative care to the communities. Preliminary process and outcome indicators from national surveys on Chhattisgarh has generated a renewed energy around CHW programmes, and its possible efficacy at scale. More recently the National Rural Health Mission (2005) has placed the CHW – the Accredited Social Health Activist (ASHA) in this case – at the centre of all health sector reforms.

The National Rural Health Mission and Future Opportunities

The National Rural Health Mission (NRHM)[13] was announced in September 2004 as a part of the Common Minimum Programme of the Government of India with the following goal "*to promote equity, efficiency, quality and accountability of public health services through community driven approaches, decentralization and improving local governance"*.[14] The duration of the Mission is seven years (2005-2012) and its focus is on 18 states[15] where the challenge of strengthening the weak public health system and improving key health indicators is the greatest. Taking an 'omnibus approach' by integrating existing vertical health programmes,[16] the NRHM seeks to provide effective health care to the rural population,

[12] Sundararaman, T. 2005.

[13] National Rural Health Mission (2005- 2012), Ministry of Health and Family Welfare, Government of India.

[14] Ibid.

[15] These include: Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu & Kashmir, Assam, Arunachal Pradesh, Manipur, Nagaland, Meghalaya, Mizoram, Sikkim and Tripura.

[16] The vertical health programmes converged under the NRHM include the Reproductive and Child Health II project (RCH II), the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP).

especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralisation.[17]

The key components of the NRHM to achieve these objectives include the following:[18]

- **Accredited Social Health Activist (ASHA) Programme:** The core component of the NRHM is the Accredited Social Health Activist (ASHA) Programme, which involves placing a community based change agent at a 1000 population level, to catalyse a sustainable community-owned process for behavioural change and to facilitate access to basic health services by the poor. The primary role of the ASHA is to create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of desired health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

- **Strengthening public health infrastructure:** The NRHM recognises that strong public health systems are imperative for achieving improved health outcomes. The Mission has allocated additional funds for strengthening the public health service delivery infrastructure, particularly the sub centres, the PHCs and the CHCs for the provision of primary and first contact curative care. This would be accompanied by improved management capacity to organise health systems and services in public health by emphasising evidence based planning and implementation.

- **Fostering public-private partnerships:** The NRHM will support civil society participation to increase social participation and community empowerment, promoting healthy behaviors at the community level, and improving intersectoral convergence. This component also includes the regulation of the private sector to improve equity, transparency and accountability and reduce out-of-pocket expenses.

- **Decentralisation of health planning:** One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services. It envisions the setting up of the State Health Mission led by the State Departments of Health and Family Welfare, the District Health Mission led by the Zila Parishad and the Village Health Plan to be formulated by the Gram Panchayat. The NRHM has created structures at each of these levels for the planning and implementation of the initiatives to be undertaken within the Mission.

Given the failures of CHW programmes at scale and the hopeful experiences from the recent Mitanin Programme in Chhattisgarh, the NRHM has identified the impediments of the past scaled CHW programmes and has recognised the need for change. The disparity in experiences of CHW programmes initiated by civil society groups in intensive field areas and by states at scale can be traced to three main factors namely, *programme design* that involves the conceptualisation of the role and profile of the community health worker, support structures at the level of the community and linkages with the health system; *lack of state*

[17] National Rural Health Mission (2005- 2012), Ministry of Health and Family Welfare, Government of India.

[18] Ibid.

capacity in terms of technical resources to conceptualise and implement the programme at scale; and *lack of civil society participation* in designing and implementing these programmes in order to draw on the experience and technical knowledge of such groups to formulate informed state policies. It is in the light of this problem analysis that the NRHM has adopted the above mentioned core strategies.

Dr. D.C. Jain's presentation about the NRHM and the ASHA highlighted the opportunities for the state, civil society and other stakeholders to participate in the design and operationalisation of what would be the largest CHW programme in the world, and make a significant impact on the health of the country. Though improvements in some parameters like disease control depict a picture of achievements, the country cannot afford to overlook the overwhelming concerns and deterioration of health standards among the poor.

The main constraints that faces the state and the programme currently related to the differences in vital health indices such as infant mortality, neonatal mortality and maternal mortality among socio-economic groups; critical shortage of human power in the health sector; huge regional disparities between states, between rural and urban areas, and between different classes; the largely unregulated private sector that is gaining prominence with the continued absence of the public system; and issues related to quality of care in both public and private health systems . In programmatic implementation, lack of adequate monitoring mechanisms in formulation of schemes by the centre poses as one of the major barriers to the success of programmes with desired results on the ground. Besides these, the workshop highlighted the issues, debates and queries relating to the perceived lack of autonomy for states in decision making and fund utilisation vis-a-vis the central government, the gap that arises due to this between conceptualisation and implementation, and the lack of state capacity to independently undertake these functions. Moreover, the ambiguity in the implementation plan regarding selection, training, support structures, linkages with the public health system, monitoring and evaluation, and fund allocation for the ASHA programme was also raised.

However, the workshop perceived the current political prioritisation of health with optimism, as an opportunity for the community to participate in health production and in holding the public system accountable for the provision of mandated health services. The NRHM was perceived as a renewed political commitment of the present government, presenting an opportunity for mainstreaming the experiences and learnings from civil society innovations.

Innovations in Training Content and Methodologies in Community Health Worker Programmes

In the current context, though a large amount of work has been undertaken on CHW field experiences by different groups, a need exists to consolidate the learnings from these. Selection and training of CHWs have been identified as critical factors contributing to the success or failure of a CHW programme and its impact on the health outcomes of a community. Within the paradigms of sustainability and quality of CHW initiatives, 'training' acts as the base for any programme. Whether the programme is at scale or at the level of small programmatic intervention, its quality and impact is reflected through the quality of the training imparted to the CHWs. As isolated populations increase, their dependence on these frequently over-burdened health workers also increases; and providing CHWs with the tools to do the best job possible falls to those who supervise and train them. Access to basic training has been found to be a fundamental need of CHWs, and improving access to training is an important element of improving retention.[19] Despite the importance of CHWs and the need and

[19] Landon et al., 2004

relevance of training, the challenges of providing them with high-quality training opportunities remain. Training of CHWs in different programmes is variable in terms of content and methodologies, and keeping with the challenges of limited infrastructure, distance from population and lack of capacity in personnel, cultural and social norms, and the high turnover of key staff, various CHW programmes have innovated in the area of training content and methodologies.

The workshop highlighted innovations in training community health workers in various programmes from different parts of the country. The discussions on the training models and systems in the Comprehensive Rural Health Care Project of Jamkhed; the training methodology and content developed by FRCH; the innovations in using information-communication technology in CHW training; and the training structures and support systems in the Mitanin Programme of Chhattisgarh contributed to ideas about planning and implementation of CHW programmes at scale.

Learning by Sharing – Jamkhed: The approach in the Comprehensive Rural Health Project in Jamkhed has focused on training CHWs on social determinants of health. The problems of ill health, undernutrition and starvation, maternal and child morbidities are rooted not merely in biological causes, but have strong social, economic, political and cultural determinants. The training of CHWs, therefore, to address these problems cannot be restricted to medical knowledge, but in bringing about social change and community mobilisation, and to act as a bridge between the community and the health system. The CHW's role in this project has been to demystify health, demand accountability from the public health personnel, and educate the community to utilise the system. As a community organiser and educator, and as an independent person outside the health system, the CHW needs to have a strong sense of self-esteem, which can be derived from these trainings. The project focuses 50 percent of training time on the individual growth of the woman who is selected to play the role of a health worker, incorporating sessions on income generation programmes, optimal utilisation of natural resources, accessing different schemes for poverty alleviation and other entitlements. The other 50 percent of the training programme covers technical issues such as knowledge and skills to diagnose and manage minor illnesses in an attempt towards demystification of health and in order to make the women experience the fact that knowledge on health is not the monopoly of medical doctors, but is people's knowledge.

The core innovation in the Jamkhed project was however, learning by experience and sharing among the CHWs. Apprenticeship where new participants accompanied the already trained CHWs during their work in the communities formed a major methodology of training. Another innovation was the organisation of residential training for the participants to learn from each other's experiences, analyse constraints to their work and formulate problem-solving strategies through locally contextualised folk media and pictorial content. The residential sessions also succeeded in overcoming prejudices that the participants had about caste and religion, as women would share the same living space, cook and eat together, and share water sources. Sharing therefore, formed the most crucial component of the training process to inspire new CHWs, learn from experiences, and form a consolidated support system for each other to facilitate and strengthen their work.

Empowering to Learn – The Foundation for Research in Community Health: Drawing primarily from Paulo Freire's concept of 'conscientisation', the main aspects of the FRCH training approach draw from theories of 'education for change'[20] and are aimed to take the

[20] The concept of 'education for change 'was first utilised by the Brazilian educator Paulo Freire , an

CHWs through a process of awareness, professionalism and idealism, harnessed within the individual women in congruence with the needs of her community. FRCH's approach to training constitutes a judicious mix of social and technical components of health, with focus on socio-economic and political determinants of their communities' health status, introducing cross cutting themes of integrity, equity, and gender equality, as well as initiatives in confidence building and attitudinal change of the women. The primary aim of training is understood as empowering the rural women to learn – seek new knowledge, information, and inculcating the confidence to translate this into practice by applying the knowledge to their environment. With the larger aim of creating a 'people's health movement', all training seeks to 'demystify' medicine and emphasise people's own role in their health care.

Continuous revision and updation of training curricula and material, ensuring hands-on clinical and technical training and continuing education for the trainees are other aspects of their training approach. The FRCH approach is not just concerned with imparting training for the current issues, but also about the individual's self development, charting out future directions for CHWs in constructing career ladders through accreditation of training and promotion in roles and functions. The trainings begin with mere exploration of ones self and surrounding environment, followed by becoming a participator from a spectator, and then becoming a contributor. Lateral linkages among the health workers are essential for continuous learning, which in turn facilitates social change.

Another significant innovation by FRCH has been the discourse on training of trainers. The trainers are believed to be learners and facilitators than merely teachers. Adopting a non-formal methodology of organising training – completely decided by the problems and needs of the community, and the comfort and competencies of the CHWs to absorb new information – the trainers take an Amygdalian Approach, which focuses on the "emotional" versus the "logical". The knowledge through training is therefore, not the 'What', but the 'Why' and the 'How'.

Cascade Approach – The Mitanin Programme: Given the criticality of training, the Mitanin Programme needed to articulate its training curriculum and strategy at the outset. The training curriculum constitutes what competencies the programme would build, that is, the training syllabus, and how these competencies would be transacted, that is, the training methodology. The training strategy relates to how the training of such large numbers of community health volunteers, their trainers and the various cadres of personnel in the programme would be organised and undertaken.

Because of the scale of the programme with 60,000 health workers, one in each hamlet of the state, the training in the Mitanin Programme adopted the cascade approach – where different cadres of trainers and supervisors were created, and training was undertaken systematically through these levels. This structure has one Prashikshak for every 20 Mitanins, who train the Mitanins directly, and in-turn are trained by the 3 coordinators in each block acting as district resource persons. These are supported by the field coordinator, at the level of 5 blocks,

approach centrally conceptualised to undertake adult literacy training. This methodology emphasises building abilities in adult learners to critically examine their own situation, understand and analyse the problems existing therein and then solving the problems through collective action. With Freire's methods, non- literate workers and peasants learned to read and write in record time, as their learning focused on what concerned them the most; their problems, hopes, frustrations etc. in their lives. For more details refer to Werner, David (2002): *Communication as if People Mattered: Adapting Health Promotion and Social Action to the Global Imbalances of the 21st Century*. Background Paper #5, for the People's Health Assembly, December, 2002.

providing regular inputs, monitoring and feedback to the State Health Resource Center. While the basic training methodology and strategy was conceptualised for the entire programme, there was scope for contextualisation of training methodologies made possible by the decentralised cascade approach. For example, although the medium of training and the training content were primarily in Hindi and Chhattisgarhi, in contexts where these languages were not apt media to transfer information, hand made modules and posters in local dialects were used. Due to the scale of the programme, mass media could be effectively used in the training and orientation of the CHWs. A radio programme of 16 episodes along with supplementary television accompaniments broadcast 'Kahat Hai Mitanin', as well as innovative folk media and theatre, 'Kalajathas', were used towards this effort.

The innovation in the Mitanin Programme was therefore, to operationalise CHW training at scale – not through a centralised group of trainers, but in a decentralised way with trainers who are closer to the CHWs and more accessible to extend supportive supervision. Besides this, contextualisation of content and methodologies to suit local sensibilities, and balancing this with the need to have a common approach and ideology that do not get lost in transmission through the various levels of the cascade approach, have been issues that this programme has addressed continually.

Teaching Skills to Community Health Workers

A WHO Study Group defines the term community health workers as, '*Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers'.*[21]

Although this definition describes the profile of a CHW and her relationship with the community, it does not prescribe her role or the activities that she undertakes, and there has, indeed, been immense diversity in the roles that CHWs have played under different programmes, in different geographies. Therefore, the broad umbrella term CHW includes the most generic type of community-based workers who create awareness and mobilise the community around health, as well as a range of more specialised workers who perform specific roles such as prevention of communicable diseases like malaria or HIV/AIDS, undertake community-based directly observed therapy short-course for tuberculosis, provide immunisation and other basic child health services, or provide family planning and other reproductive health services. All these types of CHWs perform one or more functions related to health care delivery, and are trained in knowledge and skills related to their envisaged role. As is evident, the training content, methodology and approach are determined by the defined role of the CHW. This in turn, is ideally determined by the needs of the community, the context in which the CHW programme is conceptualised and implemented, and ultimately the problem analysis and the objectives of the CHW programme.

Broadly, the roles and therefore, the training of CHWs can be classified into two categories – teaching clinical skills and training on health education.

Training on Health Education: Information asymmetry, especially on health related knowledge, is widespread among rural populations living in poverty. Information asymmetry and lack of knowledge and information among the community, leads to faulty practices related

[21] World Health Organization. Strengthening the performance of community health workers in primary health care. Report of a WHO Study Group. Geneva, World Health Organization Technical Report Series No 780, 1989.

to child caring, feeding and food practices for women, especially during pregnancy and after delivery, as well as pose barriers to health seeking behaviours. The consequences of such asymmetries also get manifested in lack of awareness about entitlements from the public health system, and therefore, inability to access them. For instance, the lack of awareness about services being provided by the Sub Centre leads to a lack of demand, inaction when services are not provided, and a perpetuation of inefficiencies and performance of these facilities in the absence of any community monitoring and accountability. Besides these, various social determinants of ill health relate to behavioural factors that can be changed through information, knowledge and empowerment to translate this into practice. These realities have necessitated community mobilisation and organisation around health, and various programmes have envisaged the CHW to represent the community and play the role of a mobiliser or a health activist who educates communities to take collective action and facilitates the process of empowerment.

In many resource poor contexts where there is an acute shortage of clinical personnel and healthcare professionals for delivering care and counselling families for behaviour change, training CHWs as agents of behaviour change communication and health and nutrition educators has been shown to yield significant impact. The advantages of this strategy are manifold – these local workers are familiar with and sensitive to the contextual realities and can therefore, impart culturally appropriate messages. Besides, the mothers and families can identify with these local workers more than they can with healthcare professionals in health facilities. The CHWs are present in the community, and are not subject to transfers and changes on the basis of human resource policies of the health system. The sense of permanency and rapport with the community increases the probability of affecting sustainable behaviour change.

Focusing on the need to change behavioural determinants of health and improve health seeking behaviours of communities, Dr. M.S. Menon presented the theoretical constructs of behaviour change communication. The identification of determinants of health behaviours at various levels of the environment – individual, household, community and systemic; the skills to impart knowledge about appropriate health behaviours; and the ability to translate this knowledge into practice in an enabling environment form the core of training curricula of CHW programmes. Training on health education for CHWs have mainly focused on knowledge of social, economic and political determinants of health at The experiences, as presented in the workshop, of the CHW programmes in FRCH, Jamkhed and Chhattisgarh have concentrated on this component in training. Even at scale, the NRHM has envisaged the training to concentrate primarily on preventive-promotive and health education roles for the ASHA in the first few phases.

Due to its nature of recognising the multifactorial interrelationships among the determinants of health, training on health education and behaviour change often extends beyond preventive-promotive functions of the CHW to include community mobilisation and action around other social issues. Illustrations exist in various contexts, and some of them were highlighted in the workshop – action against gender discrimination (such as FRCH Sahyoginis mobilising women to take action against domestic violence), deforestation and right to food (such as Mitanins actively opposing and monitoring their entitlements to food schemes and forest produce for livelihoods), and caste discrimination (as addressed in innovative ways in the Jamkhed training process).

Teaching Clinical Skills: Teaching clinical skills to CHWs arise out of the existing context in which there is a complete lack of availability and accessibility to primary health care. In certain

geographies the absence of the public health system and exclusion of certain communities on the basis of caste, class, religion or gender has necessitated the training of local workers on providing basic primary health services. One common debate regarding clinical training is the level and depth of knowledge and skills imparted to the CHW. The range of clinical skills of CHWs has itself been varied in different programmes, from only diagnosing illnesses and referring to appropriate health facilities, providing symptomatic curative care for common ailments such as paracetamol for fevers, cold and cough, oral rehydration salts for diarrhoea, and chloroquine for malaria, to more advanced clinical skills such as syndromic diagnosis, prescription of generic medicines, antibiotics and administration of injections. Training on clinical skills to neo-literate women in rural areas has adopted different approaches to transfer the technical knowledge, reinforcing this and applying this in practice.

Sharing the approach used by the Yashwantrao Chavan Maharashtra Open University (YCMOU), Dr. Shyam Ashtekar highlighted the diagnostic matrices and classification of illnesses into minor, medium, acute and chronic with correlated symptoms used in training clinical skills to CHWs. The flow charts that begin with a single manifested symptom for example cough and analyse it for possible complications and syndromes, from laryngitis to congestive heart disease, systematically. The Swasthya Sathi Programme, on the other hand, uses completely pictorial material to train non-literate CHWs on diagnosis of common illnesses and provide first contact curative care. While the pictures depict single symptoms such as fever or cold, diseases such as malaria is depicted as a collection of multiple symptoms such as fever at night, shivers, headaches and nausea.

The nature of clinical skills is accompanied by the dangers of irrational drug use, incorrect diagnosis or treatment, iatrogenic effects, as well as degeneration of the programme into quackery. While in smaller programmes close supportive supervision and monitoring of curative functions of the CHW can be practiced to prevent such outcomes, these dangers get magnified in the context of large scale programmes. The experience with the state-wide Jan Swasthya Rakshak Programme in Madhya Pradesh illustrates this point, where the CHWs were primarily trained on clinical skills, but the lack of strong supervision led to widespread malpractices and the eventual demise of the programme. Related to this issue is the debate about the right time to introduce curative component in training. While the experience in some contexts is to have clinical skills as the first component of training to equip the CHW to address the large unmet community needs for curative care and thus establish her credibility as an agent of health, other programmes have believed that training needs to start with health communication for preventive-promotive components, so that the CHW is familiar with the concept of health and illness and their social determinants before practicing diagnoses and prescriptions. The ASHA Programme has adopted the latter approach, and has introduced first contact curative care training in one of the last phases of the training process.

A prominent debate concerning the clinical role of the CHW is related to the need for demystification of medicine versus the trivialisation of health for the poor. Demystification of medicine has been a significant rationale for training poor, rural, often non-literate women on biomedical knowledge and skills, that has been overwhelmingly exclusive to medical doctors, mostly male, from urban, socio-economically privileged backgrounds. Integration of social determinants and local knowledge on health in CHW programmes has questioned this hegemony and has placed “people's health in people's hands”. On the other hand, a clinical role of CHWs has been critiqued on grounds of trivialisation of health of the poor. While the socio-economically privileged groups access healthcare from super-specialty hospitals, the poor rural populations of the country, which have been long denied even the basic minimum health services, are perceived to suffer from “small” problems and would access healthcare from a non-literate CHW with basic training on curative care. These arguments were presented

by Dr. Yogesh Jain in the workshop, who highlighted the difference in health services and medical prescriptions envisaged for "us" and "them", captured aptly by his statement - "shorn of all components of primary health care, it is a second rate 'doctor' that we offer to the "others"." However, while the need for organising communities around health, having decentralised representation of the vulnerable, and extending access to primary care for unreached populations are essential in the current context, and these roles can be played by a CHW, the need for secondary and tertiary care, of health facilities and medical doctors for these communities cannot be substituted.

CHW Training in Varied Contexts

CHWs engage with the health effects of gender discrimination, illiteracy, hunger and food insecurity, militarism and conflict. The workshop discussed issues related to the need for contextualisation of CHW training to respond to the heterogeneous realities like the relative strength and ubiquity of public health facilities, the prevalence of non-literacy among CHWs and situations of political strife and conflict.

Dr. Lindsay Barnes highlighted the issue of **integrating gender in CHW programmes**. Experiences of Jan Chetna Manch from rural Jharkhand emphasised the need to focus on gender as an underlying factor in health, and therefore, the necessity to build perspectives on gender into training programmes for CHWs. Given that women suffer from a disproportionate burden of ill health but have lesser access to health care and related resources, and that the design of a majority of CHW programmes, including the NRHM, have conceptualised poor rural women to be trained as health workers with the primary focus on maternal and child health and nutrition, integrating perspectives on gender in planning and implementing these programmes is imperative. Some of the core areas of emphasis to operationalise such integration are selection of CHWs, designing gender sensitive training content, selecting and training trainers to be gender sensitive, and empowering women CHWs to assert their rights for equal opportunities in health and other areas. The CHW's attitudes towards social justice, equality and gender equity, and her social background (to ensure representation of the most powerless) are important factors that need to be considered for building a gender perspective into the training programme. The workshop raised concerns about the selection of only women as volunteer health workers, thereby adding to their workload. As the woman's context remains unchanged within the constraints of a patriarchal society, with the added roles of a CHW she has to counter discrimination and negotiate for opportunities in multiple spheres. In this, the presentation highlighted the gender determinants of health. The content and methodology of CHW training should recognise that differences in living and working conditions of men and women, and their differential access to various resources including healthcare and food significantly affects women's health and their health seeking behaviours. Moreover, gender is an omnipresent theme that interacts and exacerbates discrimination on the basis of caste, class, and religion, and cannot be addressed in isolation. Training needs to build a gendered understanding of health, and include gender analysis to mainstream this understanding into the CHW programme and healthcare service delivery at large.

Education, especially for women, have been shown to improve health outcomes. Even basic literacy is correlated with greater use of health services, increased social status and decision making power for women. However, the burden of illiteracy falls overwhelmingly on rural women living in poverty. The illiteracy rates among rural women in the Empowered Action Group states is as high as 91 percent. Given the design of the NRHM of focusing on these states, and selecting disadvantaged women from the most backward and vulnerable areas as CHWs, non-literate women would form a majority of the ASHAs. In this context, recognising

the unique needs of this population, and addressing them in the conceptualisation and implementation of CHW training programmes, by innovating on content and methodology, is imperative for the training to be meaningful and for the ASHA programme to be effective.

Dr. Abhay Shukla shared the experiences of the Swasthya Sathi programme in tribal Maharashtra of training non-literate CHWs. The presentation highlighted the specificities of conceptualising training for non-literate workers by focusing on their knowledge and maturity gained through life experiences and strengthen their ability for abstract thinking. Their unfamiliarity and limited attention span with textual material, and firm socio-cultural beliefs, often superstitious due to information asymmetries are constant challenges that the content and methodology of the training programme had to counter. Given the unique characteristics of the population, Dr. Shukla spelled out some prerequisites in planning and operationalising training for non-literate CHWs. Adopting a 'user friendly' approach, the training content was designed with clear learning objectives where each new concept was organically linked to pre-existing knowledge in the communities, and used multi-coloured pictorial material with standardised symbols and innovative training aids to understand human physiology, disease, diagnosis and care. The training methodology was also contextualised to suit the needs of the CHWs. Avoiding didactic presentations and information overload, the methodology used small group discussions, role plays and games for learning by drawing from life experiences.

Political strife has an enormous and tragic impact on people's lives. It accounts for death, disability, destroys communities and cultures, and diverts limited resources from health and human services and damages the infrastructure that supports them. It is invariably the health of poorer and more vulnerable groups that is worst affected by political strife, terrorism and conflict. Conflict damages the fragile coping strategies of vulnerable households. While some of the impacts of political strife and conflict on health are obvious, some are more indirect and complex. The direct impact on mortality and morbidity of populations is apparent.

Dr. Sunil Kaul's presentation narrated his experiences in implementing CHW programmes in eco-politically unstable areas of Assam, with a complete absence of health facilities. The region has suffered deaths, physical and psychological disability resulting from almost 30 years of insurgency. Health supporting infrastructure, which was already in poor condition, have been destroyed – including health care facilities, electricity generating systems resulting in 87 percent unelectrified villages, transport and communication infrastructure shown by only 10 percent concrete all weather roads, and a complete lack of public health human resources, depriving the local population of access to basic health services. An indirect impact of this unrest has been the diversion of already limited resources of the government from strengthening these infrastructure towards measures for controlling terrorism. The area has only 3 ANMs for a population of over a lakh, and less than 5 percent immunisation coverage. Almost all other health infrastructure – sub-centres, primary health centres and health personnel are non-existent due to the prevalent violence in the area and an apathetic response arising out of delayed salaries and corruption. In this context of a cash starved economy, poor infrastructure, state bankruptcy, continuous political strife and poor governance, the CHW programme was conceptualised to mobilise the community around health and thereby create a sense of unity through a stable support structure. Given this context and the complete absence of health services, with medical expenses being the largest cause of debt, the CHWs were trained as healthcare providers in clinical skills, including diagnosis of illnesses and prescription of medicines. While facilitating community participation has been a constant challenge, training clinical skills to the CHWs have contributed to building confidence and a sense of empowerment among these chronically neglected people.

Evaluation and Monitoring of the Training Process

The desirability of assessing CHW knowledge and skills before, during and after training to stimulate learning and inform them about their own progress is almost unanimously recognised. Evaluation and monitoring involves setting standards or objectives and then comparing actual achievements against them. Evaluation and monitoring of the training process helps to refine planning and implementation of training, as well as to improve the skill level of individual CHWs. Monitoring of the training process involves the collection and analysis of a set of core training indicators for improvising training, assessment of learners and trainers, and directing learning towards meeting programme goals. CHW effectiveness and the impact of training depends greatly on various interrelated factors, including the pedagogy of the training, its methodology and approach, the organisational structure of the CHW programme with supportive human resources, capacity of trainers and the availability and accessibility of healthcare services. Due to this complexity of training evaluation, Ms. Seema Deodhar's presentation highlighted it is important to analyse a programme in both quantitative and qualitative aspects, in order to capture the behavioural, social and political determinants that contribute to differences in CHW training effectiveness. Monitoring and evaluation of a training process can be undertaken at various levels for evaluating different aspects of the training programme. The include process evaluation that focuses on correlating plans and set standards with ongoing implementation of the training programme; output evaluation that assesses the knowledge and skills that CHWs have acquired at the end of the training programme; evaluation of retention that focuses on post-training assessment of CHW knowledge, attitudes and skills after field experiences. In all levels of evaluation, Ms. Deodhar highlighted the importance of participation and eliciting feedback from the CHWs about their experiences in the training programme, and the recommendations that they have for the content and methodology of the training. The evaluation methods used by different CHW programme. Experiences of using pictorial logical frameworks by SATHI-CEHAT, structured examinations accredited by the National Institute of Open Schooling (NIOS) by FRCH, and community based structures and forums, such as the Prashikshaks in the Mitanin Programme, and cluster level meetings and village health committees in the Sahiyya Programme in Jharkhand are all innovative methods of evaluating and monitoring the CHW training process.

Another issue that was discussed in the workshop was accreditation and certification of CHW training programmes. The advantages of such arrangements are evident due to the need to ensure a desired level of standardised quality of services and effectiveness in their performance. The pedagogic involvement in the programme from professional educational institutes, through accreditation can raise the level of training-learning with technical inputs, and regular evaluation to enhance the quality of both trainers and learners. Moreover, accreditation can help in mainstreaming and replicating the CHW training content and methodologies. The experiences of the NIOS accredited CHW training modules of FRCH that are widely used by different accredited vocational institutes and civil society groups across the country exemplify these advantages. Despite agreement on these advantages, accreditation of CHW training is a contentious issue. The introduction of accreditation may delimit the selection of candidates on a basic literacy criterion. Besides, accredited evaluations of CHW training tend to over-emphasise knowledge of the CHW. Given the community mobilisation role of the CHW, it is not merely her knowledge about health, but her ability to translate it into practice, her negotiations with the community, and her skills in changing health related behaviours and practices are of significance, but are difficult to be evaluated through structured procedures.

All these experiences necessitate innovations in the area of training evaluation and monitoring, in order that these procedures comprehensively cover all aspects of a CHWs work, and are

designed to suit her context and profile.

CHW Training at Scale

There is no blue print for scaling any CHW training programme. The eventual success or basic effectiveness of the programme is dependent on a multifactorial base. This could include effectiveness of the existing system, conceptualization and planning of the programme, channels of implementation, assertion and replication of the basic tenets of the programme from the state, to the district to the block, village and hamlet levels, and eventually the kind of the political will that initiates the programme. The workshop discussed approaches to achieving scale for development programmes through state systems and people's movements. Experiences of the state level Mitanin Programme in Chhattisgarh in its attempt to sculpt out its own approach by integrating fundamental innovations in its design and implementation, have the potential to provide learnings for such programmes at scale. The workshop facilitated focused discussions on various aspects of CHW training at scale – content, methodology and human resources; monitoring and evaluation of training processes; support structures and partnerships.

Approaches to scale - missions and movements: This session on approaches to scale attempted to deconstruct the undertheorised concept of scale by highlighting the processes, resources and the shift in conceptualisation that are involved in undertaking interventions at scale. Scaling up is not just a process of multiplication, of more providers, more drugs, more facilities in more places, but entails a process of tackling the social, economic, and political contexts in which people live and in which health institutions are embedded to ensure that healthcare is accessible to and used by all those who need it. Both dimensions—concrete operational issues and wider, contextual issues—need sustained attention and investment. Social, economic and political conditions present complex environments that resist formulaic solutions, particularly when imposed from outside and above. But too often recognition of this fact spells paralysis or, even worse, new rounds of technical solutions designed to dodge the issues altogether.

It was this difference in thought and approach between scaled and smaller programmes, that was highlighted by Dr. T. Sundararaman in his presentation. His key point was that one needs to acknowledge the difference between scaled CHW programmes and small scale programmes. This is not merely a difference of numbers and geographical spread, but have implications on all aspects of implementing these programmes and hence, these should be viewed as two distinct entities and not classified generically as CHW initiatives. He went on to highlight the differentiating factors between small scale and large scale programmes. He explained that small scale programmes tend to be very focused, with high quality inputs. Analysing the experiences of small scale programmes, he pointed out that strong and dynamic leadership has been a core factor in these initiatives, which is very critical to their functioning and eventual success. Although these factors have made possible wide ranging innovations, evidence based outcomes and impact, and social change in the project geographies, he questioned the sustainability and replicability of these programmes in the absence of such concentrated efforts and leadership.

His presentation also highlighted the critical enabling and disabling factors that operate in the context of large scale programmes. Detailing out aspects for operationalising large scale training and a need to understand that the quality of training (which includes ongoing support, monitoring, referral support, evaluation) he explained that the idiom of opportunity needs to be explored in such large scale programmes. He also shared his experience of operationalising large scale programmes, that a certain pace within the programme needs to be maintained, and is critical to capture political commitment. He also felt that by reaching full coverage, a

large scale programme creates for itself a critical space within a state and is therefore, faced with issues of social, economic and political processes at the macro level, as well as problems of balancing contextualisation versus a uniform approach and perspective throughout the programme. Discussing the criticality of human resources in scaled CHW programmes, Dr. Sundararaman said that because of the large scale, motivation and capacity of personnel follow a Gaussian curve, where approximately 5 percent of all the individuals involved would have the sensibility, motivation and potential to contribute substantially to the work and impact the overall programme. Thus the training programmes need to address these differences, and be a learning experience for all sections of the human resource.

Analysisng the discussions in this session, the following points can be inferred as implications for conceptualising and operationalising scaled CHW programmes. First, context matters. The drive for technocratic, managerial fixes fails because of its inability to acknowledge that effectiveness in highly discretionary, transaction-intensive services, such as the aspects of healthcare in which failure has been most acute, truly cannot be one size fits all. Until initiatives genuinely draw on context-specific knowledge and local capacity, health initiatives will not succeed at scale. Second, values matter. When problems that are deeply political, that involve the distribution of power and resources, are systematically converted into managerial problems addressed by technical adjustments that avoid the heart of the problem, the result cannot be success. Standard health sector reform attempts at promoting equity are deployed around the edges of a system whose structure is profoundly inequitable. Until the structure is addressed, the solutions will not work. This does not necessarily mean that a massive, immediate overhaul is necessary. It does mean that values must play an important role in setting the direction of change, even if change is managed and gradual. Third, process matters. Conventional views of policymaking as a linear, top-down process of agenda-setting, policy design, and implementation miss the many forces from the ground up that have the power to sabotage or neutralise such plans. They also ignore the fundamental rights of people to have a say in their societies. Superficial attempts to engage so-called stakeholders will be experienced as just that. Fourth, acknowledging responsibility matters. To truly achieve the substance of the goals of the programme, one has to scrutinise how one's actions block progress and at the constraints faced by those on the other end of the process. This is not an excuse for status quo, but is the first step in changing the structure of development programmes and strategies at scale.

Content, methodology & human resources for CHW training at scale: Although training is only one element in the implementation of a CHW initiative, much of its content and methodology must reflect the underlying philosophies of the programme as a whole. Various CHW initiatives have innovated in creating inventive, engaging and contexualised content for training CHWs in their projects. This process becomes difficult as one aims to create similar quality content for scaled programmes. It also becomes difficult as programme designers of scaled programmes aim at large scale implementation; roll out strategies, which had been circumscribed within preset time periods and number based designs. The question to ask here would be how does a large scale programme ensure the creation of content with quality and sensitive to local realities. It is also critical to understand how a large scale programme will implement good quality training which contains within its methodology, a process of contexualisation and reflection on the realities and issues of particular areas and vulnerable groups. In state level initiatives the issue of providing training in vernacular languages as well as local dialects needs to be looked at critically and allocation of human resource and budgets needs to keep this in the purview.

The methodology of training at large scale is also faced with unique constraints and issues. A balance has to be maintained between the overall perspective of the programme and the need for contextualisation of the methodology to suit local needs. In this balance the dangers of transmission loss and dilution of the core approach of the programme are faced continually. It has been found that the didactic approach differs significantly from a more participatory methodology of imparting knowledge to semi literate adult learners. Though the didactic approach may work for imparting some aspects of the training content and may be easier to implement in large scale programmes, it has the risk of creating non- analytical, non reflective workers, who may perceive themselves as passive recipients rather than active participants in the process of social change. On the other hand, the introduction of a participatory approach requires strong and consistent management and the willingness to persist with it. Scaled programmes are also at a much greater risk of regressing into didactic forms of teaching, to meet their training round targets.

The length of the training period and the organisation of training sessions are also important considerations in scaled CHW programmes. Small scale programmes have mostly managed to provide on going, intensive supportive supervision, continuous reinforcement of training, and close engagement with their work to address the problems that may rise within it. This becomes particularly difficult in the case of scaled programmes, where the numbers are just too large, contexts are diverse, and capacity and motivation levels of human resources are varied. While a single training programme for an extended period of time has been found to be inadvisable for large scale programmes – mostly involving volunteers who have other engagements of livelihood activities – short term residential training is essential for the women to interact informally and form a support system. Concentrated pre-service training, followed by in-service training spread over a considerably long period of time can be adopted for large scale programmes, accompanied by on-going support, reinforcement, evaluations and refresher trainings.

This brings us to the issue of who should be the trainers and how should they be selected. This is an equally complex issue which involves understanding learning and teaching competencies of trainers, finding and selecting these trainers and then running them through rigorous routines of training. Although it is an operational issue, policy makers of scaled programmes need to carefully consider its implications for the overall planning and effectiveness of a programme and of the CHW's work. As it is understood in any form of education and conscientisation the effectiveness of any learning depends on those who have been selected to undertake the teaching process. It is also dependent on how they function within this teaching process and deliver the knowledge to the learners. Trainer selection and preparation, along with the choice of teaching methods, have great impact on the trainees ability to learn and also impart training to others. In scaled programmes, it gets difficult to ascertain the competency of each and every trainer and hence engaging and intensive training needs to take place for these trainers, before they begin to train others. Many large scale state run health worker programmes introduced CHW trainings, through teams of doctors and nurses existing in the primary health centers. This was found to be extremely problematic as the form and content of training became limited to medicalised knowledge on health, and ignored the larger socio-economic and political determinants of health. Other CHW initiatives created inter-disciplinary teams, with doctors, nurses, nutritionists, and social workers to impart their training and aimed to ensure a wider range of knowledge to be imparted to health workers. In selecting the trainers for a large scale programme, another crucial issue is continuous supportive supervision to the CHW. While technical knowledge is important, equally important in the context of CHW programmes is to select trainers who can provide continuous support to the hamlet/village level worker, and who is easily accessible by the worker. Due to these

considerations, large scale programmes have adopted cascade approaches to training where trainers at decentralised levels impart knowledge and provide support to the CHW, rather than a single resource group of trainers at the central level.

To address the issue of support structures, large scale CHW programmes need to rely on decentralised social capital, rather than a centralised resource group. As mentioned above, a large cadre of local trainers, at the cluster level, can play this role. However, to facilitate participation of the larger community in the CHW programme, other forms of support structures such as village health committees, women's groups, youth groups, Panchayats and other community based organisations have been explored.

Partnerships for CHW training at scale: The workshop emphasised the need for partnership building, capacity building and sharing of resources between the state and civil society in conceptualising, operationalising and implementing CHW programmes at scale. Drawing from the evidence and experience of the varied and contested history of state-civil society partnerships in the health sector, there was an emerging consensus that political spaces for productive engagement exist in certain situations and can be opened up and negotiated in others. The issue of partnerships was approached in this context and spirit of critical reflection on the scope, framework, types and the processes involved in building these relationships. Innovative ways of integrating civil society efforts and experiences in the field of CHW training with the vision and space provided by the state as articulated in the NRHM were discussed and hoped to be achieved.

Understanding the complexities for delivering quality in large scale CHW initiatives, it is important to conceptualise partnerships for a system of scaling. There have been a large number of experiments introduced to deliver this, whether it is inter-departmental collaborations between governments of different countries or states, between central and state governments, state governments and district administrations, inter-departmental partnerships, or partnerships between state and civil society organisations, as well as among different civil society organisations. The experiences have been too varied to propagate, although it has been seen that where civil society groups engaged closely with state departments, innovative partnerships could be initiated which had higher effectiveness at the field level.

There has been a varied and contested history of partnerships in the health sector. Rich evidence and experience from the past in Jharkhand, Chhattisgarh, Nagaland, Rajasthan and Gujarat were illustrated in the workshop. Although experiences have been too varied to propagate one particular model of partnership, there is emerging consensus however, that political spaces for productive engagement exist in some places and can be opened up and negotiated in others. It is in this context and in the spirit of critical reflection, that the workshop approached the question of partnerships. The nature of partnerships and the processes of facilitation are dependent on state-specific histories, current contexts and opportunities that exist because of various factors, ranging from political will, to perceived and actual openness on part of civil-society groups to engage with the state, experiences and opportunities to inform the programme and the availability of motivated human resource to translate this information into practice. Besides this, the purpose of forming partnerships may also differ. Programmes have experienced collaboration between multiple stakeholders in different stages – partnerships at the conceptual level, where stakeholders may come together to design the programme and formulate its strategy; or partnerships for operationalising and implementing the programme, which may involve policy detailing and the development of tools and instruments for implementation, as well as actual implementation aspects. The basic principles irrespective of the context is however, the shared ownership of the success or failure of the programme amongst all the partners, criteria for partnerships at various levels, and transparent

procedures for selection of partners.

Contributing to this discussion of partnerships for CHW training at scale, Dr. Alok Shukla and Mr. Biraj Patnaik shared their experiences of formulating innovative partnerships for the Mitanin Programme in Chhattisgarh. The process of partnership building involved consultations with government, funding agencies, professional bodies, NGOs, Panchayats and village level groups. The innovative partnership in the Mitanin Programme involved European Commission – which was the funding agency, Action Aid – a civil society organisation, and the Government of Chhattisgarh, which came together to create the State Health Resource Centre – an autonomous institution, with the role of technical assistance to the Ministry of Health and Family Welfare (GoC). Besides these partnerships at the level of conceptualisation and policy, implementation partnerships have been formed with grassroots level civil society groups, government health facilities, Panchayati Raj Institutions, and community based organisations. This unique collaboration and the creation of a unique structure like the SHRC facilitated the participation of different stakeholders in the programme, provided a platform for sharing and incorporating varied experiences and skills of the partners, and built a common ownership for the programme.

Summarising the need for building partnerships for CHW training at scale, it needs to be emphasised that partnerships can mobilise various stakeholders for participation in the programme. This is essential to create decentralisation in a large scale programme and counter the creation of singular power structures. Certain partners in the collaboration can play different roles in the process of operationalising the CHW programme, including training. Since government training initiatives tend to be more focused on technical inputs to CHWs for achieving quantitative outcomes (as seen in the Community Health Volunteer Scheme or the Jan Swasthya Rakshak Programme), partnerships with civil society groups can infuse field level experiences, community mobilisation skills, information about entitlements and rights, and analysis of social determinants of health into training. In formulating partnerships, the unique skills of each partner need to be maximised and expressed to benefit the programme. While civil society groups may contribute better in developing training content and methodology, the government departments bring the experience of operationalising programmes at scale and is mandated to meet the supply side of resources, health personnel, drugs and other requisites. On the other hand, engaging with heterogeneous civil society groups can bring in different social perspectives to the field.

Themes for Action:

The workshop is the beginning of a sectoral dialogue and indicates various initiatives that can be undertaken in the future to sustain and forward this effort. Some of the main recommendations and themes for action are the following:

- Government and civil society partnerships at each level of the decentralised structure of the NRHM – at the state, district, block and village levels – to facilitate training of the ASHAs, their trainers and the other personnel involved in this process.

- Capacity building and training of government personnel, especially at the district and block levels, on developing and implementing training for the ASHAs. At the state level, this can involve efforts such as workshops to orient the State Mission Directors / State Facilitators about the various innovations and best practices in CHW training in the sector.

- Integrating learnings from civil society innovations about community mobilisation and CHW training into the conceptualisation and implementation of, and support to the ASHA programme at the level of scale.

- Undertaking review and development of state training modules in a participatory manner by involving personnel from different levels, as well as seeking feedback from local and sectoral experts. Related efforts have been initiated in Jharkhand for the development of the Sahiyya training modules. The training content which was initially defined by personnel from the state, district and block levels, in collaboration with local civil society groups, is now being reviewed and finalised in a state level workshop by sectoral experts from across the country.

- Developing contextualised training content and methodologies, that can sensitively respond to the unique contextual realities in different geographies across the country. Contextualisation can involve development of training modules in local languages/dialects; designing content to address local problems, beliefs and practices; defining the roles and scope of the ASHA to best suit local needs; and adapting training to suit the profiles of the human resources available in different regions.

- Building gender sensitivity into training content for the ASHAs, as well as for personnel at all levels associated with the training system.

- Developing specific training content for non-literate ASHAs, keeping in mind the high prevalence of illiteracy in the country, especially among rural women.

- Consolidating sectoral experiences in CHW training into easily accessible resource material and undertake its active dissemination to facilitate the ASHA programme.

- Undertaking research on training content, methodology and systems in different contexts to build the body of sectoral knowledge.

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ANNEXURE: 1
Workshop Programme

Community Health Worker Training: Linking Pedagogy and Practice
A National Workshop
April 10 – 12, 2006
Tata Management Training Centre, Pune

Day I (April 10, 2006) **Community Health Worker Training: An Introduction**	
12:00 – 12:30	**Arrival & registration of participants**
12:30 – 13:00	**Welcome Address** by Dr. N.H. Antia, Director, Foundation for Research in Community Health, Pune
Lunch	
14:00 – 14:30	**Introductory Key Note: Historical overview of CHW programmes internationally** Speaker: Prof. David Sanders, University of Western Cape, South Africa
14:30 – 15:00	**Introductory Key Note: The Community Health Workers of India – Training Extension Workers or Activists?** Speaker: Dr. Ravi Narayan, Community Health Cell, Bangalore
Tea	
15:15 – 15:30	**The National Rural Health Mission: an overview** Speaker: Dr. D.C. Jain, Deputy Commissioner, Child Welfare and Training, MoHFW Government of India,
15:30 – 15:45	**Presentation by Health Workers**
15:45 – 16:30	Film on **'Life of a CHW:Reflections on training programmes and policies'** followed by discussion Director: Dr. Parvez Imam, f20 Communications, Delhi
16:30 – 17:00	**Setting the agenda of the Workshop** Speaker: Dr. Rakhal Gaitonde, Foundation for Research in Community, Health, Pune

Day II (April 11, 2006) **Innovations in Training Content & Methodologies in Community Health Worker Programmes**	
09:00 – 09:30	**Key Note: Adult learning principles – How community health workers learn** Speaker: Dr. K. Balasubramanium, Commonwealth of Learning
Session I: Panel Discussion	
09:30 – 10:30	**Approaches to training: Focus on content, methodology and human resources for training** Speakers: Dr. R. Arole, Comprehensive Rural Health Project, Jamkhed Mr. V.R. Raman, Mitanin Programme, State Health Resource Centre, Chhattisgarh Dr. N. Mistry, Foundation for Research in Community Health, Pune Dr. Shyam Ashtekar, Yeshwantrao Chavan Memorial Open University, Nasik
10:30 – 11:30	**Discussion** Discussants: Dr. Anant Phadke, SATHI - CEHAT, Pune Dr. D.C. Jain, Deputy Commissioner, Child Welfare & Training, MoHFW, Government of India
Tea	
Session II: Presentation of Case Studies	
A. Teaching Skills to Community Health Workers	
11:45 – 12:00	**Teaching clinical skills to CHWs** Speaker: Dr. Shyam Ashtekar, Yeshwantrao Chavan Memorial Open University, Nasik
12:00 – 12:15	**Training CHWs for behaviour change communication** Speaker: Maj. S. Menon, Kripa Foundation, Mumbai
12:15 – 13:00	**Discussion** Discussants: Dr. Yogesh Jain, Jan Swasthya Sahyog, Chhattisgarh Dr. S.C. Mathur, SIHFW, Rajasthan
Lunch	
B. Community Health Worker Training in Varied Contexts	
14:00 – 14:15	**Gender & social exclusion in CHW training** Speaker: Dr. Lindsay Barnes, Jan Chetna Manch, Jharkhand
14:15 – 14:30	**Training CHWs with low literacy levels** Speaker: Dr. Abhay Shukla, SATHI-CEHAT, Pune
14:30 – 14:45	**Training CHWs in the context of political strife** Speaker: Dr. Sunil Kaul, Action Northeast Trust, Assam

Day II (April 11, 2006) **Innovations in Training Content & Methodologies in Community Health Worker Programmes**	
14:45 – 15:45	**Discussion** Discussants: Dr. Narendra Gupta, Prayas, Rajasthan Ms. Arzoo Dutta, State Facilitator, NRHM, Nagaland
C. Partnerships for Community Health Worker Training	
15:45 – 16:00	**Partnerships for innovations in training CHWs in state programmes** Speakers: Dr. Alok Shukla, Secretary of School Education, Chhattisgarh & former Secretary of Health, Chhattisgarh Mr. Biraj Patnaik, Principal Advisor, Office of the Commissioners of the Supreme Court, Delhi
16:00 – 16:30	**Discussion** Discussants: ***Dr. D.K. Saxena, Joint Secretary, Department of Health and Family Welfare, Jharkhand*** Dr. Peter Berman, The World Bank, New Delhi Mr. J.P. Mishra, European Commission Technical Assistance
Tea	
Session III: Evaluating Training	
16:45 – 17:15	**Evaluation and monitoring of the training process** Speaker: Ms. S. Deodhar, Foundation for Research in Community Health Pune
17:15 – 17:45	**Discussion** Discussant: Dr. Nandita Kapadia, Institute of Health Management, Pune
17:45 – 18:15	**Pedagogy and Social Context of Empowerment - a Peoples' Health Movement Reflection** Speaker: Dr. Ravi Narayan, Community Health Cell, Bangalore

Day III (April 12, 2006) **Training Content & Methodologies for Community Health Workers at Scale**	
09:00 – 09:30	**Key Note: Approaches to achieving scale: Missions and Movements** Speaker: Dr. T. Sundararaman, State Health Resource Centre, Chhattisgarh Dr. Abhay Shukla, SATHI - CEHAT, Pune
Session I: Group Discussions	
09:30 – 09:45	**Introduction to group processes** by Mekhala Krishnamurthy, Social Initiatives Group, ICICI Bank, Mumbai
09:45 – 11:15	**Group Discussions on aspects of CHW training at scale** Chair: Prof. David Sanders, University of Western Cape, South Africa
Topics:	**Content, methodology & human resources for CHW training at scale**
	Partnerships at scale – focus on training CHWs
	Support structures for CHW programs at scale
	Monitoring training processes & outcomes at scale
Tea	
11:30 – 13:00	**Presentation by Groups**
Lunch	
Session II: Panel Discussion	
14:00 – 15:00	**Discussion on group presentations** Discussants: Dr. T. Sundararaman, State Health Resource Centre, Chhattisgarh Mr. J.P. Mishra, European Commission Technical Assistance, Delhi Dr. Abhay Shukla, SATHI - CEHAT, Pune
15:00 – 15:30	**Open Discussion**
Session III: Reflections and Future Directions	
15:30 – 15:45	**Open House: Participants' suggestions for future directions**
15:45 – 16:15	**Discussion** Chair: Dr. N. Mistry, Foundation for Research in Community Health, Pune Dr. Narendra Gupta, Prayas, Chittorgarh
Tea	
16:30 – 16:45	**Reflections on the Workshop** Speaker: Prof. David Sanders, University of Western Cape, South Africa

Day III (April 12, 2006) **Training Content & Methodologies for Community Health Workers at Scale**	
09:00 – 09:30	**Key Note: Approaches to achieving scale: Missions and Movements** Speaker: Dr. T. Sundararaman, State Health Resource Centre, Chhattisgarh Dr. Abhay Shukla, SATHI - CEHAT, Pune
16:45 – 17:00	Concluding remarks

ANNEXURE: 2

Participants

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